CASE 9

A Knot of Contradictions: Systems of Intersectionality and Muslim LGBTQ+ Mental Health Programs[1]

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To Sara (سارة): I'm sorry we couldn't find you sooner and I'm sorry we weren't there for you. Rest in Peace, you will not be forgotten.

On the flight back to Ottawa, Yasmin Baytar's mind is racing. She has never experienced such an intense connection to a project before. Yasmin, a policy analyst in the Canadian Centre for Health Equity (CCHE or the Centre) a research arm for a top Canadian East Coast University, is returning from Vancouver after attending the Women Deliver 2019 conference. Women Deliver is an organization that advocates for gender equity and the health and rights of girls and women worldwide. Every three years Women Deliver holds a conference to address ongoing global, inequity-based issues affecting women and girls. Because the conference was held in Vancouver this year, Yasmin was able to fly there to represent the CCHE.

Yasmin distinctly recalls the workshop she attended that sparked her interest. She cannot remember the name of the organization that hosted it, but she certainly remembers what they do, which is support and address the unique mental health needs of the Lesbian, Gay, Bisexual, Transgender, and Queer plus (LGBTQ+) Muslim community in Vancouver. She is excited and re-energized by the work being done and by what she has learned.

Yasmin has been at CCHE for several years after completing her Master of Public Policy degree, and has worked at several projects over the years. This time, she felt different; she was excited about the next project she wanted to focus on – a community-based intervention aimed at addressing the mental health needs of the Muslim LGBTQ+ community. Through her unique lived experience, Yasmin knows what it is like to feel as if you are a small minority in the world and to feel like you do not belong. After all, she does belong a small minority of people who openly identify as being both Muslim and LGBTQ+. The vast majority of Muslim LGBTQ+ individuals hide their true identities, afraid of speaking out on their faith in LGBTQ+ community and of openly identifying as LGBTQ+ in their Muslim communities. They live in a knot of contradictions that allows them to see the world through a unique lens. Only after attending this workshop did she finally feel seen and understood. Yasmin has not worked in a community capacity before, but she has read about it and knows she can apply her comprehensive

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knowledge to developing such an intervention. Plus, she knows that her lived experience will help. Remembering her recent Sex- and Gender-based Analysis Plus (SGBA+) (Exhibit 1 & 2) training and thinking about the possibility of a multisectoral partnership through CCHE, Yasmin decides to use her background knowledge to develop an intersectional intervention that addresses her community's mental health concerns. SGBA+ is an analytical tool and process that ensures that policies, programs, and initiatives are planned, implemented, and evaluated through an intersectional lens. SGBA+ supports program organizers in assessing how their programs may impact diverse populations beyond sex and gender (Women and Gender Equality Canada, 2018b).

Currently, very little programming exists in Canada to address the very specific mental health needs of the Muslim LGBTQ+ community. LGBTQ+ Muslims face hardships and stigma because of their intersecting identities, which can contribute to negative health outcomes. Unfortunately, literature on this marginalized population is sparse, making it difficult to evaluate which public health interventions would support this community best. In Canada, there is a growing need to address negative health outcomes in the Muslim LGBTQ+ community, which continues to be under researched, underserved, and rendered invisible. Yasmin is inspired by the work the Vancouver organization is doing and decides to bring this information back to CCHE with her, having identified a service gap in her LGBTQ+ Muslim community. She needs to design and implement a program that will fit the needs of the LGBTQ+ Muslim population across Canada.

BACKGROUND

Intersectionality

In 1989, Kimberlé Crenshaw coined the term "intersectionality" and described the underlying theory behind it (Crenshaw, 1989). The theory emerged from concepts debated in critical race theory circles. Crenshaw's paper delves into three legal cases that simultaneously deal with sex and racial discrimination (Coaston, 2019). In her paper, Crenshaw argues that the courts need to recognize that Black women face discrimination both because they are female and because they are Black, with discrimination sometimes "intersecting" on those margins so that these women experience a combination of both systems of marginalization (Crenshaw, 1989). Viewing discrimination in silos, either on the basis of gender or on the basis of race, does not address the intersection and interplay of these systems of power.

Since then, the concept of intersectionality has evolved, and its use has expanded beyond its original meaning. It is now used to describe the way people's identities intersect diversely, thereby impacting their everyday lives as a result of their identities. However, according to Crenshaw, the mere recognition of intersecting identities is not enough to describe the way intersectionality should be used. Rather than merely focusing on people's individual identities, and the way people exist through their individual identities, intersectionality moves to recognize the intersecting systems of power and how they impact the groups who lack this power (Coaston, 2019). Intersectionality can help us understand not only how systems of power can interconnect, thereby affecting populations in a multitude of ways on various axes of power and discrimination, but also how to mitigate those impacts by addressing the root cause of the discrimination.

Yasmin wants to make sure she was not focusing her program only on individual identities, but rather on how these identities are affected by existing systems of power in society. She needs to understand both individual and community level impacts of discrimination and power dynamics.

The Social Ecological Model

The Social Ecological Model or Socio-Ecological Model (SEM) (Exhibit 3) is a concept that considers the complexity of interaction between various levels in society (Centers for Disease Control and Prevention [CDC], 2019). These levels include societal, community, relationship, and individual level factors (CDC, 2019). The model posits that, in order to implement successful public health interventions using an upstream approach, the four different levels need to be addressed simultaneously (CDC, 2019). For example, when thinking about health inequity at the individual level, important factors to consider include biological and personal factors such as age, gender, sexuality, income, and other determinants of health. At the relationship level, social support networks, including close family and friends, need to be considered. At the community level, interventions that include social settings that define who we are and what we do are important. The fourth and broadest level is the societal level, which looks at factors in society that influence health inequity, such as systems of power.

As a tool, the SEM provides the ability to think about how these different levels act on their own, as well as how they may influence each other. Yasmin knows that for her program to be a success, she needs to think of ways to implement her program to include these different levels.

Equality, Equity, and True Equality

The concepts of equality, equity, and true equality (Exhibit 4) are closely related but represent different ways of understanding and addressing different population needs. Equality assumes that in order to achieve positive health outcomes for different populations, everyone from diverse backgrounds and populations should be treated the same (Women and Gender Equality Canada, 2018a). Equality does not recognize that varying populations experience different forms of discrimination and power dynamics that may have differing outcomes on their health.

Equity, on the other hand, builds on the concept of fairness, wherein individuals are provided with different treatments and supports depending on what barriers they encounter (Women and Gender Equality Canada, 2018a). This allows them to receive the supports they need, depending on their requirements and circumstances. Equity recognizes that different populations experience power dynamics and discrimination in different ways, depending on their identities and the systems of power they face.

In order to truly address the needs of diverse populations, the systems that enforce and maintain the barriers should be broken down and removed (Women and Gender Equality Canada, 2018a). The third concept, true equality, looks to improve health needs by breaking down systemic barriers that keep different populations marginalized. SGBA+ is a tool that can be used to help recognize and address these systemic barriers (Women and Gender Equality Canada, 2018a).

Sex- and Gender-Based Analysis Plus

By signing the 1995 United Nations Beijing Platform for Action declaration during the Fourth World Conference on Women (United Nations, 1995), Canada committed to utilizing SGBA+ in all projects and programs. SGBA+ supports program organizers in assessing how their programs may impact diverse populations beyond sex and gender (Women and Gender Equality Canada, 2018a). By incorporating Crenshaw's theory of intersectionality into the tool, Canada recognizes that people's identities and experiences involve more than their sex (biological) and gender (social and cultural). SGBA+ allows government branches and agencies to address health inequity for diverse populations across their policies, programs, and initiatives.

Since its inception, CCHE has been incorporating SGBA+ into its internal and external work. Through internal capacity-building efforts, the Center is working to build internal capacity by incorporating SGBA+ into its diverse programs and portfolios. Further, by collaborating through multisectoral partnerships, the Center supports analyzing the way SGBA+ is used to inform each community partner's program, depending on their population of interest.

The process of conducting SGBA+ begins by identifying the issue being faced (Women and Gender Equality Canada, 2018b). Once the issue is identified, SGBA+ asks to examine assumptions and challenges them depending on the issue raised (Women and Gender Equality Canada, 2018b). The identified assumptions can then be challenged through researching, consulting, and gathering facts about the population of interest (Women and Gender Equality Canada, 2018b). Through this, options and recommendations are developed based on the research findings, and progress is continually tracked and evaluated (Women and Gender Equality Canada, 2018b). Although this may seem like a linear process, SGBA+ can be utilized in a cyclical fashion. SGBA+ also requires that the people using the tool document and communicate findings to stakeholders to ensure transparency and accountability (Women and Gender Equality Canada, 2018b).

Yasmin has supported multisectoral SGBA+ partnerships through her work at the Center and she hopes she could do the same with her new project.

SPECIFIC AREA OF INTEREST

Mental Health Disparities in the LGBTQ+ Population

From her research, Yasmin knew the systems of oppression such as homophobia that impact LGBTQ+ people contribute to negative health outcomes for this population (CDC, 2017). Discrimination and violence resulting from homophobia account for higher rates of bullying and harassment at school among LGBTQ+ people (CDC, 2017). When interacting with other systems of oppression and marginalization, such as discrimination based on gender identity or discrimination based on race or culture, these systems of oppression begin to intersect, creating more harmful impacts for those vulnerable populations. Yasmin knew the harsh realities – LGBTQ+ youth are about 14 times more likely to die by suicide, a leading cause of death for this population, than non-LGBTQ+ youth (Canadian Mental Health Association [CMHA], n.d.; National Alliance on Mental Illness, 2018). Furthermore, in Ontario, LGBTQ+ people are over-represented in lower socioeconomic status brackets, with approximately half of transgender individuals living on less than $15,000 a year (CMHA, 2019). Transgender people are also more at risk of death by suicide and suicidal ideation; an Ontario-based survey of trans respondents showed that 77% of Ontario's transgender population had considered suicide and 45% had attempted it (CMHA, 2019). This population is further marginalized when LGBTQ+ identities intersect with other forms of oppression and marginalization (CMHA, 2019). The systemic inequalities experienced by LGBTQ+ people because of their identities points to the importance of providing mental health support for the LGBTQ+ population.

Over the past few years, research has shown the importance of community engagement for populations that experience systemic violence and marginalization (Kulick et al., 2017). For marginalized populations, community engagement not only supports their ability to heal together from traumatic experiences linked to systemic oppression and marginalization, but it also supports individual self-efficacy by mitigating the impacts of these systemic barriers (Kulick et al., 2017). However, it is important to note that community engagement takes time and energy, and this often manifests in the form of unpaid labour. When the communities experiencing the brunt of systemic marginalization are highly involved in community engagement, this

engagement can have negative rather than positive effects (Kulick et al., 2017). As such, to understand the connection between community engagement and mental health and wellbeing for LGBTQ+ populations, a nonlinear association must be used. This is because low and high levels of community engagement are associated with higher rates of depression, whereas a moderate level of community engagement results in lower rates of depression and benefits individual mental health and wellbeing (Kulick et al., 2017).
Moderate levels of community engagement support LGBTQ+ populations in their efforts to develop social support networks without detrimental impacts on mental health and wellbeing (Kulick et al., 2017). For LGBTQ+ people who also have other identifying factors such as race and culture, being involved in LGBTQ+ community engagement mitigates the impacts of depression (Kulick et al., 2017). Yasmin wanted to ensure community engagement was built into her program while making sure to recognize that everyone has different accessibility barriers and different time and energy capacities.

To ensure her program fit the needs of the community, she had to find balanced community engagement programming that achieved a moderate level of engagement.

Mental Health Disparities in the Muslim Population
Because the North American Muslim population is rapidly increasing, there is a growing need for culturally competent mental health interventions that are specific to this community (Mir et al., 2015). Of the nearly one million Muslims residing in Canada, approximately half live in Ontario (Warsi, 2019). Research has shown that ethnocultural immigrant groups have low rates of mental health consultations, with the Canadian Muslim population having half the rate of mental health consultations with physicians compared with the Canadian-born population (Islam et al., 2017). This gap in service, coupled with the stress of migration and relocation and their negative impacts on mental health, requires that a specialized mental health intervention focused on Muslims be developed (Islam et al., 2017).

Research suggests that developing population-specific interventions and incorporating religious and cultural practices into mental health interventions can render better health outcomes, especially for ethnically marginalized groups (Mir et al., 2015). For many Muslims, the use of religion and faith as part of a holistic mental health intervention is vital to ensure positive health outcomes (Warsi, 2019). Muslims in Canada need special consideration when mental health interventions are designed because they observe varied religious practices that could affect their daily wellbeing. For example, during Ramadan, the Islamic month of fasting, different religious practices and customs need to be considered when clients who have mental health concerns are treated (Furqan et al., 2019). These could include accounting for medication intake timing if patients are taking medication for their mental health, and incorporating different spiritual group activities to ensure that social networks allow for support and social integration (Furqan et al., 2019). Yasmin needs to determine a way to incorporate religious and cultural practices, when appropriate, into the planning of her intervention.

Mental Health Disparities in the Muslim LGBTQ+ Population
Unfortunately, there is a lack of published literature on the mental health needs of the Muslim LGBTQ+ population. This is going to make it more complicated for Yasmin to make her case for funding a mental health pilot program. Determined to find answers, Yasmin sat at her computer typing furiously, searching for answers to the questions whirling around her head. She has not investigated this topic for a while, the last time being a few years ago when she was trying to find answers about herself and her own identity. Holding a coffee in one hand, she skims through the literature to find the most recent articles on the topic, first focusing on the

intersection of spirituality and LGBTQ+ identity. She finds a study showing that spiritual LGBTQ+ people who are condemned by mainstream religious sects can be negatively impacted by this condemnation (Beagan & Hattie, 2015). Further, depending on the degree of intolerance from the religious sect, the harm experienced can be emotional, mental, and/or spiritual (Beagan & Hattie, 2015). Yasmin changes direction, searching now for any research that discusses the intersection of Islam and LGBTQ+ identity. An article catches her attention. She sighs because it is the same article she found years ago when she was trying to find answers about her own contradictions and identity struggles.

The article explores the influence of Islam on people who are Muslim and LGBTQ+ in North America who access a support organization called Al-Fatiha Foundation (Minwalla et al., 2005). Al-Fatiha was a North American grassroots organization founded in 1997 ("Al-Fatiha Foundation," n.d.). The name Al-Fatiha refers to the first *Surah,* or chapter, from the Qur'an, and means "the opening". The organization is predominantly online and has various regional offices across North America. It supports Muslim LGBTQ+ individuals by connecting them with other Muslim LGBTQ+ people across North America, and by running annual events that explored the intersection of Islam and LGBTQ+ identity (Minwalla et al., 2005; "Al-Fatiha Foundation," n.d.). Unfortunately, because of unsustainable leadership and ongoing pressures from conservative Muslim sects, including threats to safety and the issuing of a *fatwa* (Islamic ruling issued by a religious leader) against the organization and its members, the organization dissolved in 2011 (Minwalla et al., 2005; "Al-Fatiha Foundation," n.d.). Although the findings from the original research article are valid and could potentially be replicated in a different study, the context in which it existed has changed.

This article is one of the first to document the Muslim LGBTQ+ experience in the North American context and to explore what it means for Muslim LGBTQ+ members to live this intersection (Minwalla et al., 2005). Minwalla and colleagues (2005) state that, although some Muslim scholars are moving toward accepting homosexuality as part of Islam, the stress and anxiety that LGBTQ+ Muslims carry, because they are unable to reconcile their sexuality or gender identity with their faith, can cause negative mental health outcomes. Minwalla et al. (2005) stated that Muslim LGBTQ+ people initially reject their religious identity and traditions during the early coming out stage, but eventually accept and own both their sexual/gender identity and their religious identity and find there is a need to incorporate both identities. On a fundamental level, the study proved that Muslim LGBTQ+ people exist, and that their experiences with religion and sexuality or gender identity should not be seen as irreconcilable differences, but rather as coexisting identities that should be integrated (Minwalla et al., 2005). This meant that Yasmin has to think about what this might mean for the mental health and emotional and spiritual wellbeing of Muslim LGBTQ+ people.

Yasmin decides to explore the grey literature on this topic. If she could not find the results in peer-reviewed literature, maybe she could find out what Muslim LGBTQ+ people were saying online and in other contexts. Yasmin comes across a TEDx talk by Blair Imani, a Black, Muslim, bisexual historian, writer, and activist (Imani, 2019). Imani, standing on a lit stage, speaks passionately and unequivocally about being Black and Muslim and queer, and how those identities exist within her, finding that she needs to reconcile nothing between them because she herself exists (Imani, 2019). Yasmin realizes that for her program to be successful, she needs to integrate Islam and queerness rather than attempt to see them as differences that need to be reconciled. This realization brings up intersectionality for her all over again. Intersectionality posits that we cannot simply add the varying systems of oppression and marginalization that populations experience, but rather that these must be understood from a

more contextual perspective (Kulick et al., 2017). Yasmin needs to figure out a way to incorporate intersectionality into her program design while keeping in mind that to address the mental health needs of the Muslim LGBTQ+ community, religion and queerness need to coexist as identities.

SPECIFIC PROBLEM OF DECISION

Yasmin faces several issues. She has a growing concern for the mental health needs of her Muslim LGBTQ+ community members, minimal programming to support the Muslim LGBTQ+ population, a lack of evidence to help her inform her work, and a program to plan with no idea where to start. She needs to find robust evidence to show the unique health disparities that this population faces. She knows support for this community is needed urgently. How is she going to show this is truly a public health issue when the published literature on this topic is essentially nonexistent? How is she going to capture the diversity of experiences, genders, sexualities, and people in this population? Where is she going to find this evidence? How is she going to prove the need for funding? Should she jump into her pilot program? At what level of intervention should she direct her program? Where should she start planning this program? Most important, how is she going to reach such an invisible and diverse population?

CONCLUSION

The Muslim LGBTQ+ community is a unique and often unseen population. There is a serious need for a community program that addresses the mental health needs of the Muslim LGBTQ+ community in Ottawa. Yasmin is excited to plan this program, but she is overwhelmed and not sure where to start. She wants to jump right in, but she knows that taking time to consider all the angles will help make this program a success. Yasmin has a lot to think about. How and where was she supposed to start?

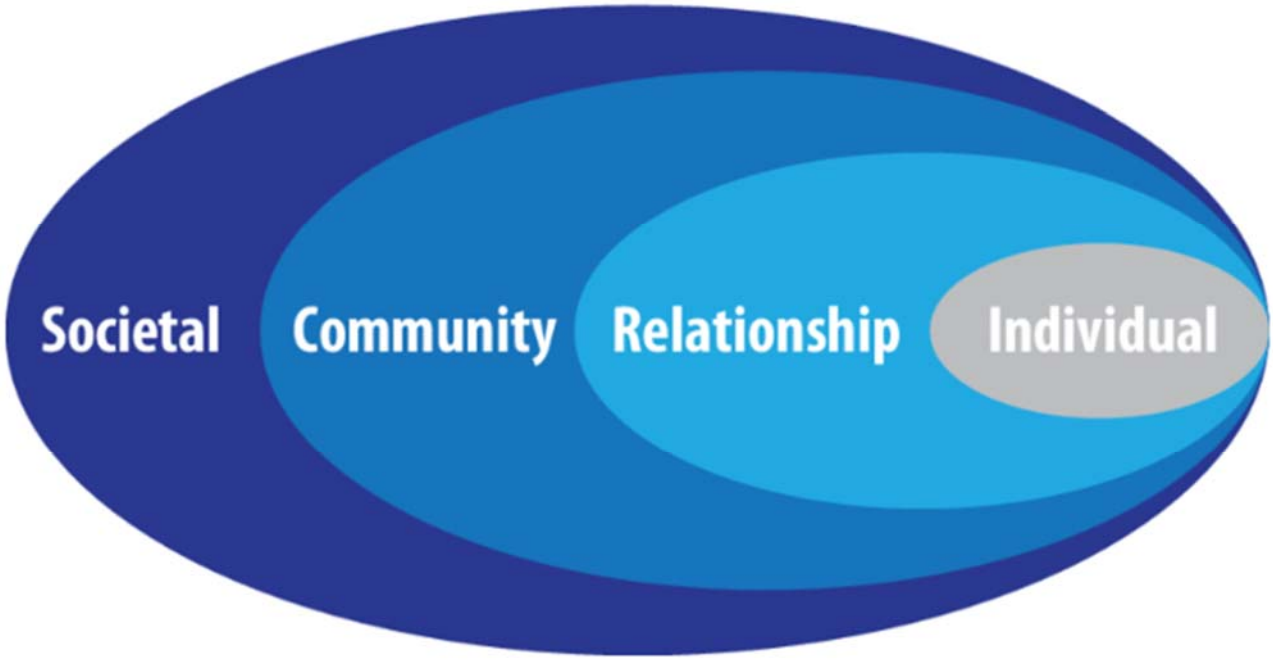
EXHIBIT 1
Sex and Gender Based Analysis+ Flower

Source: Women and Gender Equality Canada, 2018a.

EXHIBIT 2
Sex and Gender Based Analysis+ Process

Source: Women and Gender Equality Canada, 2018b.

EXHIBIT 3
The Social Ecological Model



Source: Centers for Disease Control and Prevention, 2020.

EXHIBIT 4
Equality, Equity, and True Equality

Source: Adapted from Craig Froehle's image, and inspired by Anti-Oppression Workshop by Anna Soole, with wording revised.

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INSTRUCTOR GUIDANCE

A Knot of Contradictions: Systems of Intersectionality and Muslim LGBTQ+ Mental Health Programs[1]

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BACKGROUND

The case involves the protagonist, Yasmin Baytar, a queer Muslim woman who returns from the 2019 Women Deliver conference with the goal of implementing a community mental health program focusing on the LGBTQ+ Muslim population in Ottawa. She has extensive Sex- and Gender-Based Analysis Plus training and knowledge about intersectionality that she can use to develop a program that embraces true equality. However, she also needs to figure out how to obtain funding for her program and collaborate with different stakeholders while making sure she is keeping her population of interest involved and at the centre of her work.

Students must use systems thinking approaches and recognize the importance of intersectionality when building the community mental health program. Incorporating an element of cultural sensitivity/competency into the program will show the students' ability to critically think about an issue while taking intersecting identity factors into account. Furthermore, recognizing the importance of various levels of intervention, students will use the Social Ecological Model to ensure a multipronged, multileveled approach is included as the program is built. Students will be able to collaborate with a variety of experts/stakeholders to ensure the success of the intervention.

OBJECTIVES

1. Adopt and implement the health planning process, which includes completing the planning cycle for health planning and conducting a needs assessment.
2. Understand and apply intersectionality and a Sex- and Gender-Based Analysis Plus lens throughout the health planning process. Use and apply learning from the Master of Public Health course "Social Determinants of Health".
3. Apply stakeholder engagement and collaboration knowledge from the Master of Public Health course "Leading People and Organizations in Public Health".

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DISCUSSION QUESTIONS

1. What is intersectionality? What makes this an intersectional case?
2. What factors and systems are intersecting that make it more challenging for planning a health program? What challenges will arise?
3. What does Yasmin require to plan this program? How is she going to find evidence to demonstrate the program need for her population of interest?

KEYWORDS

Cultural competency/cultural safety; health inequities; systems; systems of power; Muslim LGBTQ+ identity; mental health; SGBA+