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Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula / Exigences en matière d'enseignement et d'évaluation pour la santé et le bien-être des personnes LGBTQI2S+: un appel pour inclure du contenu dans les programmes de baccalauréat en sciences infirmières de langue anglaise au Canada

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Introduction

Nursing education is an exceedingly complex field with many demands for content. Sexuality and gender identity have been on the North American radar for a number of years, but something about the subjects, in relation to other professional curricular demands, means there has been a failure to appropriately address such content in a systematic way (Barrett & McKay, 1998; Brondan & Paterson, 2011; Coleman et al., 2013; Colpitts & Gahagan, 2016; Eliason, Dibble, & DeJoseph, 2010; Lim, Johnson, & Eliason, 2015; Malhorta, Khurshid, Hendricks, & Mann, 2008; Obedin-Maliver et al., 2011). These and other studies demonstrate that health care students lack accurate knowledge about important sexuality and gender identity health and wellness issues.

Community-based studies can also attest to the impact of limited Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Two-Spirit, and Ally (LGBTQI2S+) information in health care curricula (e.g. The Centre, 2006; Daley & MacDonnell, 2015; L'Heureux, 2006). The simple fact is that some LGBTQI2S+ people are treated by caregivers who are unaware or insensitive to their health care needs (Aguinaldo, 2008; Bonivicini & Perlin, 2002; Fish, 2006; Harbin, Beagan, & Goldberg, 2012; Hinchliff, Gott, & Galena, 2005; Mosher, 1999; Waldura et al., 2016). Situations arise where the (in)visibility of sexuality and gender diversity cause LGBTQI2S+ people to avoid seeking care, receive inappropriate care, or face prejudice when in care (Brotman et al., 2007; Harbin et al., 2012; Irwin, 2006; Kitzinger, 2005; Neville & Henrickson, 2006). Health care providers can cause adverse health consequences, the least of which are delays in seeking care (see Dreyer, 2007; Harbin et al., 2012; Meyer et al., 2008; Mulé et al., 2009; Sinding, Barnoff, & Grassau, 2004).

Patient safety has been recognized as a central professional mandate by the Canadian Nurses Association (Canadian Nurses Association [CNA] & University of Toronto School of Nursing, 2004). Brennan, Barnsteiner, de Leon Siantz, Cotter, and Everett (2012) state, "Faculty in schools of nursing need to incorporate content related to LGBTQI2S+ needs across the curriculum to help eliminate health care deficiencies and move toward the goal of health equity for all populations" (p. 103). Nursing, like all disciplines that prepare the next generation of health care providers, is working diligently to produce well-rounded knowledgeable health care providers, yet without appropriate education, recent graduates may not be prepared to adequately provide care to LGBTQI2S+ communities (Coleman et al., 2013; Goldberg, Rosenburg, & Watson, 2018; Lim et al., 2015).

Research in nursing curricula often focuses on the educator as a site of influence, rather than the profession's curricular policy. Spenceley, Reutter, and Allen (2006) state that "the individually focused view has had the effect of limiting our [nursing's] assessment of the root causes of injustices or inequalities, leading us to pursue short-term one-off solutions to the individually experienced effects of systemic problems" (p. 183). However, nurses are uniquely positioned to significantly contribute to promoting health equity, justice, and wellbeing due to their large numbers in the workforce and influence on direct patient care (see Goldberg et al., 2018).

Within our cissexist and heterosexist system, Boehmer (2002) suggests that LGBTQI2S+ people have not been identified as a population with specific health and wellness concerns outside of a framework of sexually transmitted blood borne infections (STBBIs) (see also Mulé at al., 2009). Furthermore, existing medical discourses have been (and continue to be) critiqued

for framing sexuality simplistically as a matter of STBBIs/HIV/AIDS, contraception, pregnancy, and ignoring a range of other factors (Coleman et al., 2013; Dean et al., 2000; Makadon, Mayer, Potter, & Goldhammer, 2008; Manning, 2009; Sagarin et al., 2009; Sandnabba, Santtila, Allison, & Nordling, 2002; Steinauer et al., 2009). A limited view of sexuality and gender identity may result in substandard care, while an anti-oppressive critical framework of intersectionality suggests that all social determinants of health impact the issues faced by LGBTQI2S+ peoples (Dean et al., 2000; Jackson et al., 2006; Makadon et al., 2008; Mosher, 1999; Mulé et al. 2009; Ricters, et al. 2008).

Because of this limited view of sexuality and gender diversity, LGBTQI2S+ people can experience minority stress and encounter microaggressions while receiving care (Kitzinger, 2005; Mulé et al, 2009). Primarily used in race theory, microaggressions are delivered by well-meaning and well-intentioned individuals who are unaware of the unconscious biases they hold (Shelton & Delgado-Romero, 2011). For instance, assumptions of having an opposite sex intimate partner or a biological match to a particular gender presentation affect care in many situations (Brotman et al., 2007; Harbin et al., 2012; Kitzinger, 2005; Mathieson, Bailey, & Gurevich, 2002; Waldura et al., 2016). These assumptions (and the communicated microaggressions) contribute to minority stress and convey a lack of knowledge about the social location and lived realities of individuals who are sexually or gender non-conforming, resulting in unfavourable patient-centred care.

As part of a larger Health Canada funded research project in 2006, L'Heureux conducted telephone interviews with 11 schools of nursing (Hellquist, 2006). There were no mandatory courses devoted entirely to sexuality and gender identity health and wellness; nonspecific content was included under the umbrella of "diversity" (L'Heureux, 2006, p. 6). LGBTQI2S+ health and wellness issues were not identified as a primary focus in any institution. At best, it was "a special topic in a third-year course" or touched on "several times in a single course" or "covered in one lecture" (L'Heureux, 2006). Nursing school leadership also said it "arose from student discussions only," "material [was] provided in the textbook," "students are encouraged to reflect on LGBTQI2S+ issues on their own," or that it was "part of the program's philosophy of inclusiveness, respect, and diversity" (L'Heureux, 2006). Without the ability to provide concrete evidence of curricular materials, L'Heureux's research demonstrated significant curricular variations and found that there were significant shortcomings in nursing curricula across Canada. L'Heureux (2006) also found that most Canadian nursing programs reported the need for 1) information/resources on issues of gender diversity and inclusive language, 2) research on access to care issues, and 3) guidance on how nursing students can approach the health history interview without immediately assuming heterosexuality (L'Heureux, 2006, p. 10). The institutions interviewed also requested consultation with the LGBTQI2S+ communities to address the quality of resources being used in nursing programs (L'Heureux, 2006). L'Heureux (2006) suggested the need to conduct curricular review using a queer lens.

Brennan et al. (2012) found weaknesses in US nursing curricula with limited amounts of core sexuality and gender identity content included. More recently Lim, Johnson, and Eliason (2015) received 1231 surveys from US nursing faculty finding that over 50% of respondents seldom to never taught 13 pertinent LGBTQI2S+ health and wellness topics in the last two years (Lim et al., 2015, table 2, p. 147). Outside of curricular review, exploring educational competencies for known LGBTQI2S+ health and wellness issues constitutes a gap in the literature. This research is a first step in filling that gap; there has not been academic research

into LGBTQI2S+ content in the Canadian Nurses Association (CNA), the Canadian Association of Schools of Nursing (CASN), the Canadian Council of Registered Nurse Regulators (CCRNR), and other provincial colleges and professional associations' documents. Additionally, Lim et al. (2015), note that the American National League for Nursing and the American Association of Colleges of Nursing do not have clear recommendations for including sexuality and gender identity content for nursing schools and educators.

Since this research has been conducted (2013–2015), the Canadian Nursing Students Association has committed to advocating for the inclusion of curricula in the area of LGBTQI2S+ health and wellness (CNSA, 2017).

Method

A survey was developed to answer the following question: "What information on sexuality and gender identity health and wellness exists in Canadian English baccalaureate nursing programs and related policy?" Obedin-Maliver et al. (2011) granted permission to adapt some of their survey questions, which queried the inclusion of LGBTQI2S+ content in undergraduate medical curricula in Canada and the US. The final thesis (Shortall, 2017) was sent to their research centre as well as Lim, Eliason, Mulé and all Canadian national and provincial nursing professional organizations mentioned.

Critical discourse analysis of 52 professional nursing education policy documents was scaffolded against survey data to situate responses within a broader framework. Ethical approval was granted by the university in which the study was being conducted. The survey was put online at LimeSurvey and piloted by a thesis committee member. Seventy-six institutions teaching Canadian English-language BN programs were identified through online searches of accredited and non-accredited programs. Department heads, deans, faculty chairs, or otherwise leadership, for all 76 nursing schools were contacted. Regrettably, no French language nursing programs were included due to language barriers. Only one institution refused participation on the basis of their religious doctrine. Seventeen institutions responded (some provided multiple responses), and 24 completed surveys were returned (six from British Columbia, two from the Prairies, seven from Ontario, and two from Atlantic Canada). Provincial frequencies were in line with expected frequencies to provide a proportionally representative sample. Multiple responses from the same institution were used to check internal validity pertaining to that institution. Of the 17 reporting institutions (circa 2015), seven reported part-time BN programs, 15 reported full-time BN programs, five reported fast-track programs, 12 reported collaborative programs, and eight reported post-RN programs, as the requirement to standardize BN for entry-to-practice was coming into effect at the same time.

The survey consisted of 24 questions with open comment boxes. No demographic information was collected other than the name of the responding institution. The survey was intended to be completed by faculty leadership, someone who is generally familiar with the institution's entire nursing curriculum; its development, transmission, evaluation, and accreditation. The survey was left open for a full calendar year with multiple calls for participation. The survey included questions about the CRNE provincial licensing exam (since changed to the NCLEX-RN), whether or not faculty members had access to LGBTQI2S+ professional development opportunities, and the availability of student internships/practicum/placements with LGBTQI2S+ populations. It also asked how specific information was communicated and if independent student projects in LGBTQI2S+ health and

wellness issues were available. The bulk of the survey asked how LGBTQI2S+ content is taught in curriculum, and what nursing school leadership believed to be the main sexuality and gender identity health and wellness issues that should be included in future curricula. Respondents were asked to supply available curricular resources and to note if faculty conducted any research in the area.

Documents are important social products nestled within a specific discourse, and their presence or absence in the world depends on a collective organized action (Prior, 2003). Prior (2003) states that "dismantling documents is packed tight with assumptions, concepts and ideas that reflect on the agents who produced the documents, and its intended recipients, as much on the people and events reported on" (p. 48). Document analysis is the qualitative analysis of textual data to identify prominent themes in written materials, and subsequently reveal patterns among those themes (Polit & Tatano Beck, 2008; Thorne, 2016). More precisely, critical discourse analysis is a research technique for making replicable and valid inferences from textual data to their context (Krippendorff, 1980). It is a systematic way of analyzing text focusing on the political and social import to denaturalize the ideologies within them; giving insight into the ways in which micro and macro contexts are linked together. Rogers, Malancharuvil-Berkes, Mosley, Hui, & O'Garro-Joseph (2005) argue that critical discourse analysis often identifies unintended consequences of educational decisions, policies, and social practices.

Using inclusion/exclusion criteria, this research investigated provincial and national entry-to-practice competencies, core educational requirements, nursing practice standards, position statements, educational program policies, and the CNA Code of Ethics (2008) to identify where and how LGBTQI2S+ sexuality and gender identity health and wellness issues were mentioned. Documents were collected through online searches and snowball sampling. Provincial and national professional nursing association websites were checked multiple times during the multi-year research. Documents were saved and searched using the PDF find function for the following: sex, gender, client, person, cultur*, divers*, vulnerab*; truncated words reveal all possible extensions. Using Elo and Kyngäs's (2007) combined inductive and deductive method, documents were read multiple times completely with 16 known health and wellness issues in mind (see Table 1).

Texts were highlighted for relevance. Then, sections were read and reread alongside the survey results and comments. An understanding of if and how inclusion of LGBTQI2S+ health and wellness issues was built (Shortall, 2017).

Results

Most institutions had a required course that included some discussion of adolescent sexual health, STBBIs/HIV/AIDS, and/or safer sexual health. While not all institutions educate on these fundamental sexual health issues, there was greater variety in institutions reporting LGBTQI2S+ health and wellness issues. The following topic areas were not formally structured throughout curricula, and the content location and particularities varied greatly depending on the instructor and their comfort level with the topics.

Table 1

Inclusion of LGBTQI2S+ Content in Curriculum (raw data uncorrected for institution)

Topic	Covered in a required course	Maybe covered in an elective	Not in the curriculum per se	Don't know/no answer
Sexual orientation	13	1	6	4
Coming out	6	2	10	6
Gender expression	9	2	7	6
General mental health	13	1	6	4
Body image generally	18	1	3	2
Safer sex generally	19	1	1	3
Adolescent sexual health	17	1	1	5
STBBIs/HIV/AIDS	20	1	0	3
Sex reassignment therapy (GAS or GCS)	5	2	10	7
Intersex and "disorders of sexual development"	5	3	8	8
Transitioning (including MtF and FtM)	6	2	10	6
Barriers to accessing medical care for LGBTQI2S+ people	11	2	9	2
Problematic alcohol, tobacco, and/or drug use generally	20	1	1	2
Chronic diseases relevant to LGBTQI2S+ populations	10	0	10	4
Unhealthy relationships/partner violence	20	1	0	3
Parenting/insemination/sexual reproduction	11	1	7	5

Survey categories, such as "problematic alcohol, tobacco, and drug use generally" were intentionally worded "generally," as it was assumed that specific evidence from LGBTQI2S+ communities would not be commonly known. These "general" questions were designed to solicit information on whether topics of known health concerns for LGBTQI2S+ populations were currently being taught regardless of subjectivity. While half of respondents reported "barriers to accessing medical care for LGBTQI2S+ people" and "chronic diseases relevant to LGBTQI2S+ people" were covered in a required course, the other half said they are not in the curriculum at all. This result shows great disparities in the curricula of Canadian nursing institutions.

On the whole, it seems that transitioning, Sex Reassignment Surgery/GAS/GCS, and intersex, (i.e., issues related to gender identity, intersex, and diverse trans life experiences) are only possibly if rarely addressed in nursing curricula. Furthermore, discussions about more widespread issues such as coming out and gender expression do not appear to be discussed much more. Largely, the primary type of information circulating about LGBTQI2S+ health and wellness may be limited to the simplistic framework of adolescent sexual health and issues of safer sex/STBBIs/HIV/AIDS.

Respondents offered their five most important issues they felt needed to be addressed in developing future LGBTQI2S+ curricula. Similar to the findings of L'Heureux (2006) 10 years previous, these 78 grouped and coded issues resulted in the following four themes: 1) relational practice/ how to create a safe space, 2) addressing heterosexism, cisgenderism, and personal assumptions, 3) celebrating diversity, and 4) evidence relating to specific health issues faced by LGBTQI2S+ people (Shortall, 2017, Appendix E). Of the institutions that did not use established LGBTQI2S+ curricular resources, they cited that resources were probably available in social work, through the university's student services, the university library, and/or online elsewhere, though few could point to any directly.

The survey results indicate that individual institutions are liable for deciding the content and inclusion of LGBTQI2S+ health and wellness. Most institutions appear to have limited requirements for LGBTQI2S+ curriculum in content streams. Furthermore, it is usually left to the sole discretion of the instructor to take the lead on integrating complex sexuality and gender identity health and wellness content. Some nursing school leadership admitted to not doing it well or avoiding it because of a lack of comfort or knowledge in the area. No respondents could offer examples of curricular materials used in class, with the justification that they were not sure if they were allowed to share resources due to copyright. Nursing leadership reported limited opportunities for faculty to engage in continuing professional development in the area. A total of 70.5% (12/17) said they were not aware of any (or there were no) faculty professional development opportunities in the area. Similar to L'Heureux (2006), respondents acknowledged limited opportunities to offer practica/internships/placements at sites that had services tailored to LGBTQI2S+ people. It should be noted that 59% (10/17) had faculty interested in or were already conducting research on LGBTQI2S+ issues in their respective programs.

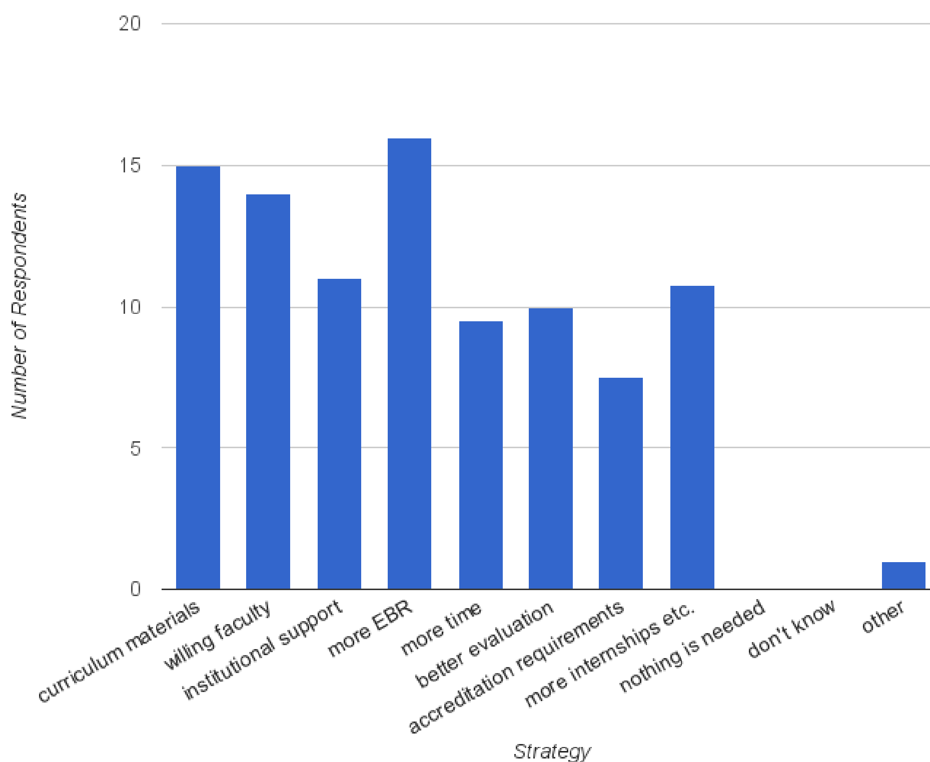
Finally, survey respondents were asked, "Are you aware if the licensing exam in your region contains questions about sexuality and gender identity?" Four institutions only from Ontario said yes, while two institutions said no (one from Ontario and one from BC). 65% (11/17) of nursing school leaders reported that they were not aware if the Canadian Registered Nurse Examination (CRNE) licensing exam had any requirement to address issues of sexuality and gender identity health and wellness. The CRNE has since been changed to the North American standardized NCLEX-RN licensing exam, which may contribute to additional uncertainty since this survey was conducted.

A "select all that apply" question revealed that the least favoured strategy for improving curricular content in the area of sexuality and gender identity was "changes to accreditation requirements" (see Figure 1). However, this is the only recommendation that could offer standardization of sexuality and gender identity content in nursing curricula across the country. It could be argued that respondents are not thinking of the global picture and are instead reflecting on themselves and their specific situations as busy educators. The expected barriers to knowledge translation and exchange / implementation science are present (see Grimshaw, et al.,

2012; Lomas, 1993; Straus, Tetroe, & Graham, 2013). “More evidence based research (EBR)” and “more curriculum materials” implies faculty members’ lack of direction on what constitutes appropriate and relevant information; “willing faculty” translates as lack of experience/knowledge and time/energy for searching out, learning, integrating, and subsequently teaching available information; while “more time” suggests the burden of adding information to a currently overtaxed curriculum. In short, they do not know where to start or how to integrate information. With less than half of the respondents recognizing the possibility of accreditation requirements as systemic integration, it seems respondents view the absence of LGBTQI2S+ content as problematic, but not as a systemic problem.

Figure 1

Strategies for Improving LGBTQI2S+ Content (raw data uncorrected for institution)



Critical discourse analysis of curricular policy identified and reviewed 52 provincial and national documents. Sexuality and/or gender identity content was not found to be a required CASN program standard or accreditation requirement (2014). Gender was identified in the *Code of Ethics* (CNA, 2008) as singular and not open to a diversity of identities, and the terms and topics under investigation were not included or inadequately defined in many documents (Research Update: gender identity and gender presentation have since been included in the 2017 edition of the CNA *Code of Ethics*). None of the reviewed CNA documents adequately referenced sexuality and gender identity even when opportunities presented themselves (e.g., CNA *Joint Position Statement on Workplace Violence and Bullying*, 2015; CNA *Position Statement: Social Determinants of Health*, 2013). Failure to articulate on topics of LGBTIQ2S+ health and wellness leads to ambiguity and invisibility.

One CNA position statement (CNA *Promoting Cultural Competence in Nursing* 2004 & 2010) had actually removed the terms sexual orientation and gender from their rubric of cultural competency between two versions of the same document (see Prior, 2013). Indeed, there does not appear to be any articulated requirements at the federal level regarding LGBTQI2S+ content. The CCRNR (2012) and the CNA *Code of Ethics* (2008) assume entry-level nurses are prepared to practice safe, competent, compassionate, and ethical care with all genders and sexualities, without outlining any particular notions or directives in these areas. While the CNA *Code of Ethics* (2008) definition of family is inclusive, the CASN *National Nursing Education Framework: Baccalaureate* (2015) does not mention sexuality or gender identity but uses the terms diverse clients and vulnerable populations. Diverse clients and vulnerable populations were also the preferred terms for the survey respondents.

These slight but important mentions of sexuality and gender identity (or lack thereof) in national policy documents have an impact on practical guidelines for institutions to address, and therefore the curriculum that is transmitted. Less than 50% of institutions reported teaching in the areas of gender expression, gender confirming surgery, intersex, and or transitioning; only 29% saw the need for increasing content in these areas.

Several provincial documents referenced sexuality and gender identity in important ways, but there was no consistency, and they remain limited in their general applicability in our federalist system (see College of Nurses of Ontario, 2009; College of Registered Nurses of British Columbia, 2014; CRNNS, 2016a; CRNNS, 2016b). The only articulated LGBTQI2S+ policy document identified during the research (2013-2016) was the Registered Nurses' Association of Ontario *Position Statement on Respecting Sexual Orientation and Gender Identity* (2007). More content analysis findings are available in the full thesis (Shortall, 2017).

Limitations

This study was conducted by a student in Applied Health Services Research with no experience in the formal structure and organization of nursing curricula or nursing policy. The research did not have connections to any nursing schools or nursing professional organizations. The sample is small, but the country is proportionally represented. It is possible that a great deal of behind-the-scenes work is already underway in provincial and national curricular policy renewal that is simply invisible to the outsider researcher. For example, the CNA *Promoting Cultural Competence in Nursing* (2018) has reverted back to including LGBTQI2S+ health and wellness issues in the latest version that had previously removed all mention of LGBTQI2S+ subjectivity.

While this research is based on a snapshot, the situation is presented as a verifiable interpretive description that is open to the reader to assess and judge its accuracy and applicability (see Aguinaldo, 2004). In true queer theory terms, it aims to incite dialogue rather than dictate a static truism authoritatively representing the global state of affairs.

The knowledge translation and exchange struggles of the research cycle are a particularly interesting limitation of this research. This hot topic area is being addressed faster than research can be conducted and published. For example, the survey did not ask about pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and undetectable equals untransmittable (U=U), among many other more specific topics. As well, nursing education is changing faster than research can be completed: CASN now has a voluntary national exam, the Canadian

Examination for Baccalaureate Nursing (CEBN), which will launch in late 2019, but will not replace the mandatory NCLEX-RN.

The year after the data were collected, the Canadian Registered Nurse Examination (CRNE) was replaced by the North American standardized NCLEX-RN, which has been found to not have any sexuality and gender identity content requirements (Lim et al., 2015). The author does not have any understanding about the Canadian procedural involvement in developing/renewing the NCLEX-RN standardized exam, and as an outsider non-nurse it remains outside of the possibility of inclusion in the present research, yet it is relevant. Without required inclusion of LGBTQI2S+ content in the NCLEX-RN exam, there is a possible curricula policy loophole for BN programs (as found by Lim et al., 2015).

The survey also did not ask the respondents the number of years teaching or other faculty demographic information that may have been useful. As with L'Heureux (2006), no specific curricular resource materials were shared with the researcher. Course descriptions, reading lists, textbooks, etc. available in the public sphere were deemed to yield too much data for a single novice researcher inexperienced with nursing scholarship. Furthermore, CASN's *Accreditation Program Standards* (2014) indicate that syllabi, student assignments, exams, papers, clinical performance reports, evaluation rubrics, and course evaluations are scrutinized as part of accreditation.

Finally, it was recognized that each institution is uniquely different, as is each course offering of the same topic area. Even if using the same curriculum and textbook materials variations occur based on students and the didactic nature of education. The research question "What information on sexuality and gender identity health and wellness exists in Canadian English baccalaureate nursing programs and related policy?" was only partially answered as LGBTQI2S+ health and wellness teaching and evaluation/assessment requirements remain elusive.

Conclusion and Recommendations

This study reiterates the findings of L'Heureux (2006) that English-language Canadian BN curricula are arbitrarily communicating sexuality and gender identity health and wellness content to entry-level nurses. Despite the profession's increasingly specific ethical duty to provide safe compassionate competent ethical care for LGBTQI2S+ people, new graduates may not be prepared to care for people of all genders and sexualities. As a result, there is a very real possibility of adverse health experiences for LGBTQI2S+ populations, as Lim et al. (2015) concluded.

Lim, et al. (2015) found that 75% of US respondents cited the importance of reviewing curriculum using a queer lens when studying US nursing educators' knowledge, ability, and interest in the area. Much more critical content analysis is needed to assess the exact quality of LGBTQI2S+ content being circulated in Canadian English-language nursing baccalaureate programs. Respondents indicated they would like to know specifically how to teach about heterosexism, cisgenderism, and relational practice for creating safe spaces, as well as how to talk about LGBTQI2S+ health and wellness issues outside of the entrenched discourse on safer sex/STBBIs/HIV. They felt unprepared to teach in the area of LGBTQI2S+ social location and particularly unable to teach on trans, intersex, and gender non-conforming health and wellness issues. In the face of limited professional development opportunities for learning about LGBTQI2S+ subjectivities and a lack of curricular policy direction, faculty are left to their own

devices. Faculty should not be expected to take on the unsustainable role of gathering information and incorporating it into curriculum to meet the professional expectations as part of their own personal self-realization and pedagogical practice development amid other life, work, and career demands (Eliason et al., 2010). Without sustained and committed institutional support in the way of explicit LGBTQI2S+ health and wellness curricular teaching and evaluation rubrics, in combination with continued professional development opportunities, LGBTQI2S+ health and wellness issues will continue to be arbitrarily addressed in curricula.

These results do not focus on the individual educator as a site of reform, as other studies have, but on a heterosexist and cisgendered system that has neglected to coordinate and steer a response to a pressing contemporary phenomenon. In the absence of documented LGBTQI2S+ teaching and evaluation rubrics, as Mulé (2006) found with social work, there are problematic inconsistencies between professional ethical expectations and adequate education standards for its students. To resolve this issue, stakeholders in nursing professional organizations, in partnership with LGBTQI2S+ experts and organizations, can lead the way to policy reform and curricular renewal. Leadership in policy and social justice is a core competency in all Canadian nursing jurisdictions, and there are recent calls for better inclusion of LGBTIQ2S+ health and wellness issues (see CNSA, 2017). While provincial professional associations such as British Columbia, Ontario, and Nova Scotia appear ahead of the curve, there are great variations in how LGBTQI2S+ health and wellness is being transmitted in English BN curricula across Canada. Similar studies have determined that individual educators are the sole reason for any LGBTQI2S+ inclusion in curriculum at all (Coleman et al., 2013; L'Heureux, 2006; Lim, et al., 2015; Mayer et al., 2008; Obedin-Maliver et al., 2011).

One of the greatest threats to the appropriate inclusion of LGBTQI2S+ health and wellness content in nursing curricula is the purported lack of scientific information on the topic. This is further compounded by the reported need for more research and a lack of knowledge/ability to search out and distill the most up to date and relevant information. The normal barriers of knowledge translation/implementation science seem to be a hindrance (Grimshaw et al., 2012; Lomas, 1993; Straus et al., 2013). The vast existing phenomenological epidemiological information about LGBTQI2S+ subjectivities exists and has been synthesized (see Bockting & Goldberg, 2006; The Centre, 2006; Davis & the Social and Sexual Issues Committee Members, 2000; Dean, et al., 2000; Israel & Tarver, 1997; Johnson, Mimiaga, & Bradford, 2008; Peterkin & Risdon, 2003; Makadon et al., 2008; Mulé et al. 2009; Shortall, 2017). A LGBTQI2S+ entry-to-practice competency framework could provide a systemic way to begin to infuse sexuality and gender identity content that does not currently appear to exist. Mulé et al.'s (2009) theoretical approach focusing on Canadian public health goals could influence developing a BN entry to practice framework (see also Jackson, et al., 2006).

LGBTQI2S+ experts and service organizations are often willing to assist with reviewing these LGBTQI2S+ core competency framework materials and some useful resources already exist (e.g., Shortall, 2017, Appendices A & B). Without adding to the overtaxed curricula, materials must be reworked to become more attentive to intersectional cultural humility and embed examples relevant to LGBTQI2S+ subjectivities outside of the single-faceted adolescent health and STBBIs/HIV/AIDS.

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