Community Alliance for Accessible Treatment

Rainbow Resilience Program Needs Assessment Report:

Barriers to HIV, HCV, and Sexual Health Services for LGBTQ+ Immigrants, Refugees, Newcomers, and Non-Status Individuals in Ontario

July 2026

CAAT Community Alliance for Accessible Treatment

Rainbow Resilience

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Acknowledgements

We begin by acknowledging that this work was conducted across what is now known as Southern Ontario, on the traditional territories of many Indigenous Nations, including the Anishinaabe, Haudenosaunee, and Wendat peoples. These lands are covered by numerous treaties and continue to be home to diverse First Nations, Inuit, and Métis communities. As a project focused on settlers, we recognize the layered histories of migration and displacement that shape this region. We are grateful for the opportunity to live, work, and engage in this work on these lands, and we commit to ongoing reflection of our responsibilities within this context. We encourage all settlers living on these lands to take time to learn whose land they are on, the histories and ongoing impacts of colonization, and the responsibilities that come with living and working on Indigenous land.

We would also like to acknowledge the financial support of the Government of Canada through the Department for Women and Gender Equality (WAGE). The Pathways to Queer & Trans Health Equity: Rainbow Resilience Project was made possible through WAGE funding, which supported the development of this needs assessment and the broader efforts to improve health equity for LGBTQ+ immigrants, refugees, newcomers, and non-status (IRNN) individuals across Ontario. We are grateful for this investment in community-driven research and knowledge mobilization, and for the opportunity to amplify the experiences and priorities of LGBTQ+ IRNN communities through this work.

This needs assessment would not have been possible without the generosity and collaboration of our many community partners. We extend our sincere thanks to the AIDS service organizations (ASOs), community-based organizations (CBOs), and other groups who welcomed us into their spaces, shared their networks, and supported engagement. Thank you for opening your doors to us, for your trust, and for the essential work you do every day to support your communities.

We are deeply grateful to our Advisory Committee, whose guidance shaped this project at every stage. Your thoughtful feedback, critical insights, and consistent engagement strengthened both our process and our findings. We also appreciate the care and openness you brought to each meeting, even (and especially) when entertaining our icebreakers.

We would also like to acknowledge the team at the Community Alliance for Accessible Treatment (CAAT), whose ongoing support and collaboration made this work possible. We extend special acknowledgement to Ann Faith Jacob for their invaluable support of this project. Your dedication to community approaches is reflected throughout this project.

Finally, and most importantly, we extend our deepest thanks to the community members who participated in this report. Your willingness to share your experiences and insights is the foundation of this report. We recognize the trust it takes to speak candidly about often difficult realities, and we are grateful. We hope that this report reflects your voices, and that it contributes meaningful ways to the changes you wish to see.

Authorship

This report was authored by the Rainbow Resilience team at CAAT, including Wania Amir Khan, Syed Mustafa Jamal, and Muhammad Furqan Waleed.

Community Validation and Review

To ensure the accuracy and relevance of the findings, a draft version of this report was shared with

participating community members, service providers, and project partners for review and feedback. Community members were invited to provide input over a two-week consultation period. Feedback received during this process was carefully reviewed and incorporated into the final report where appropriate. This validation process helped confirm that the findings accurately reflect the experiences, priorities, and perspectives shared by participants and strengthened the credibility of the recommendations presented.

Content Warning

This report contains discussions of HIV and sexual health, stigma and discrimination, homophobia and transphobia, mental health crises, trauma, housing instability, and experiences of systemic discrimination. These topics reflect the lived realities shared by participants in this needs assessment. Readers are encouraged to engage with this material at their own pace and to seek support if needed.

Executive Summary

Background and Purpose

The Rainbow Resilience Needs Assessment was conducted by the Community Alliance for Accessible Treatment (CAAT) as part of the Pathways to Queer & Trans Health Equity: Rainbow Resilience Project, funded by Women and Gender Equality Canada (WAGE). The purpose of this assessment was to better understand the barriers, gaps, and opportunities related to Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), sexual health, and related health and social services for Lesbian, Gay, Bisexual, Trans, Queer+ (LGBTQ+) immigrants, refugees, newcomers, and non-status individuals (IRNN) across Ontario.

While research has examined LGBTQ+ health and IRNN health separately, far less attention has been paid to the experiences of individuals who exist at the intersection of both identities. LGBTQ+ IRNN often navigate multiple and overlapping forms of marginalization related to sexuality, gender identity, race, migration status, language, socioeconomic position, and HIV status. These intersecting experiences can shape access to care in ways that are not adequately captured within existing health systems, policies, and service delivery models.

Methodology

Between September 2025 and February 2026, the Rainbow Resilience team engaged 198 participants, including 96 service users and 102 service providers, through surveys, interviews, and focus groups conducted across Southern Ontario. Participants were connected through partnerships with 31 organizations representing healthcare, settlement, housing, legal, HIV, and community sectors. The needs assessment sought to answer three questions:

1. What are the key gaps in resources, knowledge, or system capacity that limit effective HIV/HCV and sexual health service delivery for LGBTQ+ IRNN?
2. What barriers and challenges do LGBTQ+ IRNN face in accessing HIV/HCV and sexual health services in Ontario?
3. What changes to services, systems, or policies would most improve access to affirming, equitable, and culturally responsive HIV/HCV and sexual health care for LGBTQ+ IRNN?

Key Findings

Across participant groups, findings demonstrated that barriers to care are rarely isolated and instead operate through interconnected systems. While many services technically exist, participants described significant challenges navigating fragmented healthcare, settlement, legal, housing, and community support systems. Long waitlists, limited provider capacity, funding constraints, and uneven service distribution across regions created substantial barriers to accessing care. These challenges were particularly pronounced in smaller cities and rural communities, where specialized LGBTQ+, HIV, and IRNN-focused services were often unavailable.

Participants consistently highlighted difficulties navigating complex systems. Many reported uncertainty about where to seek services, confusion regarding insurance eligibility and healthcare coverage, lack of awareness of available resources, and imited understanding of their rights within Canadian systems. Frequent changes in immigration status often created additional uncertainty around service eligibility and continuity of care. Service providers similarly described relying on informal networks and personal relationships to coordinate services due to the absence of integrated referral systems and coordinated pathways.

Experiences of stigma and fear of disclosure emerged as pervasive influences on healthcare access. Participants described navigating stigma related to sexual orientation, gender identity, HIV status, immigration status, race, and mental health. Concerns regarding confidentiality were common, particularly among individuals accessing services within their own linguistic or cultural communities. Many participants described feeling disconnected both from their cultural communities due to fears of homophobia, transphobia, or HIV-related stigma, and from broader LGBTQ+ spaces due to a lack of cultural representation and understanding. These experiences often resulted in social isolation and delayed engagement with services.

Language barriers and the lack of culturally responsive care further compounded access challenges. Participants described difficulties communicating with providers, limited access to professional interpretation services, and a shortage of translated educational materials. Many also reported encountering care that did not adequately reflect their understandings of health and well-being. Participants highlighted experiences of discrimination, misgendering, racism, gatekeeping, and dismissive treatment within healthcare and social service settings, contributing to distrust and healthcare avoidance.

Despite these challenges, participants also highlighted numerous strengths within their communities and existing service systems. Throughout interviews and focus groups, both service users and providers frequently shared examples of compassion, advocacy, community leadership, and innovative service delivery. Many organizations were described as providing critical support despite operating with limited resources, while peer workers were consistently identified as trusted sources of information, support, and connection.

Priority Areas for Action

Participants identified four broad areas for action. First, increased and sustained investment is needed to strengthen organizational capacity, expand services, reduce waitlists, and improve access across regions. Second, healthcare, settlement, housing, legal, and community sectors must become better integrated through coordinated referral pathways, centralized navigation tools, and stronger partnerships. Third, organizations must invest in culturally responsive, linguistically accessible, trauma-informed, and affirming care that reflects the realities of diverse LGBTQ+ IRNN communities. Finally, participants emphasized the importance of strengthening peer-led approaches through improved compensation, training, supervision, and support structures.

The findings of this assessment are already informing the next phase of the Rainbow Resilience Program. Key recommendations have directly contributed to the development of the Sexual Health Services Roadmap, an Ontario-wide resource directory; the Connected Care Pathways Tool, an interactive navigation platform currently under development; and a Peer Navigator Training Program designed to build community-based navigation capacity across the province. In response to identified language barriers, program materials are also being translated and culturally adapted in partnership with community members.

Conclusion

Ultimately, this needs assessment demonstrates that improving HIV, HCV, and sexual health outcomes for LGBTQ+ IRNN requires more than increasing service availability alone. Participants emphasized the need for systems that are coordinated, culturally responsive, linguistically accessible, trauma-informed, and rooted in community relationships. By centering the experiences and expertise of LGBTQ+ IRNN themselves, this report offers practical recommendations for strengthening health equity and improving access to care across Ontario.

Background

Organizational Context

The Community Alliance for Accessible Treatment (CAAT) is a community-based, non-profit organization incorporated on December 1, 2022 (World Acquired Immunodeficiency Syndrome (AIDS) Day), building on the longstanding legacy of the Committee for Accessible AIDS Treatment, which has supported communities impacted by Human Immunodeficiency Virus (HIV)/AIDS since 1999. For more than two decades, CAAT and its predecessor initiatives have worked to advance equitable access to care through community mobilization, education, capacity-building, service planning, and community-driven research focused on racialized, immigrant, refugee, and newcomer communities living with and affected by HIV/AIDS.

CAAT emerged from extensive community consultation and cross-sector collaboration among legal, health, settlement, and social service partners to address systemic barriers faced by people living with HIV, particularly those experiencing precarious immigration status and limited access to services. This collaborative foundation continues to shape CAAT's approach, which emphasizes partnership, lived experience leadership, and community-engaged solutions to improve health and wellbeing outcomes.

The Rainbow Resilience Program was developed in response to growing recognition that Lesbian, Gay, Bisexual, Trans, and Queer+ (LGBTQ+)* immigrants, refugees, non-status individuals, and newcomers, including those on student or temporary work visas (IRNN)*, experience unique and intersecting barriers when accessing HIV, Hepatitis C (HCV), sexual health, and broader health and social services. Despite these realities, the experiences of LGBTQ+ IRNN communities remain underrepresented in mainstream health research, service planning, and policy discussions, contributing to gaps in care.

CAAT's longstanding relationships with IRNN-serving organizations, AIDS service organizations, healthcare providers, and community leaders across Ontario positioned the organization to undertake the Rainbow Resilience Program. Supported through funding from the Equality for Sex, Sexual Orientation, Gender Identity and Expression (SSOGIE) Program by Women and Gender Equality Canada (WAGE), this initiative enabled the development of a province-wide needs assessment focused on understanding and addressing barriers to sexual health and related services experienced by LGBTQ+ IRNN across Ontario.

The needs assessment represents one component of a broader program that includes dedicated knowledge mobilization workshops, LGBTQ+ IRNN-focused resource development, and the creation of a peer navigator training program. Grounded in collaboration, the program has been shaped through ongoing consultation with community members, partner organizations, and the Rainbow Resilience Advisory Committee. Through these relationships, the program sought not only to identify barriers to care, but also to surface opportunities for strengthening systems of support across the province.

Research Team Positionality and Approach

This needs assessment was informed by a community-based and reflexive approach to research. The project team itself brought together individuals with diverse professional experiences, but also lived experiences as newcomers, members of LGBTQ+ communities, and people living with HIV. Throughout the project, the team remained mindful of the ways that power, institutional systems, and social identities can shape both participation in research and the interpretation

*See definitions section

of its findings.

Recognizing that no single perspective can fully represent the diversity of LGBTQ+ immigrant and refugee experiences, the project prioritized participant voice, collaborative interpretations, and continuous feedback. The findings and recommendations presented in this report are intended to reflect identified service gaps and priorities shared by participants throughout the assessment process.

Introduction

Ontario's IRNN Demographic Context

The term "Immigrant, Refugee, Newcomer or Non-Status Individual" (IRNN) does not correspond to a single official category.* In this report, it is used broadly to refer to people who have immigrated or relocated to Canada, regardless of immigration stream or status, or length of time since arrival. This includes permanent residents, refugees, refugee claimants, international students, temporary foreign workers, individuals with precarious or undocumented status, and others navigating settlement and integration within Canada.

Ontario remains the primary destination for IRNN to Canada and is home to one of the largest immigrant populations in the country. According to the 2021 Census, more than 4.2 million immigrants reside in Ontario, including nearly 585,000 admitted between 2016 and 2021.[1] In addition to permanent residents, Ontario is home to substantial populations of temporary residents, including international students and temporary foreign workers, reflecting the increasingly diverse pathways through which people arrive and settle in the province. During the 2016-2021 period, Ontario welcomed nearly twice as many permanent and temporary immigrants compared to the previous five-year census cycle, highlighting the province's rapidly changing demographic landscape.[1] This growth has continued in more recent years, with Ontario receiving over 40% of all permanent residents admitted to Canada in 2024.[2]

Settlement within Ontario is heavily concentrated within the Greater Golden Horseshoe (GGH), a region encompassing the Greater Toronto Area (GTA) as well as municipalities such as Hamilton, Niagara, Waterloo Region, Guelph, Barrie, Brantford, and Peterborough.[3] The GGH is Canada's largest urban and economic region and continues to experience significant population growth driven largely by immigration.

In 2021, Toronto was home to 29.5% of all recent immigrants in Canada, while nearby communities such as Kitchener-Cambridge-Waterloo, Hamilton, Oshawa, and St. Catharines-Niagara also attracted substantial populations.[4] However, IRNN settlement extends beyond the GGH as well to cities such as Ottawa, Kingston, Windsor, and London, as well as smaller urban and regional communities across the province.[4]

The concentration of IRNN populations within Ontario's urban and suburban centres has important implications for health service planning and delivery. As immigration continues to shape the demographic landscape of the province, healthcare systems, community organizations, and public services are increasingly required to respond to the diverse linguistic, cultural, and social realities of IRNN communities. Despite the size and growth of these populations, there are currently no direct population-level estimates of LGBTQ+ IRNN in Canada. This gap reflects a broader tendency within research and service planning to examine IRNN and LGBTQ+ populations separately, limiting understanding of how these identities intersect to shape health outcomes and access to care. The growing recognition of these limitations contributed to Statistics Canada's decision to include a sexual orientation question in the 2026 Census.[5]

*See definitions section

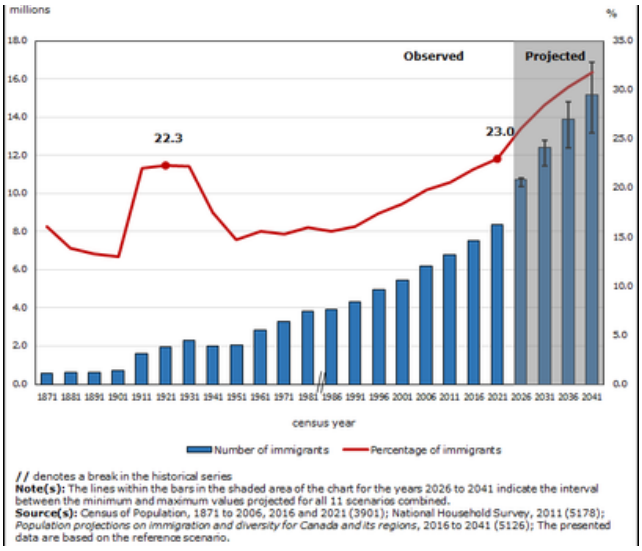

Figure 1. Nearly one in four people in Canada are immigrants, the highest proportion of the population in more than 150 years.[6]

Health Inequities Among LGBTQ+ and IRNN Populations

Substantial evidence demonstrates that LGBTQ+ populations in Canada experience significant health inequities compared to their heterosexual and cisgender counterparts. LGBTQ+ individuals exhibit elevated risks of mood disorders, anxiety, substance use, sexually transmitted infections (STIs), and chronic conditions such as arthritis and diabetes.[7-10] A landmark analysis of Canadian Community Health Survey (CCHS) data found that gay men, bisexual men, and bisexual women were significantly more likely to report poor mental and physical health than heterosexual respondents.[8] Longitudinal data from the Canadian Longitudinal Study on Aging (CLSA) further demonstrate that these disparities persist across the life course, with older sexual minority adults experiencing higher rates of new-onset mental health conditions and greater use of psychological services than heterosexual older adults.[9]

In addition to broader health inequities, LGBTQ+ communities encounter barriers to accessing quality healthcare. Structurally, Canada's primary care system struggles with timely access, leaving many without a regular primary care provider - a deficit particularly acute for transgender individuals, who experience high rates of unmet health needs.[7] At the provider level, a widespread lack of competency among both medical and non-clinical staff remains a critical barrier, forcing patients to either educate their own clinicians, face discomfort and invasive questioning, or experience discrimination. This lack of safe clinical environments cultivates a distrust of the healthcare systems, ultimately driving healthcare avoidance.[10]

These inequities are commonly understood through the minority stress model, which posits that health disparities among LGBTQ+ populations arise not from sexual or gender diversity itself, but from chronic exposure to stigma, discrimination, social exclusion, and structural barriers.[11] Minority stress theory distinguishes between distal stressors, such as discrimination and harassment, and proximal stressors, including concealment, hypervigilance, and internalized stigma. Together, these stressors contribute to increased psychological distress, poorer health outcomes, and healthcare avoidance over time.[11]

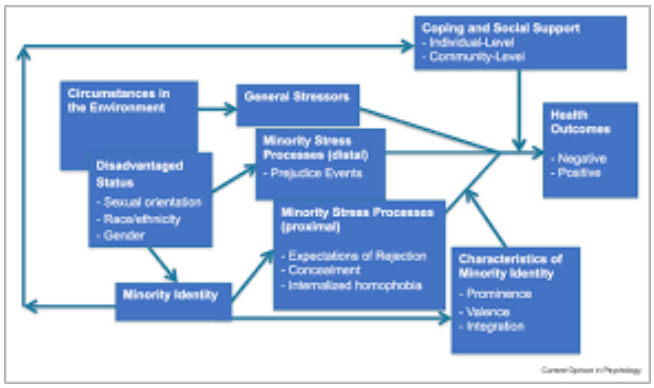

Figure 2. The Minority Stress Model.[11]

IRNN populations experience a different but equally significant set of health challenges. Acculturative stress refers to the psychological and physiological strain that arises when individuals undergo the process of adapting to a new culture.[12] Unlike general life stress, it is uniquely shaped by factors such as language barriers, loss of social support networks, and, critically, experiences of discrimination and marginalization within the host country, leading to elevated risks for anxiety, depression, and other long-term health

disparities.[12]

Research has consistently documented a deterioration in health following settlement in Canada, often referred to as the "healthy immigrant effect."[13-16] Analysis of the Longitudinal Survey of Immigrants to Canada (LSIC) found that 15% of recent immigrants reported a severe decline in self-rated health within their first four years in Canada, compared to only 6% of non-immigrants in a comparable age group.[16] This decline has been linked to post-immigration stressors, dietary and lifestyle changes, social isolation, and challenges navigating Canadian healthcare systems.[13-16] Recent HIV surveillance data further highlights the importance of understanding newcomer health experiences, with nearly half (47.7%) of first-time HIV diagnoses in Ontario in 2023 submitted by immigration clinics or physicians.[17]

Structural barriers further compound these challenges. IRNN often encounter language barriers, limited knowledge of available services, financial constraints associated with uninsured healthcare costs, and difficulties accessing primary care. These barriers can contribute to delayed care, unmet health needs, and poorer health outcomes.[18] Additionally, concerns related to immigration status and distrust of institutions may discourage some newcomers from seeking care.[18]

As such, experiences of health and healthcare are shaped by multiple and intersecting social identities. For LGBTQ+ IRNN; sexual orientation, gender identity, race, ethnicity, immigration status, language, socioeconomic position, and HIV status may interact in ways that create unique experiences of marginalization that cannot be fully understood through either a IRNN or LGBTQ+ lens alone.

LGBTQ+ IRNN at the Intersection

At the intersection of immigration status and sexual and gender diversity, LGBTQ+ IRNN experience compounding health inequities and distinct barriers to care. Research has identified elevated rates of mental health challenges, post-immigration social isolation, discrimination, and sexual health vulnerabilities, including increased risks associated with HIV acquisition.[19-22] Despite these needs, accessing healthcare remains challenging.

Evidence from Trans PULSE Canada demonstrates that trans and non-binary immigrant, refugee, and newcomers, particularly those with non-permanent residency status, face significant barriers to obtaining a primary care provider.[19] Even when care is accessed, many LGBTQ+ IRNN report encountering healthcare environments that are not culturally responsive or affirming. Providers may lack training in cross-cultural and gender-affirming care, resulting in experiences of discrimination, microaggressions, invasive questioning, or the burden of educating healthcare providers themselves.[19-22]

Although substantial research exists on LGBTQ+ health disparities and IRNN health outcomes independently, far less attention has been given to the experiences of individuals who occupy both identities simultaneously. Existing literature frequently treats these populations as separate groups, creating important gaps in understanding the barriers, service needs, and health outcomes experienced by LGBTQ+ IRNN. As immigration continues to increase across Ontario, there is a growing need for policies, programs, and services that recognize and respond to these intersecting realities.

Contribution of this Needs Assessment

CAAT as an organization has longstanding experience supporting people living with and affected by HIV and HCV across Ontario. Through partnerships with IRNN-serving organizations, AIDS service organizations, healthcare providers, and community leaders,

CAAT identified growing concerns regarding access to affirming and culturally responsive sexual health services for LGBTQ+ IRNN.

Funded by Women and Gender Equality Canada (WAGE), CAAT's Pathways to Queer & Trans Health Equity: Rainbow Resilience Project is a 28-month Ontario-focused initiative designed to address these gaps. The project seeks to better understand the health equity needs and barriers experienced by LGBTQ+ IRNN communities impacted by HIV/HCV through a province-wide needs assessment, intervention development, and external evaluation process.

The needs assessment was guided by three core questions:

1) What are the **key gaps in resources, knowledge, or system capacity** that limit effective HIV/HCV and sexual health service delivery for LGBTQ+ IRNN?

2) What **barriers and challenges do LGBTQ+ IRNN face** in accessing HIV/HCV and sexual health services in Ontario?

3) What **changes to services, systems, or policies would most improve access** to affirming, equitable, and culturally responsive HIV/HCV and sexual health care for LGBTQ+ IRNN in Ontario?

These questions position the report to address documented gaps in literature and practice regarding the intersection of residency status and LGBTQ+ identities. By centering the perspectives of community members, service providers, and community organizations, the findings aim to inform service design, provider education, peer navigation initiatives, and future interventions that advance health for LGBTQ+ IRNN communities across Ontario.

Methodology

Research Design and Conceptual Framework

This needs assessment used a community-based, mixed-methods approach to understand the sexual health landscape for LGBTQ+ IRNN across Southern Ontario. Our work is grounded in a holistic understanding of sexual health, one that extends beyond the absence of disease to include physical, emotional, mental, and social well-being, consistent with definitions from the World Health Organization.[23]

Recognizing that LGBTQ+ IRNN often face intersecting systemic barriers, we developed a framework outlining eight interrelated dimensions of sexual health support (Figure 3). These dimensions reflect the structural, clinical, and social determinants that shape access to care and overall well-being for LGBTQ+ IRNN communities and informed the questions explored throughout the needs assessment.

Governance and Stakeholder Engagement

This study was guided by a provincial Advisory Committee composed of service providers, researchers, and community members with lived experience. The committee met quarterly to provide input on research tools, recruitment strategies, and interpretation of findings, ensuring the process remained community-informed. Ethical approval for the project was obtained from the Community Research Ethics Office (CREO). All consent processes, needs assessment questions, data privacy protocols, and compensation structures were reviewed and approved prior to data collection.

Data Collection Strategy

Data collection took place between September 2025 and February 2026 and included 198 total participants including 96 service users and 102 service providers across Southern Ontario.

We used multiple data collection methods to ensure both accessibility and depth of insight. To preserve clarity of analysis and avoid duplication or misrepresentation of responses, participants were asked to engage in the needs assessment through a single data collection channel (survey, interview, or focus group).

Environmental Scan

We first conducted an environmental scan to map sexual health, HIV, and HCV services across Ontario. Southern Ontario was divided into Central, Eastern, and Western regions (Figure 4) to identify region-specific supports and gaps that would inform subsequent resource development.

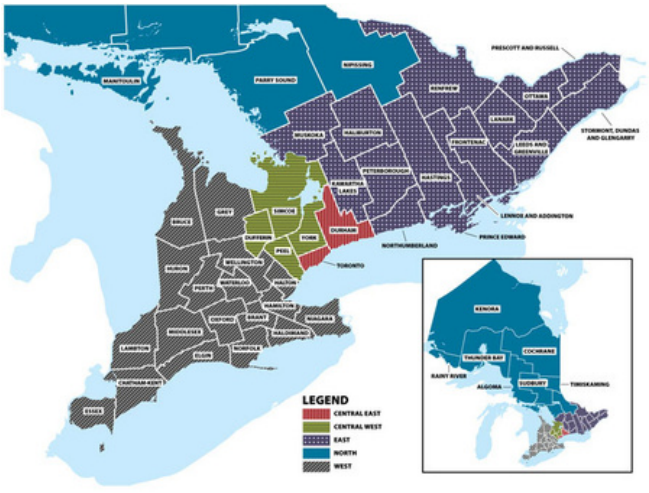

Figure 4. Map of GGH Regions.[24]

Figure 3. Core Dimensions of Sexual Health Support

Focus Groups

The preliminary findings of the environmental scan were subsequently validated through hybrid focus groups/workshops. Each 1.5-hour session served a dual purpose: to verify the completeness and share the findings of the environmental scan and to function as a semi-structured dialogue in which participants reflected on their lived experiences across the dimensions of our framework. Sessions were facilitated by a member of the research team in both in-person and virtual formats. Separate sessions were held for service users and service providers to create space for open dialogue and ensure participant comfort. All sessions were recorded and transcribed using the built-in Microsoft Teams transcription software, with a second team member monitoring the process in real time to ensure accuracy and data integrity.

Individual Interviews

To gain deeper, individualized insights, we also conducted semi-structured interviews lasting approximately one hour with service users and providers. These interviews explored personal experiences navigating sexual health systems, structural barriers to care, and participant-informed recommendations across the dimensions of our framework. As with the focus groups, interviews were conducted primarily in virtual formats and followed the same monitored transcription protocols to ensure accuracy and data integrity.

Surveys

An online survey was also administered to complement qualitative findings and identify broader patterns in service access, resource utilization, and perceived gaps. In addition to structured questions on services that participants accessed, the challenges they faced, and potential solutions they would like to see, there were also open-ended text fields to share qualitative insights and elaborate on their lived experiences.

Demographic Information

Demographic information was collected from all participants. Individuals self-identified as either service users or service providers, acknowledging that many participants hold overlapping roles within community systems; participants selected the perspective from which they wished to respond. Additional demographic data, including key identity characteristics and employment details for service providers, were collected to contextualize findings. All demographic information was stored separately from survey, interview, and focus group responses to ensure confidentiality.

Recruitment

Recruitment was conducted through an extensive network of partner organizations across Southern Ontario, including AIDS service organizations (ASOs), community-based organizations (CBOs), healthcare institutions, settlement agencies, and university-affiliated groups. These efforts were further strengthened through digital outreach, including social media engagement and online community networks.

Developmental Evaluation and Iteration

Rather than following a rigid, linear design, this study incorporated a developmental evaluation approach in partnership with the Centre for Community Based Research (CCBR). This approach positioned the methodology as adaptive. Participation patterns and emerging findings were reviewed on an ongoing basis, allowing for timely adjustments. This continuous cycle of reflection and adaptation ensured that the study remained responsive to community dynamics while maintaining the core research objectives. Evaluation findings can be found here.

Data Analysis

Following the completion of data collection, a multi-phase analysis strategy was employed to synthesize qualitative and quantitative findings.

To prepare the qualitative data for analysis, the research team engaged in a transcript cleaning process. All interview and focus group transcripts were reviewed to remove fillers, such as dialogue from the facilitator, and to redact any personally identifiable information. Furthermore, the team corrected errors generated by the AI transcription software, ensuring that the transcripts were reflections of participant contributions.

Once finalized, these cleaned transcripts were imported into Dedoose for systematic coding. We utilized a hybrid approach to codebook development, blending deductive and inductive methodologies:

Deductive Coding: The initial codebook was structured around our research questions, core dimensions of our sexual health framework, as well as common themes we had pre-identified.

Inductive Coding: Recognizing that new themes often emerged as coding progressed, the research team collaboratively refined, added, or edited codes to ensure that the codebook remained responsive to the emerging narratives of participants.

Following the initial coding phase, the team engaged in a thematic synthesis, grouping related codes to identify patterns, recurring barriers, and opportunities for improvement. This process allowed us to move the data to high-level thematic findings that address our core research questions.

The quantitative data derived from the surveys was analyzed using descriptive statistics to identify trends in service utilization, prevalence of specific challenges, and recommendations. These numbers allowed us to quantify some of the gaps reported by our participants, providing weight to the qualitative themes identified in the focus groups and interviews.

Demographic data were analyzed using the same descriptive statistical approach, we developed a profile of our study population, including breakdowns of service users versus service providers, ethno-racial distribution, LGBTQ+ identity distribution, immigration status, and other identities. This demographic analysis was essential for contextualizing the findings of our final report.

Participant Ethics and Compensation

Finally, the research upheld ethical standards through a commitment to informed participation. All participants reviewed and signed a consent form prior to engagement, outlining the purpose of the study, data collection procedures, confidentiality measures, and their right to withdraw at any time without consequence.

To recognize the time, knowledge, and lived expertise of participants, honoraria was provided ($15 for survey completion, $25 for interviews, and $40 for focus groups). Multiple payment options were offered to reduce barriers to participation, and identifiable information was collected separately from needs assessment responses to safeguard anonymity.

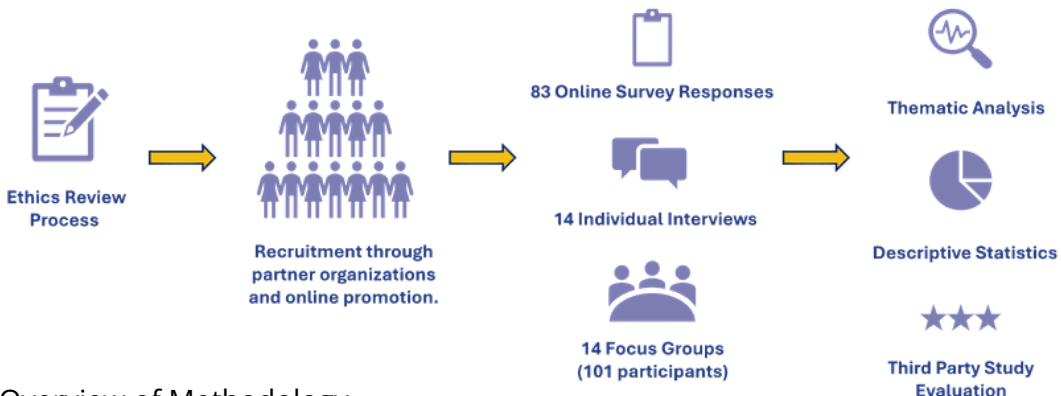

Figure 6. Overview of Methodology

Findings

Overview of Participants

A total of 198 participants contributed to this needs assessment, including 96 service users and 102 service providers from across Southern Ontario. Participants were engaged through partnerships with 31 organizations spanning multiple sectors and geographic regions, providing a diverse range of perspectives on access to HIV, HCV, sexual health, and related health and social services.

Method of Participation

Participants engaged through multiple methods to ensure both accessibility and depth of insight. Service users primarily participated through surveys (n=66), with additional engagement through focus groups (n=21) and individual interviews (n=9). Service providers participated predominantly through focus groups (n=80), alongside surveys (n=17) and interviews (n=5).

This distribution reflects the needs assessment's design offering multiple, flexible pathways for participants to share both narrative and structured experiences.

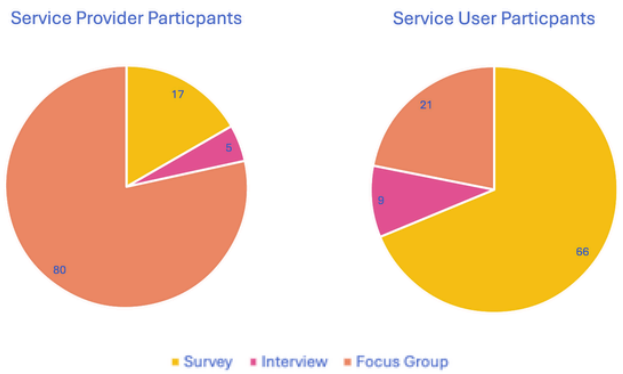

Figure 7. Method of Needs Assessment Participation

Geographic Representation

Participants were from across the Central, Eastern, and Western regions of Southern Ontario. The largest proportion of participants were located in the Central region (n=108), followed by the Eastern (n=42) and Western (n=34) regions. A smaller number of participants identified as working or residing across Ontario more broadly (n=10), with one participant preferring not to disclose location.

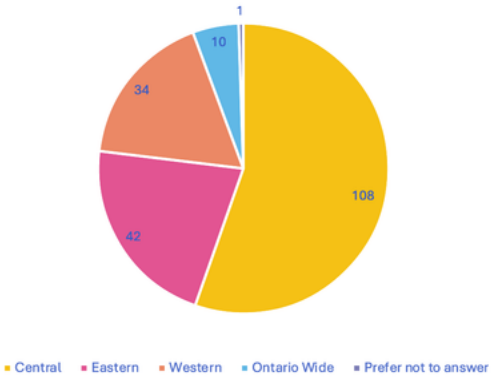

Figure 8. Geographic Distribution of Needs Assessment Participants

Service User Demographics

Gender Identity and Sexual Orientation

Service user participants represented diverse gender identities and sexual orientations. The majority identified as men, followed by women, with additional representation from transgender individuals, non-binary and gender non-conforming participants, and individuals selecting multiple gender identities.

In terms of sexual orientation, most participants identified as gay, followed by bisexual, with additional representation among those identifying as lesbian, queer, pansexual, heterosexual, asexual, and multiple identities.

Immigration Status and Time in Canada

Service user participants represented a wide range of immigration experiences. The majority had been in Canada between one and three years, followed by those residing in Canada for four to six years and those present for seven years or longer. A smaller group had arrived within the past year.

Immigration pathways varied considerably, including individuals identifying as work or study permit holders, refugees and asylum seekers, permanent residents, and Canadian citizens.

Ethno-Racial Diversity

Service users reflected significant ethno-racial diversity. The largest groups identified as Black (African, Caribbean, or African Canadian), Chinese, South Asian, and White. Additional representation included Arab, Middle Eastern, Latin American, West Asian, Southeast Asian, and individuals identifying with multiple ethno-racial backgrounds or other identities.

Service Provider Demographics

Roles and Organizational Context

Service providers represented a range of organizational settings, most commonly ASOs, CBOs, healthcare institutions, and immigration or settlement support agencies.

Participants occupied varied professional roles, including frontline service providers (e.g., counsellors and outreach workers), program coordinators and managers, healthcare providers, and policy or advocacy professionals.

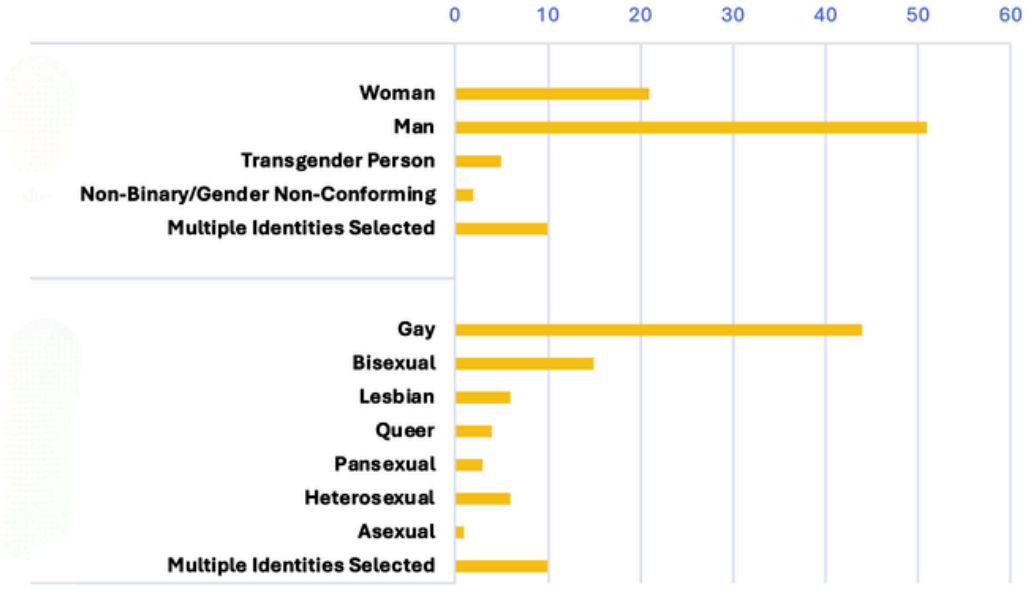

Figure 9. Sexual Orientation and Gender Diversity of Service Users

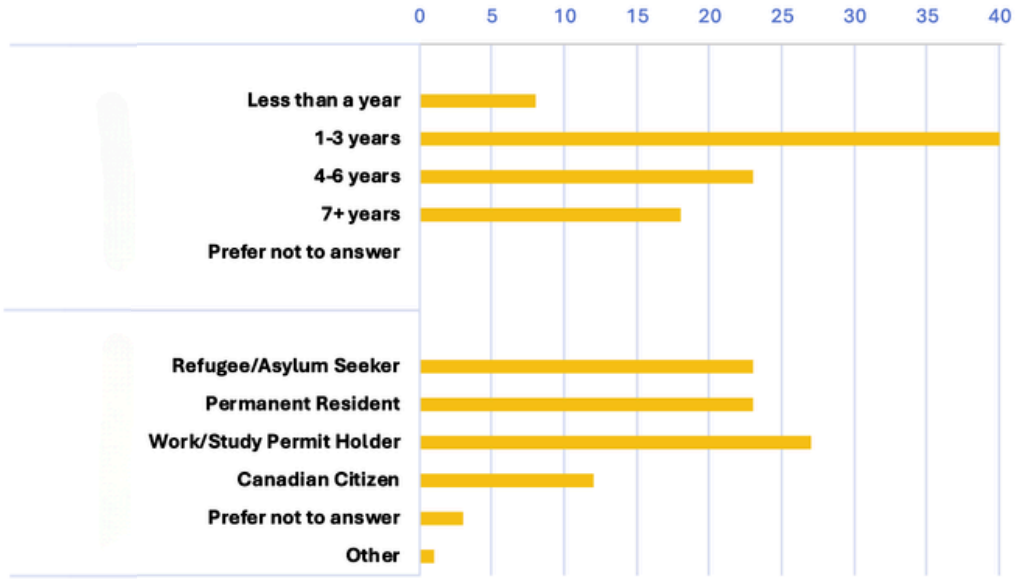

Figure 10. Immigration Status and Time in Canada of Service Users

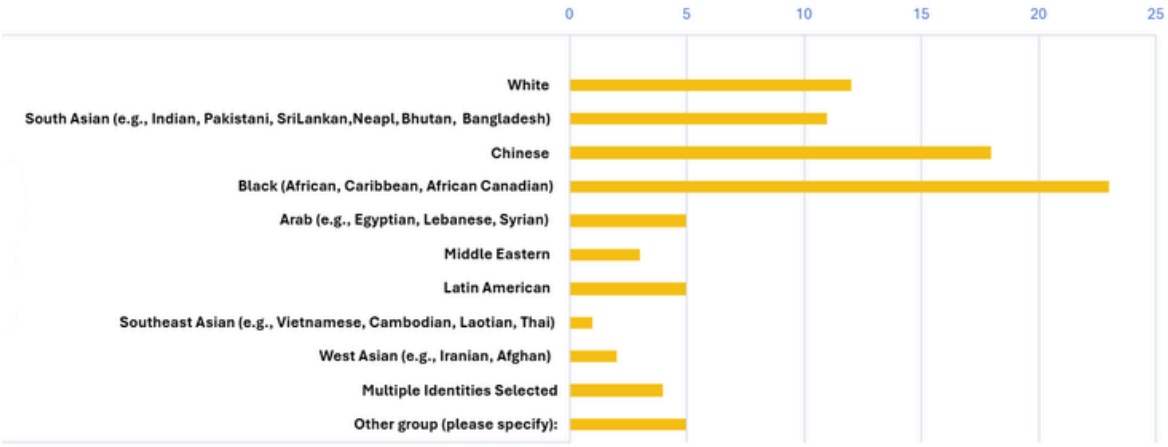

Figure 11. Ethno-racial Diversity of Service User Participants

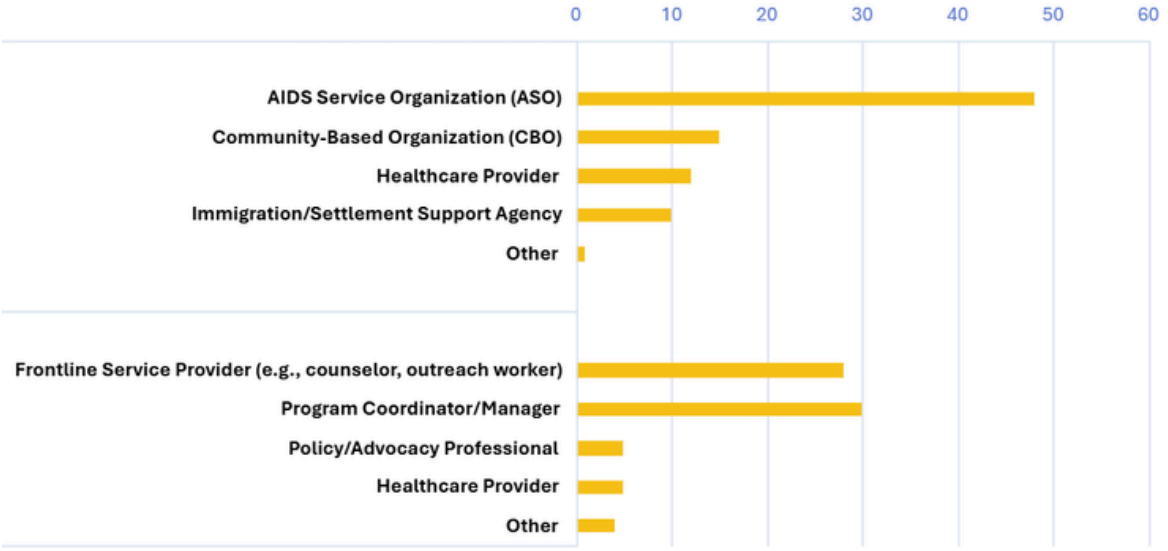

Figure 12. Roles and Organizational Diversity of Service Providers

Key Findings: Barriers and Challenges

Across interviews, focus groups, and survey responses, participants described barriers that are structural and interdependent. While services exist across Ontario, LGBTQ+ IRNN encounter challenges rooted in system capacity constraints, navigation gaps, stigma and discrimination, and cultural and linguistic needs.

Among service user survey respondents who attempted to access services (n=66), 66.7% reported experiencing barriers. Financial barriers (30%), difficulty accessing medical support (27.2%), mental health access barriers (25.7%), difficulty accessing organizational support (24.2%), and housing or legal instability (19.6%) were the most frequently reported challenges. Qualitative findings provide deeper insight into how these barriers operate in practice.

System Capacity Limitations and Service Gaps

Participants consistently described a healthcare and community support system operating beyond capacity. While services technically exist across regions, access is constrained by long waitlists, limited provider availability, funding instability, and uneven distribution of specialized programming. Across interviews and survey responses, these limitations were described as persistent constraints affecting multiple areas of care.

Primary healthcare waitlists were described as particularly severe. In some clinics serving

uninsured clients or people living with HIV, wait times were reported to extend multiple years. Mental health services, in particular, noted strain. Participants reported that individuals seeking support were frequently referred to external low-cost or free services that already had existing waitlists, resulting in delays even after reaching out for care. Although some clinics offered in-house social work or psychotherapy, capacity was limited by staffing.

Survey findings reinforce these concerns: 25.7% of service users identified mental health access barriers, indicating that psychological support is both needed and insufficiently available. Participants further emphasized that the impact of waitlists is heightened in the context of mental health. In many IRNN communities, individuals may delay seeking support until they are in crisis. When they finally reach out during moments of distress and are placed on a waiting list, this was described as deeply discouraging and, in some cases, dangerous. These challenges were further compounded by the limited availability of culturally relevant providers, as mental health support requires trust, connection, and often trial and error before finding a suitable provider.

> "Like going to a hospital and having to spend your whole day, that's one problem. Or even just waiting times to see a specialist for anything.
>
> And then even when you call 911, they're like, "is there an emergency in process now? If not, well, you got to call the non-emergency number," and they hang up before you even finish answering the question.
>
> Like, what if someone's dead? [They would reply] "Well, it's fine he's dead already"
>
> **Service User**

These capacity constraints extend into other aspects of healthcare. Access to gender-affirming care was repeatedly identified as a significant gap. Participants described long referral processes, limited prescribing providers, and a lack of financial and community support. Even when individuals were ready to pursue gender-affirming interventions, pathways were described as slow and difficult to navigate, reflecting limited system capacity in specialized areas of care.

Geographic disparities further illustrated that issues with service distribution across Ontario remain uneven, particularly outside major urban centres. Participants reported that LGBTQ+ and IRNN-focused healthcare is often concentrated in larger urban centres. In smaller cities and rural regions, options were described as limited, requiring individuals to travel or rely on generalist providers who may not have specialized training in HIV care, gender-affirming care, or culturally responsive services. For many IRNN, this travel poses a significant barrier, requiring them to assume additional financial burdens, navigate at times, multiple different unfamiliar transit systems, and undertake lengthy return journeys (often multiple times) in order to receive care.

> "Imagine being in Brampton and you're having to come to our clinic. You know, you're in Brampton, you have to use the TTC or you're having to get an Uber. You probably don't have enough money to afford an Uber.
>
> You're having to get from Brampton to downtown Toronto and do transfers and do all the things, and you don't speak the language. You don't know how to communicate [...].
>
> So just the transportation alone is a barrier."
>
> **Service Provider**

These capacity limitations were not confined to just healthcare settings. Housing instability was also raised consistently as a parallel service gap. Nearly one in five survey respondents identified housing or legal barriers. Participants described long waitlists for subsidized and supportive housing programs, as well as a broader shortage of affordable housing options. In some cases, individuals were managing complex health conditions, including HIV or mental health challenges, while navigating unstable or temporary housing arrangements.

Service users expressed that, despite encountering environments that felt unsafe, the lack of alternative options often left them feeling compelled to endure these experiences. Participants described situations in which they were retraumatized or physically and emotionally harmed. Several participants emphasized that leaving an unsafe service was not always a viable option, particularly when waitlists were long. This dynamic was especially pronounced in areas such as housing, where alternatives were limited.

> "I did my social housing application four years ago, and up to now nothing has come through.
>
> I am anxious almost every day because I can't afford the rent. If I lose my current place, how do I find a new place to live? If you cannot, you will go to the street. That makes me anxious every day.
>
> I have no family here. I just live by myself. I'm also getting older. There are so many challenges you have to face and deal with at the same time."
>
> **Service User**

Service providers themselves expressed frustration with the limits of what they are able to offer within these constraints. Many described working within systems where demand exceeds available resources, and and where funding cuts restrict options while simultaneously increasing their workload, as responsibilities from discontinued programs (such as harm reduction) are absorbed into their existing roles. Despite a strong commitment to their communities, providers reported feeling constrained by referral bottlenecks, funding limitations, and systemic delays.

> "I think it's becoming more challenging across the sector, especially with government funding cuts, for example, cuts to supervised consumption sites.
>
> What's happening is that services are being reduced or shifted, and that pressure is moving into other parts of the system. It becomes overwhelming and starts to take away from our own programming."
>
> **Service Provider**

Across regions and participant groups, these findings point to consistent capacity limitations: long waitlists across healthcare and housing, limited specialized services outside major urban centres, and growing frustration by service users and providers within overstretched systems. Together, these constraints shape both the accessibility and sustainability of care for LGBTQ+ IRNN.

Lack of System Knowledge, Navigation, and Coordination

Even when services were technically available, participants consistently described challenges related to navigating complex and fragmented systems. For individuals who wanted to access health, social or legal services, not knowing where to go was identified as a major barrier by 27.2% of service user survey respondents. Participants described confusion about which organizations provided which services, how to access them, and what documentation or eligibility requirements were needed.

> "I think like the resources are there, like for example despite not having insurance and stuff, I've been able to access services through like Hassle Free or Planned Parenthood.
>
> But it definitely was very difficult realizing that I could do that. I don't know if that information is necessarily very public or shared well. And I only really found out through word of mouth through people who had been through like similar issues."
>
> **Service User**

Insurance-related confusion emerged as a prominent theme. Participants described uncertainty about what services were covered, where they could receive care based on their insurance status, and how coverage changed as their immigration status evolved. As individuals moved between statuses (such as from refugee claimant to permanent resident, or from international student to worker), their insurance eligibility shifted. In some cases, this meant that organizations previously accessed were no longer available due to funding or eligibility restrictions, and participants described not knowing where to go next. This confusion and subsequent fear of having to pay for high-cost services was identified by 39.3% of service user participants as a barrier to care.

Even if an individual was to access services, participants also described systems as highly fragmented. Many reported being required to complete similar registration forms at each new organization. Language barriers further complicated these processes, making paperwork and intake procedures more difficult to navigate. Several participants noted the emotional toll of repeatedly recounting personal histories and traumatic experiences in order to receive support.

Lack of system knowledge was further reflected in participants' uncertainty about

> "So, for me, I graduated from my university last year and I spent almost half year to get my PGWP (Post-Graduation Work Permit).[...] So, from that time to now, I don't have any medical insurance. [...] If I want to get an OHIP, I should find a job and work at least for three months.
>
> It's very hard for me to find a job immediately. So, I assume maybe in the future, in the next half year I don't have any medical insurance, so since I don't have any medical insurance, I don't have the family doctor. [...] I think my situation is typical, it's typical for all newcomers, all new international students."
>
> **Service User**

> "I think bureaucracy is also one challenge. I mean, of course it comes with the system, but they are multiple forms, multiple things you need to do in order to get that service.
>
> For example, in every organization that you go to, they would have an intake and then again doing the same thing in every single organization in order to get your health checkup or referral to an organization or to a service.
>
> That would also be a challenge that comes up in your system navigation."
>
> **Service Provider**

their rights within healthcare and social service systems, as well as confusion about what information they were required to disclose. Some described not knowing whether they were required to disclose their sexual orientation, gender identity, or HIV status in order to receive care. Others were unsure about confidentiality protections and whether sensitive information could affect their immigration status. Concerns were raised about whether HIV testing, diagnosis, or engagement

with certain services might jeopardize residency applications or future status in Canada. This uncertainty contributed to delays in seeking care, with 24.2% of service user survey respondents reporting concerns about their immigration status as a barrier.

Service providers similarly described the challenges of navigating fragmented systems on behalf of clients. Many reported relying on informal networks and personal contacts to coordinate referrals or expedite services. Providers described frustration when trusted referral pathways were disrupted, when previously reliable services closed or reached capacity, or when referrals frequently went unanswered.

> "One of the things that happens is sometimes when I'm connecting with other organizations or trying to connect, you just don't get connected. There's no one answering, there's no one picking up the phone, there's no one answering an email and you just--and you start wondering if they're not answering us, tomorrow if I just blindly give that contact to one of my clients [...] it can be very frustrating.
>
> Especially when you know that the person who is in touch with you is going through something really sensitive and they want someone to like talk to or they want emergency help and you yourself are not able to get in touch with anyone."
>
> **Service Provider**

Across the needs assessment, these findings point to recurring navigation challenges, including uncertainty about where to seek services, confusion regarding insurance eligibility and associated costs, fragmented intake systems, limited understanding of rights within Canadian health and social systems, and heavy reliance on informal coordination by service providers. Even when services technically exist, navigating pathways to access them was described as complex, time-consuming, and emotionally taxing.

Cultural Stigma and Fear of Disclosure

Participants described layered and nuanced experiences of stigma that shaped how, when, and whether they accessed care. LGBTQ+ IRNN often navigated both internalized and externalized forms of stigma within their communities, resulting in heightened fear of disclosure and social isolation. Survey findings reinforce the prevalence of these concerns: 43.9% of respondents identified fear of being judged or discriminated against as a barrier to accessing services.

Several participants reflected on internalized stigma related to sexual orientation, gender identity, or HIV status as a barrier. For some, stigma was rooted in experiences in their countries of origin, where discussions of sexual health or LGBTQ+ identities were limited, criminalized, or deeply taboo. Even after arriving in Canada, these fears did not immediately dissipate. Participants described ongoing anxiety about being judged, misunderstood, or rejected, which influenced their willingness to seek services or disclose personal information.

Perceived externalized stigma within IRNN communities was also frequently described. While sometimes efforts were made to connect individuals with providers or interpreters who share similar cultural or linguistic backgrounds to facilitate understanding, participants noted that this approach can create unintended discomfort for LGBTQ+ IRNN. Although culturally matched services may improve communication, some individuals described feeling guarded when discussing sexual health, gender identity, or HIV status in front of interpreters or providers from their own communities. Concerns were raised that disclosure within these settings could circulate back to their broader community networks, potentially resulting in gossip, social exclusion, or the reinforcement of stigma they had sought to escape when leaving their home countries. This aligns with broader survey findings, as 37.8% of service user respondents identified concerns about privacy as a barrier to accessing services.

> "Internalized stigma is also a factor. Internalized stigma is also a socially determined quality.
>
> You experience one bad thing, and it deters you from going to other services. For example, I went to physiotherapy last year, and something was said that suggested that, "it was probably from the AIDS." And this from a professional. Experiences like that stay with people."
>
> **Service Provider**

As a result, participants described experiencing a profound sense of disconnection. Some felt distanced from their cultural communities due to fears of homophobia, transphobia, or HIV-related stigma. At the same time, others reported feeling disconnected from the broader 2S/LGBTQ+ community in Canada, citing a lack of shared cultural understanding, racial representation, or familiarity with IRNN experiences. This dual marginalization left some individuals feeling that they did not fully belong in either space.

> "I know my personal experience when I came to Canada, it took me a long time to find a queer community that I feel comfortable in and not for lack of trying, but a lot of them are white spaces that I didn't see myself in and that I didn't feel comfortable in.
>
> Because this is not how I experienced my own queerness back home, even though it's illegal, I still had my own experiences. I still lived in a certain way, and I have a perception of it that is completely different from what people are grown into here."
>
> **Service Provider**

Fear of being recognized or "outed" was also a recurring theme. Some participants reported feeling more comfortable accessing services outside their immediate communities, even when travel was inconvenient, to reduce the risk of being seen entering certain organizations. Service providers similarly described hesitancy among LGBTQ+ IRNN in engaging visibly with services, including reluctance to take informational pamphlets, approach sexual health booths at community events, or participate openly in LGBTQ+-specific programming.

This stigma did not exclusively center on LGBTQ+ topics. Participants also highlighted that in many countries of origin, sexual health education is limited or absent, and open discussions about sexuality are rare. This lack of foundational knowledge compounded stigma and shaped expectations about care. Some described arriving in Canada with minimal information about HIV prevention, sexual health needs, or available LGBTQ+ support systems, which further reinforced hesitation around engagement.

Service providers noted that, despite visible discomfort or shyness around these topics, many IRNN remained interested in and curious about sexual health information and supplies. However, they often required additional discretion, for example, approaching providers privately after sessions to ask specific questions or requesting that materials be placed directly into their bags rather than taking them openly.

Stigma around mental health followed similar patterns, where participants described attitudes within some IRNN communities that framed mental health support as something reserved for individuals who are "crazy" or severely unwell. As a result, individuals experiencing trauma, displacement, or ongoing stress often avoided seeking psychological support openly.

In addition to stigma, participants described experiences and expectations of direct discrimination within institutional settings. Some reported being dismissed, stereotyped,

or treated differently based on their race, immigration status, sexual orientation, gender identity, or HIV status. Others described anticipating discrimination before entering healthcare or community spaces, which shaped whether they sought care at all. Fear of discriminatory treatment contributed to guarded interactions and delayed help-seeking.

> "Not only that, talking about sex itself is a big taboo. Even we do outreach at some of the universities and stuff like that. When you want to hand over condoms, "oh, this is not for me." "I'm married." Yeah, "I'm married." And I said, "you never know."
>
> I mean, I think that just constant backgrounds we come from, like the public image of a person and their private image are always 2 different things."
>
> **Service Provider**

> "And then also if you're like trans and stuff like that, [...] I never experienced in [redacted] before my name change and all my surgeries was done. But somehow for some reason when I was at the hospital here, every nurse and doctor misnamed me, misgendered me, and I'm post-op and I'm like, "OK, my name's been changed already?"
>
> [...] But down here, they try to antagonize you, I feel. Yeah, I felt it was antagonizing because it says they're not to call me that name. And then when they're doing it on purpose, they're doing it for purpose."
>
> **Service User**

Across focus group, interview and survey responses, stigma operates across multiple levels: internal, interpersonal, community-based, and institutional, shaping patterns of help-seeking and social connection. For some LGBTQ+ IRNN, this resulted in isolation not only from services, but from both their cultural communities and the broader 2S/LGBTQ+ community. Even when services exist and individuals are aware of them, fear of judgment and discrimination significantly influence decisions about where and how care is accessed.

Lack of Culturally Responsive Care and Language Barriers

Language barriers and a lack of culturally responsive care were described as challenges that compounded many of the barriers outlined above. Even when services were available and individuals were able to navigate systems successfully, the quality and accessibility of care was often limited by communication gaps and a lack of cultural understanding. Survey findings indicate that 19.6% of service users identified language, and 13.6% identified the lack of services that reflected their culture or identity as barriers to care.

While most service user participants described having a basic understanding of English, many reported difficulty when providers spoke quickly or relied heavily on jargon. In these situations, participants described needing to ask providers to repeat information in simpler language or using tools such as Google Translate during or after appointments to better understand what had been discussed. Although reportedly, providers responded positively when asked to clarify; the need to constantly request simplification was described as an additional burden.

Other participants described difficulty communicating with providers when they did not share a common language, particularly when discussing sensitive topics such as sexual health, gender identity, HIV status, or experiences of trauma. While interpretation services were sometimes available, they were described as inconsistent, expensive, or logistically difficult to coordinate. In some cases, providers acknowledged relying on tools

such as Google Translate to communicate with clients and hoping that the translation accurately conveyed information. However, providers noted that translation alone does not resolve deeper challenges around nuance, comprehension, and contextual understanding. For these discussions, automated translation tools like Google Translate being used were described as insufficient.

However, as noted in previous sections, the use of interpreters or culturally matched providers was not always a solution and introduced additional layers of discomfort for some LGBTQ+ IRNN. Participants expressed hesitation in discussing sexual health or HIV-related concerns in front of interpreters from their own communities, particularly when confidentiality and stigma were ongoing concerns. While interpretation services were intended to facilitate access, they did not always create a sense of safety.

In addition, participants noted that some existing educational materials were not always culturally aligned with their needs. LGBTQ+-affirming resources were often described as including explicit sexual or queer imagery intended to signal inclusivity. However, some IRNN from more conservative cultural backgrounds expressed discomfort engaging with these materials publicly. While the intention was to affirm, visible or explicit imagery sometimes heightened fears of being judged or outed. Others described LGBTQ+ spaces and health promotion campaigns as feeling centered primarily around cisgender, white gay men. For example, certain PrEP advertising and outreach efforts were perceived as visually oriented toward a narrow demographic, which limited catering toward racialized IRNN, women, trans individuals, and people from diverse cultural backgrounds.

Participants also highlighted that many IRNN may not initially identify with Western LGBTQ+ labels or terminology. For individuals coming from contexts where such language was unavailable, criminalized, or culturally unfamiliar, materials that rely heavily on identity-based terminology did not always resonate. As a result, some resources felt misaligned with how individuals understood or described their own experiences.

> "Yeah, I would argue that also, most of these tools are still are only are still primarily being written Bible. And like, sometimes if you're lucky that they can find a Translator.
>
> You can translate the material, but more often than not they're using Google Translate to translate the material, and that's also not accessible because it's translating it into language that like people yeah, not in the spoken language."
>
> **Service User**

Finally, participants described a broader lack of culturally responsive and trauma-informed approaches to care. Some reported experiences of being stereotyped based on race, immigration status, or sexuality. Others described being misgendered repeatedly in clinical settings or having to correct providers about their identities. In certain cases, individuals reported feeling that they had to educate their providers about LGBTQ+ health needs or advocate for appropriate care themselves.

Furthermore, participants described instances in which providers were dismissive or insensitive when serious harm had occurred, including experiences of assault. Rather than feeling supported, some individuals reported feeling minimized or not believed. Others described encountering gatekeeping behaviors, particularly in relation to access to gender-affirming care or financial supports such as the Ontario Disability Support Program (ODSP) for individuals living with HIV. In these situations, participants described

feeling that providers controlled access to necessary services in ways that were lacking empathy.

> "First of all, I'm a refugee for about 10 years, and I went through the entire refugee process. And then there is the health care thing that they give to you that represents IFHP for the federal government's coverage for health care for refugees.
>
> So when you take that to the hospital, once people see and they know that's what you get and the people who is providing care for you see your status, then the way they treat you is different.
>
> People don't understand what it is you're going through, so they automatically judge you and say from the standpoint of "you're depleting our resources." So that's on its own, is one aspect of it."
>
> **Service Provider**

Providers themselves acknowledged gaps in training and institutional preparedness to meet the complex needs of LGBTQ+ IRNN. Some described limited opportunities for education around culturally responsive and trauma-informed care, particularly at the intersection of race, immigration status, gender identity, and HIV. Others noted that institutional systems are often structured around dominant cultural assumptions, resulting in care models that do not fully reflect the communities they serve. For example, participants described an overreliance on Westernized models of mental health support, such as individualized one-on-one therapy in clinical settings. While valuable for some, participants expressed that systems frequently "prescribed" this form of therapy without recognizing alternative community-based, collective, spiritual, or land-based practices that may feel more culturally relevant to their experiences.

Ultimately, participants emphasized that receiving care that was understandable, affirming, and responsive to their identities was not guaranteed. Even when services were technically accessible, care that lacked cultural relevance, linguistic clarity, or respect for gender identity created additional barriers. In these contexts, access alone was not sufficient, and participants emphasized the need for care that was safe and inclusive to the realities of LGBTQ+ IRNN communities.

> "Education is not as widespread as we have been working with other participants. I've been working with second year medical students at University of Toronto Med School and most of them mostly not, upward of 90% of these second year students do not know about it [PrEP]."
>
> **Service Provider**

Key Findings: Recommendations and Solutions

The recommendations outlined below are grounded in the lived experiences of LGBTQ+ IRNN and the insights from providers who support them. Across interviews, focus groups, and survey responses, participants identified both practical and structural changes necessary to improve access, safety, and quality of care. In the survey component, service provider respondents emphasized the need for increased funding and expanded service capacity (76.5%), as well as greater community engagement initiatives (64.7%). Service users identified free or low-cost services (80.3%), expanded language access (34.9%), and healthcare workers who understand confidentiality (59.1%) and diverse cultural backgrounds (56.1%) as priority areas for reform. Collectively, these findings reflect a shared understanding that change requires both system-level investment and community-centered approaches that address the intersecting realities of sexuality, gender identity, immigration status, race, and

socioeconomic position.

Invest in Sustainable Funding Models and Service Expansion

Participants consistently emphasized that systemic change cannot occur without sustained and flexible funding structures. While frontline organizations were widely recognized for their dedication, both service users and providers described current systems as chronically under-resourced, operating in reactive crisis modes rather than proactive, preventative frameworks. Sustainable funding was described as foundational for all other changes.

Increased core funding for LGBTQ+ IRNN programming was identified as critical to stabilizing and strengthening services. Providers highlighted the limitations of short-term, project-based funding cycles, noting that they create staffing instability, reduce program continuity, and undermine long-term relationship-building within communities. Participants emphasized that trust-building requires consistency, particularly among communities navigating stigma, discrimination, trauma, and previous negative experiences with healthcare and social service systems. Frequent funding disruptions can interrupt services and weaken the relationships that are essential for effective care.

Participants also highlighted the need for stronger organizational infrastructure to support the delivery of sustainable services. This included increased staffing capacity, reduced reliance on short-term funding models, and greater investment in staff training, supervision, and retention. Many participants noted that service providers are often expected to respond to increasingly complex community needs while operating with limited resources, contributing to high workloads, burnout, and staff turnover. Strengthening organizational capacity through stable funding, adequate staffing levels, and dedicated administrative, coordination, and program support was viewed as essential for improving service quality and reducing wait times.

Beyond core funding opportunities, investment in practical service expansion was also central to this theme. Participants emphasized expanding clinic hours to evenings and weekends to accommodate individuals balancing employment, caregiving responsibilities, and transportation challenges. Flexible and accessible service hours are particularly important for IRNN who may hold multiple jobs or precarious employment and cannot easily take time off work.

Finally, geographic inequities were identified as an important consideration within broader discussions of service expansion. Participants recommended increasing investment in outreach models, satellite clinics, and partnerships with local service providers outside major urban centres. Rural and smaller-city communities were frequently described as having limited access to specialized LGBTQ+-, HIV-, and IRNN-focused services, often requiring individuals to travel significant distances at their own expense to access care. These geographic barriers were compounded by transportation costs, limited public transit options, and the time required to travel to appointments. Expanding decentralized and community-based service models was therefore described as a key strategy for improving access, reducing financial burdens, and ensuring that individuals can receive care closer to where they live.

> "Yeah, you can tell that it's the funding. You can tell that the workers over worked. And like, when I was still looking for some resources, I called them like 3000 times, and nobody responded. [...] It's just like you can tell like they don't have the capacity; the system didn't have enough workers to cover the demand"
>
> **Service User**

Taken together, these recommendations highlight that participants viewed funding not simply as a resource issue, but as a foundational determinant of service accessibility, quality, and sustainability. Increased investment was seen as necessary to address staffing shortages, reduce waitlists, expand service availability, strengthen organizational capacity, and improve geographic equity. Across participant groups, there was a shared recognition that many of the barriers identified throughout this assessment are rooted in broader resource constraints. Sustainable and flexible funding models were therefore viewed as essential to building systems that can move beyond crisis response and provide better care for LGBTQ+ IRNN communities.

Strengthen System Coordination and Navigation Supports

Participants described fragmentation across healthcare, settlement, legal, housing, and community sectors as a major barrier to access. Rather than functioning as a cohesive system, services were described as operating in silos, each addressing one dimension of need while failing to coordinate across the broader ecosystem.

Participants emphasized the need for stronger coordination and collaboration across organizations serving LGBTQ+ IRNN communities. Many described a fragmented service landscape in which IRNN-serving organizations often lacked explicit LGBTQ+-affirming programming, while LGBTQ+-focused organizations were not always equipped to address immigration, settlement, housing, employment, or legal complexities. As a result, individuals were frequently required to navigate multiple systems independently, repeatedly explain their circumstances, and coordinate their own needs across different service providers.

To address these gaps, participants recommended greater cross-sector integration through shared referral systems, formalized partnerships, and coordinated case management. Improved communication between organizations was viewed as essential for identifying unmet needs and ensuring that clients receive timely and appropriate support. Participants also highlighted the importance of "warm handoffs," whereby service providers actively facilitate connections to other organizations rather than simply providing referral information. This could include contacting partner organizations directly, assisting with appointment scheduling, accompanying clients through referral processes, or conducting follow-up to ensure services were successfully accessed. Warm handoffs were seen as particularly important for individuals facing language barriers, unfamiliarity with Canadian systems, experiences of stigma, or complex service needs.

Navigation simplification emerged as a core solution for addressing many of the barriers identified throughout the needs assessment. Participants frequently described the current service landscape as fragmented, difficult to navigate, and many individuals were unaware of available services or struggled to determine which programs were appropriate for their needs. To address these challenges, participants strongly advocated for the development of a centralized, regularly updated resource directory available in multiple languages. Such a directory could bring together information on healthcare services, HIV and sexual health programs, settlement supports, housing resources, legal services, mental health supports, peer programs, and community organizations in a single, accessible location. Participants emphasized that information should be presented in clear, plain language and include practical details such as eligibility criteria, costs, accessibility, referral requirements, and contact information.

Participants also highlighted the importance of ensuring that navigation tools are accessible through multiple formats. While many supported the development of digital platforms accessible through smartphones

and computers, others noted that not all IRNN have consistent access to technology or feel comfortable navigating digital systems. As a result, participants recommended a combination of online and offline approaches, including digital and printed resource guides that could be distributed through community organizations. Discreet QR codes placed in community spaces, clinics, settlement agencies, and other service settings were viewed as particularly valuable for individuals seeking information privately, especially those who may not feel safe openly disclosing their sexual orientation, gender identity, HIV status, or immigration-related concerns.

Participants emphasized the importance of early intervention pathways that provide IRNN with information. Collaboration with Immigration, Refugees and Citizenship Canada (IRCC), settlement agencies, language training programs, faith-based organizations and IRNN-serving organizations to provide accessible information upon arrival in Canada was described as a preventative strategy that could reduce confusion and delayed care seeking. Participants suggested that IRNN should receive information early in their settlement journey regarding healthcare rights and eligibility, confidentiality protections, how to access primary and sexual healthcare, available mental health and social services, and LGBTQ+-affirming community supports.

Across interviews, focus groups, and survey responses, participants emphasized that improving access requires reducing the burden placed on individuals to navigate these complexities independently. Greater collaboration across sectors, simplified navigation tools, warm handoffs, and earlier access to information were viewed as critical strategies for creating more responsive, and accessible systems of care for LGBTQ+ IRNN communities.

> "Communication between agencies is also important, to make sure they know where services are and can refer to the appropriate places. I would like to see a multi-stakeholder committee established, with groups like the City of Toronto, especially those dealing with housing, because that is a major issue for community members. [...]
>
> We need to stop operating in silos and stop talking only among ourselves. If we create spaces like this, where different groups come together, and ensure that decision-makers are also present, then what comes out of those discussions can actually lead to change."
>
> **Service Provider**

Advance Culturally Responsive, Linguistically Accessible, and Affirming Care

Participants emphasized that true accessibility extends beyond the availability of services to encompass meaningful communication, cultural safety, and affirming care environments. Throughout the needs assessment, participants described how access is shaped not only by whether services exist, but also by whether individuals feel understood, respected, and able to engage with care. Recommendations within this theme therefore extend beyond simply increasing service availability and instead focus on ensuring that services are linguistically accessible, culturally responsive, trauma-informed, and affirming of both sexual and gender diversity as well as immigration-related experiences.

Language barriers were almost unanimously described as challenges and major structural determinants that shaped communication, trust, and comprehension within healthcare encounters. Investment in professional interpretation services and professionally translated materials was widely recommended. Participants noted that reliance on informal tools such as Google Translate may be

unavoidable in some settings but is insufficient for nuanced discussions involving sexual health, HIV care, trauma, consent, insurance eligibility, or immigration-related coverage. Dedicated funding for high-quality translation services across multiple languages was therefore identified as essential. Participants emphasized that language supports should be available through multiple formats, including in-person interpretation, virtual interpretation, translated educational materials, and multilingual digital resources. Providing information in a variety of accessible formats was viewed as critical to ensuring that individuals can engage with sensitive and complex topics in ways that feel comfortable, confidential, and understandable, while accommodating differing communication preferences, literacy levels, and access needs.

However, translation alone was described as insufficient. Participants emphasized the need for culturally adapted materials and resources that account for varying health literacy levels, cultural norms, and conceptualizations of gender and sexuality. While affirming LGBTQ+ visibility is important, some participants expressed discomfort with highly explicit imagery or identity-based terminology in outreach materials, particularly among individuals navigating stigma within conservative or modest cultural contexts. Participants recommended developing resources that are both affirming and discreet, allowing individuals to engage without fear of exposure. Additionally, many IRNN may not initially identify with Western LGBTQ+ labels or terminology. Participants therefore recommended flexible communication approaches that prioritize health, safety, and well-being while remaining inclusive and respectful of diverse identities and experiences.

Representation within organizations was also described as a key component of culturally responsive care. Participants emphasized the importance of staff and volunteers who reflect the linguistic, racial, cultural, and lived experiences of the communities they serve. Representation was viewed as fostering trust and a greater understanding of the complex realities faced by LGBTQ+ IRNN. One organization described the value of employing a dedicated cultural liaison who shared the language, cultural background, and community knowledge of the population they primarily served. Participants noted that such roles can help bridge communication gaps, build trust, and support more relevant service delivery. At the same time, participants recognized that no single organization can be expected to represent or fully understand every community it serves. Representation was therefore viewed not as an endpoint, but as one component of broader efforts to create welcoming environments.

> "There's also such a lack of recognition for fluency in languages that are not English and French.
>
> And so that means that when service users are going to a place more often than not, they're not going to be able to speak to someone in their language. They're going to experience racism if they can speak to someone in their language by people in the area.
>
> Also, then it's so much harder for people to get a job, but like those are skills that are so necessary, especially in this kind of field, and employers don't value that. "
>
> **Service Provider**

However, participants emphasized that representation alone is insufficient within systems that have historically been shaped by racism, colonialism, heteronormativity, and other forms of structural exclusion. While culturally representative staff can improve trust and communication, participants stressed that these efforts must be accompanied by meaningful organizational change. This includes structured training, clear professional boundaries, and accountability mechanisms

Both service providers and service users highlighted the need for expanded training in LGBTQ+ health, immigration-related health systems, trauma-informed practice, anti-racism, and intersectionality. Such training was viewed as particularly important in healthcare, housing, legal, and immigration-related settings, where participants frequently described feeling dismissed, disbelieved, or undermined when seeking support. Participants emphasized that this competency should not be limited to frontline service providers alone but should extend to all individuals involved in service delivery, including reception and administrative staff, security personnel, volunteers, peers, and organizational leadership. Many noted that first impressions and interactions outside of formal care settings can significantly influence whether individuals feel safe and willing to engage with services. Participants emphasized that providers must be equipped not only with technical knowledge, but also with the skills to understand how multiple forms of marginalization intersect and shape individuals' experiences of care. This includes fostering cultural humility, LGBTQ+ health competency, recognizing the impacts of trauma, and developing the skills necessary to navigate professional boundaries while supporting clients with complex and often overlapping needs.

At the same time, participants stressed that accountability systems must be strengthened. Several individuals recounted experiences of discrimination, misgendering, breaches of confidentiality, dismissive treatment, or other harmful interactions within healthcare, housing, settlement, and community-based organizations. While some participants attempted to report these incidents through formal complaint processes, many described feeling that their concerns were dismissed, inadequately investigated, or resulted in little meaningful action. Others reported uncertainty about where or how to file complaints, concerns about potential repercussions for speaking up, or a lack of confidence that reporting would lead to change. For LGBTQ+ IRNN, these concerns were often compounded by fears of losing access to essential services, housing, immigration-related supports, or healthcare. As a result, some participants described tolerating harmful experiences because they felt they had few alternatives available to them.

Participants emphasized that accountability should extend beyond the existence of complaint mechanisms alone. Organizations were encouraged to establish transparent processes for receiving, investigating, and responding to concerns, while clearly communicating these processes to service users. Participants also highlighted the importance of feedback mechanisms that are accessible across languages and literacy levels, as well as opportunities for communities to meaningfully inform service improvement. Ultimately, accountability was viewed as a critical component of trust-building, ensuring that organizations are not only welcoming and affirming in principle, but also responsive when harm occurs.

Taken together, these recommendations highlight that culturally responsive and affirming care requires more than individual acts of inclusion. Participants emphasized the need for systems that are linguistically accessible, culturally grounded, representative of the communities they serve, and accountable when harm occurs. The goal is not to create entirely separate services for every cultural, linguistic, or identity group, but rather to ensure that mainstream systems are capable of providing competent, affirming, and responsive care to diverse communities. Reducing gatekeeping behaviors, addressing unconscious bias, fostering cultural humility, and strengthening organizational accountability were all viewed as necessary steps toward ensuring that LGBTQ+ IRNN can access services with dignity.

> "Violence is experienced very differently for newcomers, immigrants, refugees, people of colour. It has different types, different pieces and even when service providers don't think something is violent, they don't realize how violent it is for people who are not like that.
>
> I've taken that violence without sometimes intending or realizing it. And having to explain that it's violent in itself is violent. It's like a retraumatization."
>
> **Service Provider**

Strengthen and Sustain Peer-Based Programming

Across participant groups, peer-based programming was identified as one of the most impactful mechanisms for improving trust, belonging, and engagement. For the purposes of this report, peers refer to individuals who share lived or living experiences with the communities they support, whether through immigration and settlement experiences, sexual orientation, gender identity, HIV status, cultural background, or other intersecting identities.

Peers were described as essential bridges between formal systems of care and communities, particularly for individuals navigating stigma, isolation, trauma, and unfamiliarity with Canadian systems. Many participants noted that while information and services may technically be available, they are often difficult to access without someone who can help contextualize information and provide support throughout the process. Participants emphasized that peer workers often provide forms of relational safety that formal institutions cannot easily replicate. For many LGBTQ+ IRNN, peers were described as the first people with whom they felt comfortable discussing topics such as sexual health, HIV, gender identity, migration experiences, or mental health concerns to.

Beyond facilitating access to services, peers were also described as playing a critical role in community building and social connection. Throughout the needs assessment, participants repeatedly described experiences of isolation and disconnection from both cultural communities and broader LGBTQ+ communities. Peer-led spaces were viewed as opportunities to build relationships, share knowledge, and foster a sense of belonging. For some participants, peers represented tangible examples of individuals who had successfully navigated similar challenges, which was noted as particularly important for IRNN who may be rebuilding social networks, navigating family rejection, or adjusting to new cultural and social environments.

At the same time, participants highlighted significant structural weaknesses within existing peer support models. Despite the critical role peers play in service delivery and community engagement, they are often underpaid, precariously employed, or engaged on a volunteer basis while carrying substantial responsibilities. Participants noted that peers are frequently expected to provide support that extends well beyond formal role descriptions.

Concerns were also raised regarding burnout, compassion fatigue, boundary challenges, insufficient supervision, and lack of formalized training. Both service providers and peer workers emphasized that lived experience alone does not automatically prepare individuals to navigate sensitive conversations around trauma, HIV disclosure, mental health crises, gender-based violence, or complex service needs. Participants highlighted the importance of ensuring that peers receive adequate preparation, mentorship, and ongoing support so that they can engage in this work safely and sustainably.

As a result, participants recommended greater investment in peer workforce development. Suggested strategies included fair compensation structures, comprehensive onboarding processes, ongoing training in

in confidentiality, professional boundaries, trauma-informed practice, sexual health, and system navigation, as well as dedicated supervision and mental health supports for peer workers. Participants emphasized that professionalizing peer roles should not diminish the relational strengths that make peer support effective but rather provide peers with the support necessary to sustain their work.

Ultimately, participants viewed peer support not simply as an adjunct to existing services, but as a foundational component of community-centered care. Investment in peer networks, mentorship opportunities, and community-led initiatives was viewed as critical to reducing isolation, improving service engagement, and ensuring that LGBTQ+ IRNN have access to trusted sources of information and support throughout their settlement and healthcare journeys.

> "Yeah, I think it's absolutely essential, but also on an organizational level, I see that often peer roles are paid the least of anyone on staff.
>
> So, I think that what we need to see is an actual shift to actually valuing lived experience and living experience. And not just saying, "OK, cool. We can tokenize a few people, have them on staff in the least paid roles and not support them in moving up the ladder, so they become the decision makers."
>
> So, I think that's a huge shortcoming across the sector."
>
> **Service Provider**

Discussion

Addressing the Research Questions

This needs assessment was guided by three core research questions:

1. What are the key gaps in resources, knowledge, or system capacity that limit effective HIV/HCV and sexual health service delivery for LGBTQ+ IRNN?
2. What barriers and challenges do LGBTQ+ IRNN face in accessing HIV/HCV and sexual health services in Ontario?
3. What changes to services, systems, or policies would most improve access to affirming, equitable, and culturally responsive HIV/HCV and sexual health care for LGBTQ+ IRNN in Ontario?

Across interviews, focus groups, and survey responses, participants consistently emphasized that barriers to HIV, HCV, and sexual health care cannot be understood in isolation from broader social, economic, and immigration-related experiences. While the study was focused on sexual health service access, discussions frequently expanded to encompass housing, mental health, immigration status, language, employment, community belonging, and experiences of discrimination. This reinforces the reality that sexual health is deeply interconnected with broader social determinants of health, and that effective HIV and sexual health interventions must account for these wider contexts.

Research Question 1: What are the key gaps in resources, knowledge, or system capacity that limit effective HIV/HCV and sexual health service delivery for LGBTQ+ IRNN?

The findings suggest that the most significant gaps are not necessarily the complete absence of services, but rather limitations in system capacity, coordination, and accessibility. Across regions, participants described services that were frequently overstretched, under-resourced, and difficult to access. Long waitlists for primary care, mental health supports, housing programs, and gender-affirming services were common. Service providers repeatedly described working within systems where demand exceeded available resources, often forcing organizations to make difficult decisions regarding who could be served and when.

Participants also identified important knowledge gaps. Service users frequently reported uncertainty regarding healthcare rights, confidentiality protections, insurance eligibility, and service availability. At the same time, providers acknowledged varying levels of preparedness in supporting LGBTQ+ IRNN, particularly around immigration-related health coverage, culturally responsive care, trauma-informed practice, HIV care, and gender-affirming services. These findings suggest that improving service delivery requires not only additional resources, but also investment in workforce development and accessible public education.

Perhaps most importantly, participants highlighted fragmentation as a critical system capacity issue. Existing services often operate independently rather than as part of a coordinated network. As a result, individuals are frequently left to navigate multiple systems simultaneously, often repeating their stories, coordinating referrals, and determining eligibility requirements on their own. The findings therefore suggest that system integration may be just as important as service expansion in improving access to care.

Research Question 2: What barriers and challenges do LGBTQ+ IRNN face in accessing HIV/HCV and sexual health services in Ontario?

Participants described barriers that were structural, interpersonal, and cultural in nature. At the structural level, individuals reported challenges associated with transportation, geographic distance, limited clinic hours, insurance complexity, service eligibility

requirements, long waitlists, and financial constraints. These barriers were particularly pronounced for IRNN living outside major urban centres, individuals navigating changing immigration statuses, and those relying on public transit systems.

Navigation complexity emerged as one of the most consistent themes throughout the study. Many participants described uncertainty regarding where to access services, which organizations could meet their needs, what costs would be involved, and whether they were eligible for care. Even when services existed, participants often struggled to locate them, access them, or move between them effectively. This suggests that barriers to care are not solely related to service availability, but also to the accessibility and navigability of existing systems.

Participants also described significant social and cultural barriers. Stigma surrounding sexuality, gender identity, HIV, and mental health frequently influenced decisions about whether to seek care and where care was accessed. Fear of disclosure, concerns regarding confidentiality, and worries about being recognized within cultural communities shaped healthcare-seeking behaviours for many individuals. These experiences were often compounded by broader experiences of racism, xenophobia, homophobia, transphobia, and social exclusion.

Importantly, participants highlighted that these barriers do not operate independently. Rather, they intersect and reinforce one another. Language barriers increase navigation difficulties; stigma influences disclosure; housing instability affects healthcare access; and experiences of discrimination undermine trust in providers and institutions. Understanding these barriers through an intersectional lens is therefore essential to understanding the realities of LGBTQ+ IRNN communities.

Research Question 3: What changes to services, systems, or policies would most improve access to affirming, equitable, and culturally responsive HIV/HCV and sexual health care for LGBTQ+ IRNN in Ontario?

Participants identified several interconnected priorities for change.

First, there was a strong call for sustainable and flexible funding structures capable of supporting long-term service delivery. Participants consistently linked many of the barriers identified throughout this assessment to broader resource constraints, including staffing shortages, long waitlists, service gaps, provider burnout, and geographic inequities. Funding was viewed not simply as a financial issue, but as a prerequisite for meaningful system improvement.

Second, participants emphasized the need for integrated and coordinated systems of care. Stronger partnerships between organizations, centralized navigation tools, warm handoffs, shared referral pathways, and improved communication between sectors were all identified as critical mechanisms for reducing navigation burdens and improving continuity of care.

Third, participants highlighted the importance of culturally responsive and linguistically accessible services. Recommendations included expanded interpretation services, professionally translated materials, culturally adapted educational resources, staff representation reflective of communities served, and greater investment in provider training. Participants emphasized that cultural responsiveness must move beyond symbolic inclusion and be embedded throughout service delivery systems.

Finally, participants repeatedly emphasized the value of peer-based approaches. Peers were viewed as trusted sources of information, support, advocacy, and connection. Participants described peer navigators, peer mentors, and peer-led programs as uniquely

positioned to bridge gaps between formal systems and community members. However, participants also stressed that peers require adequate training, supervision, and compensation to ensure sustainability and effectiveness.

Taken together, these recommendations suggest that improving access requires more than expanding services. Meaningful change requires coordinated investments in infrastructure, relationships, cultural responsiveness, and community leadership.

Emerging Strengths and Community Resilience

Although this needs assessment was designed to identify barriers and challenges, conversations frequently highlighted strengths within both communities and service systems. Participants often spoke organically about organizations, providers, peers, and community spaces that had positively influenced their experiences.

Service providers described going beyond formal responsibilities to help individuals access care, frequently leveraging personal networks and relationships to navigate bureaucratic barriers. Service users shared stories of providers, peers, and organizations that created environments where they felt safe, respected, and affirmed. These examples often emerged unprompted and illustrate the considerable dedication that exists within the sector.

Perhaps most notably, participants demonstrated remarkable resilience. Despite experiences of stigma, discrimination, displacement, and social isolation, many individuals actively sought out community, advocated for themselves and others, and contributed to creating supportive environments for future IRNN. These strengths highlight the importance of recognizing LGBTQ+ IRNN not solely as recipients of services, but as active contributors to community care, knowledge sharing, and systems change.

Study Limitations

Several limitations should be considered when interpreting the findings of this needs assessment.

First, the study was conducted exclusively in English. While many participants reported a functional understanding of English, this requirement likely excluded individuals with lower levels of English proficiency. As a result, language barriers may be underrepresented within the qualitative findings, particularly among individuals facing the greatest communication challenges.

Second, participation was voluntary and recruitment occurred primarily through community organizations, networks, and online outreach. This introduces the possibility of self-selection bias, as individuals who chose to participate may have been more connected to existing services, more engaged in community spaces, or more motivated to share their experiences than those who did not participate.

Third, although both service users and service providers were engaged, we were able to collect richer qualitative data from service providers than from service users. While survey participation among service users was strong, focus group and interview participation was comparatively lower. As a result, certain findings may reflect provider observations more heavily than direct service user narratives. However, the distinction between service users and service providers was also not always clear-cut. Many providers identified as LGBTQ+ IRNN themselves and frequently drew upon personal experiences when discussing barriers and service needs. While this enriched the findings and provided valuable insight, it also complicates attempts to separate provider and service user perspectives.

An additional methodological challenge involved fraudulent and suspected automated survey responses. During online recruitment, the research team encountered a number of

submissions that appeared inconsistent with the study population or demonstrated characteristics commonly associated with bot activity. Extensive data cleaning and quality assurance procedures were undertaken, including reviewing completion times, response patterns, internal consistency, duplicate entries, and eligibility criteria. Suspected fraudulent responses were removed from analysis to preserve data integrity. While these measures strengthened confidence in the final dataset, the experience highlights a growing challenge for community-based research that relies on online recruitment and incentives. Future studies should consider additional verification measures to balance accessibility, participant privacy, and data quality.

Additionally, despite targeted recruitment efforts, the study engaged fewer women and gender-diverse participants than intended. Their experiences may therefore be underrepresented within the findings. Future research should explore targeted strategies to engage these communities more fully.

Finally, while demographic information was collected, the data were not stratified within the thematic analysis. As a result, it was not possible to examine whether particular barriers were more prominent among specific ethno-racial communities, age groups, regions, immigration categories, or gender identities. Future research would benefit from more robust intersectional analyses capable of exploring these differences in greater depth.

Future Directions and Next Steps

While this study provides important insight into barriers and service gaps, it also raises new questions for future research. In particular, participants frequently highlighted the importance of ethno-racial identity in shaping experiences of stigma, belonging, discrimination, and healthcare access. Future studies should explore how experiences differ across ethnocultural communities and examine how cultural context influences access to care. Future research may also explore how individuals remain connected to care over time as immigration status, insurance coverage, employment, housing, and social networks evolve. Longitudinal research may provide valuable insight into continuity of care, service disengagement, and long-term health outcomes among LGBTQ+ IRNN.

Importantly, the findings of this report are not intended to remain static. Rather, they are actively informing the next phase of the Rainbow Resilience Program. This report will be shared with community members who participated in the needs assessment, partner organizations, healthcare and social service providers, members of the Rainbow Resilience Advisory Committee, and other stakeholders working to improve health equity for LGBTQ+ IRNN across Ontario. Findings will also be disseminated to WAGE, whose funding supported this initiative, as well as to broader community, academic, and policy audiences through presentations, knowledge mobilization activities, and future publications. The needs identified throughout this assessment have directly shaped the development of several initiatives designed to translate community knowledge into practical action including:

Sexual Health Roadmaps of Ontario

The identified need for centralized navigation tools led to the development of the Sexual Health Services Roadmap for LGBTQ+ IRNN across Ontario. This roadmap provides region-specific information on healthcare, HIV and HCV services, sexual health programs, housing supports, legal resources, settlement services, mental health supports, and community-based organizations. Designed to reduce navigation uncertainty, the roadmap allows individuals to identify relevant services based on geographic location, service type, and support needs.

Importantly, the roadmap is intended to be a living resource that will continue to be refined and updated as services, eligibility requirements, and community needs evolve.

Feedback from community members, peer navigators, and partner organizations will be used to ensure the information remains accurate, relevant, and responsive. The roadmap will also be shared broadly among Rainbow Resilience partner organizations to support service navigation efforts and strengthen referral pathways across sectors.

To support dissemination, the Rainbow Resilience team has also developed complementary print materials and informational pamphlets that incorporate principles identified throughout this needs assessment. In recognition of the importance of confidentiality and discretion, these materials have been intentionally designed to avoid explicit references to LGBTQ+ identities, HIV, or sexual health on outward-facing materials while still connecting individuals to relevant information and supports.

Beyond resource development, the roadmap will continue to serve as the foundation for ongoing navigation workshops delivered through partner organizations across Ontario. These workshops will support LGBTQ+ IRNN in understanding available services, navigating healthcare and social systems, identifying appropriate supports, and building confidence in accessing care. By combining practical navigation tools with community-based education, the roadmap is intended to provide information and strengthen individuals' ability to successfully engage with services throughout their settlement and healthcare journeys.

Initial versions of the roadmap can be found here:

- **Central Ontario:** https://canva.link/rcwiepxrjq5po9q
- **Eastern Ontario:** https://canva.link/migx7411a3bl4uv
- **Western Ontario:** https://canva.link/se5r81rd1u12bul

Connected Care Pathways Tool

Building upon this work, the Connected Care Pathways Tool is being developed as an interactive decision-support platform that will provide tailored service recommendations based on an individual's location, language preferences, insurance status, identity considerations, and service needs. By simplifying navigation and reducing uncertainty, the tool seeks to address many of the challenges identified throughout this assessment, including confusion around service eligibility, fragmented referral pathways, and difficulty identifying appropriate supports.

The concept for the tool emerged directly from the needs assessment itself. During consultations, one service provider reflected that they wished a resource existed that could help both community members and providers quickly identify relevant services without relying on personal networks, institutional memory, or extensive independent searching. This sentiment was echoed throughout interviews, focus groups, and survey responses, where participants repeatedly highlighted the need for centralized, easy-to-use navigation supports. The Connected Care Pathways Tool represents a direct response to these community-identified priorities.

Currently in development, the tool is anticipated to launch in early 2027. The platform will build upon the information contained within the Sexual Health Services Roadmap while providing a more personalized and interactive experience. Rather than requiring users to search through extensive resource lists independently, the tool will guide individuals through a series of questions and generate tailored recommendations based on their specific circumstances. It is envisioned as a resource for both community members and service providers, helping to strengthen referrals, improve navigation efficiency, and increase awareness of available supports across Ontario.

As development progresses, ongoing feedback from community members, peer navigators, and partner organizations will continue to shape the design and functionality of the tool.

Consistent with the broader goals of the Rainbow Resilience Program, the Connected Care Pathways Tool aims not only to improve access to information, but to reduce the burden placed on LGBTQ+ IRNN to navigate complex and fragmented systems on their own. access to information, but to reduce the burden placed on LGBTQ+ IRNN to navigate complex and fragmented systems on their own.

Peer Navigator Training Program

The findings have also directly informed the development of a Peer Navigator Training Program. Recognizing the central role of peers in fostering trust, belonging, and engagement, this initiative will train peer navigators from different regions across Ontario to provide individualized support, facilitate community workshops, disseminate sexual health information, and assist LGBTQ+ IRNN in navigating healthcare, settlement, and social service systems. Throughout the needs assessment, participants consistently highlighted the importance of receiving information and support from individuals who share similar lived experiences and understand the unique challenges associated with navigating services as LGBTQ+ IRNN individuals.

Peer navigators will serve as community-based points of contact and regional experts who can provide guidance tailored to local contexts. These peer navigators will be featured within the Sexual Health Services Roadmap and Connected Care Pathways Tool, allowing community members and service providers to identify trusted individuals who can offer navigation support within their region. In this way, the program aims to create opportunities for personalized support when individuals encounter challenges accessing services or understanding available options.

In addition to one-on-one navigation support, peer navigators will play an active role in community outreach and knowledge mobilization. They will facilitate workshops and information sessions within partner organizations and community settings, helping individuals better understand healthcare systems, sexual health resources, service eligibility, confidentiality protections, and available supports. By delivering information within familiar and trusted community environments, peer navigators will help reduce barriers related to uncertainty and system complexity.

Consistent with recommendations identified throughout this needs assessment, the program recognizes that effective peer support requires more than lived experience alone. Peer navigators will receive comprehensive training not only in sexual health, HIV, HCV, and service navigation, but also in trauma-informed practice, professional boundaries, confidentiality, cultural humility, communication skills, crisis response, facilitation, and community engagement. The program aims to equip peers with the practical skills necessary to safely and effectively support individuals with complex and intersecting needs.

Recognizing the emotional labour involved in peer-based work, peer navigators will also receive ongoing mentorship, supervision, and support from CAAT throughout their involvement in the program. This includes opportunities for continued learning, skills development, debriefing, and connection with other peer navigators across the province. By investing in both the training and long-term support of peers, the program seeks to build a sustainable network of community leaders across Ontario.

Language Adapted Pilot

Finally, in response to the significant language barriers identified throughout the assessment, the Rainbow Resilience team has begun piloting the translation and adaptation of program materials into Spanish in collaboration with community members. The translation pilot will therefore serve as an opportunity to test approaches to community-informed resource development and identify

best practices for future language adaptation efforts. Lessons learned through this process will inform expansion into additional languages and support the creation of resources that are not only linguistically accessible, but also culturally responsive.

Conclusion

This needs assessment sought to better understand the barriers, service gaps, and opportunities for improving access to HIV, HCV, sexual health, and related health and social services for LGBTQ+ IRNN across Ontario. Drawing on the experiences of 198 participants, including both service users and service providers, the findings reveal that access to care is shaped by far more than the availability of services alone.

Participants described a complex landscape characterized by system capacity limitations, navigation challenges, cultural stigma, discrimination, language barriers, and gaps in culturally responsive care. These barriers rarely occurred in isolation. Instead, they intersected and compounded one another, influencing whether individuals were able to identify services, access support, disclose sensitive information, build trusting relationships with providers, and remain connected to care over time.

At the same time, the findings demonstrate that significant strengths already exist within Ontario's healthcare, settlement, and community sectors. Participants repeatedly highlighted the dedication of frontline providers, the importance of peer support, the value of community-based organizations, and the resilience of LGBTQ+ IRNN communities themselves. These strengths provide an important foundation upon which future efforts can build.

A central finding of this assessment is that improving access requires more than expanding services. Participants consistently emphasized the need for systems that are easier to navigate, better coordinated, culturally responsive, linguistically accessible, and grounded in trust. Investments in sustainable funding, integrated systems of care, peer-based programming, language access, and provider competency were identified as critical pathways toward more equitable and affirming care.

The findings also reinforce the importance of understanding HIV, HCV, and sexual health within a broader social determinants of health framework. Housing, immigration status, income, language, mental health, social support, and experiences of belonging all shape health outcomes and influence individuals' ability to access and engage with care. Addressing sexual health inequities therefore requires approaches that recognize and respond to these interconnected realities.

Ultimately, this report is not only a documentation of barriers, but a reflection of the experiences and recommendations shared by LGBTQ+ IRNN and the organizations that support them. The insights provided through this needs assessment offer a roadmap for future action and underscore the importance of centering community voices in the design of services, programs, and policies.

As Ontario's IRNN population continues to grow and diversify, there is a critical opportunity to build systems that are not only inclusive in principle, but accessible, affirming, and responsive in practice. Achieving this vision will require sustained investment, meaningful partnerships, and a commitment to ensuring that all LGBTQ+ IRNN can access care with dignity.

Definitions

Use of "LGBTQ+"

Throughout this report, we use the acronym LGBTQ+ to refer to lesbian, gay, bisexual, transgender, queer, and other sexually and gender-diverse identities. While the acronym "2S/LGBTQ+" (Two-Spirit, lesbian, gay, bisexual, transgender, queer, and other identities) is widely used in Canada to recognize Indigenous Two-Spirit communities, our use of "LGBTQ+" in this report is intentional.

The Rainbow Resilience Program focuses specifically on immigrants, refugees, newcomers, and non-status individuals (including student and work permit holders) to Canada. During community consultations and program development, we made a deliberate decision not to include "2S" in reference to these populations, as Two-Spirit is a culturally specific identity rooted in Indigenous communities of Turtle Island. We did not want to misappropriate or generalize a term that does not reflect the identities of the population engaged in this study.

When referring to broader Canadian contexts or national communities, we may use 2S/LGBTQ+ where appropriate. However, in reference to the newcomer populations central to this assessment, we use LGBTQ+ to reflect the identities of participants while respecting the distinct cultural origins of Two-Spirit identity.

Additionally, variations of the acronym LGBTQ+ exist, including LGBTQI+ and LGBTQIA+. The decision to use the shorter acronym was also intentional. While we recognize and affirm the identities represented by the "I" (Intersex) and "A" (Asexual and Aromantic), few or none of the participants in this study explicitly identified with these identities. As such, we sought to avoid using terminology that may imply representation beyond the identities reflected within our participant group. Our use of LGBTQ+ is therefore not intended to exclude, but to align accurately with the communities engaged in this assessment.

Definition of "Immigrant, Refugee, Newcomer, and Non-Status Individuals (IRNN)"

The term "IRNN" does not correspond to a single official immigration category. In this report, it is used broadly to refer to individuals who have immigrated or relocated to Canada, regardless of immigration stream, migration status, or length of time since arrival.

This includes, but is not limited to, permanent residents, refugees, refugee claimants, international students, temporary foreign workers, individuals with precarious or undocumented status, and naturalized citizens who identify as having settlement experiences within Canada.

Importantly, "IRNN" in this context is not defined strictly by years since arrival. Rather, it reflects shared experiences of migration, adaptation to Canadian systems, and navigation of health and social services in a new socio-political environment. Individuals may continue to experience barriers related to migration, language, insurance eligibility, racialization, and system unfamiliarity long after their initial arrival.

This definition acknowledges that immigration-related challenges are dynamic and may evolve over time as individuals move through different immigration statuses, insurance frameworks, and social contexts.

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