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Center for Urban and Regional Affairs (CURA)
University of Minnesota 330 HHH Center
301—19th Avenue South
Minneapolis, Minnesota 55455
Phone: (612) 625-1551
E-mail: cura@umn.edu
Web site: http://www.cura.umn.edu

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Breaking the Cycle: Funding LGBTQ Health Equity Work

Abstract
Many nonprofits offer crucial services and conduct useful research. Although some are funded through individual donors, most nonprofits rely on grants and contracts from government agencies and private foundations to fund their work. Community based nonprofits are an effective tool to address health disparities in certain populations. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations experience many unique and challenging health disparities. Considering the potential of nonprofits in addressing LGBTQ health disparities, this research project sought to understand: How does discrimination affect LGBTQ health equity programs? Which health equity funders identify LGBTQ people as targets for funding? How do funders include LGBTQ people, and to what extent?

This research was conducted through qualitative analysis of the text of requests for proposals (RFPs) issued by funders and of interviews with funders and nonprofit representatives. RFPs and organizations were selected if they included or focused on health disparities facing the LGBTQ populations.

From the analysis three themes emerged: labeling, intersectionality, and data. Only 9 of 22 RFPs explicitly labeled any LGBTQ group when listing priority populations. Even fewer prioritized individual groups within the LGBTQ label, such as transgender people or lesbians. Not only was there very little labeling of LGBTQ populations as a priority, the potential to target the most marginalized groups was lost in language that defined populations by one attribute such as age or race. It was clear that funders need to leverage intersectional identities to more effectively target programming. Finally, data collection across the public and private sectors on sexual orientation and gender identity is virtually nonexistent and needs to be expanded.

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This project was supported [in part] through student research assistance provided by the Kris Nelson Community-Based Research Program, a program of the University of Minnesota’s Center for Urban and Regional Affairs (CURA).

This research would not have been possible without the honest dialogue with interview participants. The thoughtfulness that was brought to interviews brought to life the challenges, issues, and innovation in health equity funding.

Background & Purpose
This research project focused on understanding: How does discrimination affect LGBTQ health equity programs? Which health equity funders identify LGBTQ people as targets for funding? How do funders include LGBTQ people, and to what extent?

Anyone who works in nonprofits knows that funding an organization can be difficult, to say the least. Many nonprofits heavily rely on grants or contracts from government organizations and private foundations. This is an interdependent relationship. Nonprofits rely on funders for monetary resources; in turn, funders rely on nonprofits to provide services or to execute research or community advocacy. By providing funding, funders create an opportunity for research, policy advocacy and services that otherwise would not have been possible.

While both funders and nonprofits rely on this relationship, it is not an equally dependent relationship. Funders can find viable alternative providers for the same resources (services, advocacy, community organizing, etc.) and therefore, they are in a position to pressure nonprofits to conform to their priorities (Saidel, 1991). Community based nonprofits can provide community support more easily. Nonprofits that are already based in that community are in a unique position to effectively address health disparities because they may be more knowledgeable about cultural norms. However, for populations whose work is not prioritized by funders, funding their work may be more difficult. This research focused on how the relationship develops between funders and nonprofits working in LGBTQ health equity.
Finding data on lesbian, gay, bisexual, transgender, or queer (LGBTQ) populations is difficult, as data is rarely collected and the stigma that can be attached to identifying as a sexual minority creates an additional challenge. The Williams Institute has used census data to estimate the size of LGBT populations in the United States. They report 10,207 same-sex couples live in Minnesota (Gates, 2011, 1). While this data only captures the portion of the LGBT population that identified as same-sex couples on the census (excluding single LGBTQ people or those who chose not to disclose their partnerships), it still shows that Minnesota has a large LGBTQ population. Same-sex couples live throughout Minnesota. While Hennepin and Ramsey County had the highest percentage of same-sex couples according to the census, 13 other counties had more than 50 same-sex couples (Gates, 2011). Minneapolis is the city with the fourth highest percentage of LGB population in the nation. In 2000, Minnesota was estimated to have the tenth highest percentage of population that identified as LGB at 4.7% of the population (Hennepin County Human Services and Public Health Department, 2012, 6).

Hennepin County’s Survey of the Health of All the Population and the Environment (SHAPE) collects data on sexual orientation in addition to other demographic data. Of the respondents, 6.8% identified as LGBT, primarily LGB. The survey results found disparities between LGBT and non-LGBT identified respondents (Hennepin County Human Services and Public Health Department, 2012, 18).

Across all mental health indicators included in the SHAPE 2010 survey, LGBT identified respondents fared worse than their non-LGBT counterparts. 16.3% of LGBT Hennepin County respondents experienced frequent mental distress, while only 8.4% of non-LGBT respondents did. LGBT respondents had been diagnosed with depression at a rate of 43.3%, only 23.2% of non-LGBT respondents had been diagnosed (27). The survey found that LGBT respondents’ activity was limited by physical, mental, or emotional problems at a rate of 28.5%, while non-LGBT respondents were only at 19.6% (28).

Overall, LGBT respondents were obese at virtually the same rate as non-LGBT respondents, 20.4% and 20.5% respectively (32). For LGBT respondents who experienced a secondary marginalization (i.e., poverty, mental distress, or a disability) up to 41.8% were obese (34). The same pattern of worse health experiences for LGBT respondents with a secondary marginalization continued for smoking rates in the SHAPE survey. LGBT respondents had higher rates of smoking in general, 18.8% vs. 11.7% for non-LGBT respondents (42). For LGBT respondents with frequent mental distress that rate was 34% (44).

Rainbow Health Initiative’s (RHI) survey of LGBTQ health looked at the health experiences of people who identify as LGBTQ in the state of Minnesota. Like the Hennepin County SHAPE survey, the results of RHI’s survey showed significant health disparities for LGBTQ people in Minnesota. RHI’s survey showed that 30.8% of LGBTQ respondents are regular smokers, roughly double the rate of Minnesotans as a whole. For subpopulations under the LGBTQ umbrella, RHI found smoking rates to be as high as 36.9% (Rainbow Health Initiative, 2012, 21). LGBTQ respondents reported being diagnosed with depression at a rate of 41.3% and anxiety at 37%, also twice the rate of non-LGBTQ people (ibid, 4). Both the SHAPE survey and the RHI survey reinforce the importance of LGBTQ health organizations because of the significant health disparities among LGBTQ Minnesotans. However, anecdotal evidence has shown that funding LGBTQ organizations is consistently challenging and that there is unmet need.

Because anecdotal evidence suggests that securing funding for LGBTQ health equity programs is more difficult than other populations, this report sought to better understand the landscape for LGBTQ health funding in Minnesota. The Funders for LGBTQ Issues’ most recent report on foundation funding of LGBTQ organizations identified that only 7.28% of foundation dollars funded health initiatives (Funders for LGBTQ Issues, 2011, 9). Funders for LGBTQ Issues in-depth look at Minnesota found that, in 2007, only $106,310 (6.6%) of LGBTQ funding from foundations went to health (Funders for LGBTQ Issues, 2009, 11).¹ Even among LGBTQ funders, health equity funding is a low priority.

¹ Their research only included private foundation grantmaking, excluding government philanthropy.
There has been little examination of the mismatch between community needs and prioritization by funders. In a survey of LGBTQ organizations in Massachusetts, Magnus found that the largest barriers to funding from foundations were: a difficulty identifying sympathetic foundations, a lack of paid grant writers, the need for incorporation as a 501(c)(3), foundations’ preference for funding established organizations and reluctance to fund politically-oriented work, foundations’ lack of familiarity with gay service needs, and homophobia at foundations (2001). Magnus’s research looked at all LGBTQ organizations in Massachusetts, not exclusively health-focused, and only looked at foundation funding. Although there are some differences between that study and this case, Magnus’ findings provide some insight into potential reasons for a mismatch. As noted in the graphic on page 2, the feedback loop between organizations and funders requires data. Without that data as an output from organizations, funders will not be aware of the disparities.

**Methodology**

This research analyzed two separate types of data: the text of requests for proposals (RFPs) and interviews of individuals involved with funding. The analysis worked to deconstruct the language of the sources. This was informed by a poststructuralist approach to policy, which argues that a focused analysis of the text establishes the way that language shapes policy (Allan, 2010). The language used in sources may unintentionally validate the importance of some health disparities while minimizing others. This research was guided by the questions: How does discrimination in funding affect LGBTQ health equity programs? Which health equity funders identify LGBTQ people as targets for funding? How do funders include LGBTQ people, and to what extent? This project was limited to looking at the language used in RFPs and interviews in order to understand how some populations are targeted for funding while others are excluded.

RFPs were identified from both public and private funders. Because of recent significant local and national changes in policy affecting LGBTQ people, the time frame was limited to RFPs that had been issued in the last five years. RFPs were eligible for inclusion if funds were available for organizations in Minnesota and prioritized health disparities that disproportionately or uniquely affect LGBTQ people. The RFPs fell into five categories: general health equity (n=8), mental health and addiction (n=3), sexual health (n=4), healthy eating and active living (n=3), and tobacco use (n=4). Of the 22 RFPs included in the research, 14 RFPs (63.64% of the total sample) were issued by public funders (e.g., Minnesota Department of Health, Hennepin County, etc.). Eight RFPs (36.36% of the total sample) were issued by private funders (e.g., Blue Cross Blue Shield Center for Prevention, PFund, etc.) (Appendix A). While the RFPs are relatively balanced between public and private funders and among health issues, they represent a convenience sample and may not reflect the full extent of LGBTQ health equity funding in Minnesota. Accessing RFPs from earlier funding cycles presented unique challenges so the RFPs may be biased towards the most recent cycle.

Interviews took place in June and July 2013. Both funders (n=5) and funding recipients (n=4) were included in the sample. Public and private funders were included in the interviews. Of funding recipients, two were explicitly LGBTQ-serving health equity organizations, one included LGBTQ-specific programming, and one was a general health equity organization that does not do specific LGBTQ work (Appendix B). All interviews were conducted by the same researcher using scripted questions which varied slightly between funder interviews and recipient interviews. (Appendix C) Interview subjects were chosen through snowball sampling, a form of non-probability sampling. Of the 11 organizations that were contacted, 9 completed interviews, an 82% response rate. While the response rate within the sample is high, snowball sampling makes it difficult to know if the sample size is representative. As there has been virtually no similar research, this project creates a framework for analysis for future research rather than provide representative, conclusive results.

“*These funds can be targeted to certain high-risk populations, such as adolescents, adolescent parents, or families who have been dependent on Minnesota Family Investment Program (MFIP) or who may be at risk for needing MFIP assistance in the future.*”

(Eliminating Health Disparities Initiative, 2010)

Requests for proposals and interview transcriptions were imported into NVivo 10. The text was coded by population prioritized (e.g., people of color, drug users, etc.), by strategic theme (e.g., data, culturally appropriate strategies, etc.), and by specific health issue addressed. (Appendix D) The twenty one priority population categories were selected based on the content of the text. Three priority populations were aggregate categories: age, gender, and people of color. Age includes references prioritizing youth and seniors, as well as references to general age groups.
Of the 156 references in the age category 76% (n=119) referred to youth. The category was not disaggregated because differences in prioritization of age groups were not the priority of the research.

Similarly, while “gender” predominantly refers to women, the group was not disaggregated because it was not the focus of the research.

The “people of color” category was not disaggregated into different racial and ethnic groups both because that was not the focus of this research and because most RFPs listed racial and ethnic groups as one category.

American Indians were coded as a separate category because the legal status of American Indian tribal governments is different than other communities of color and were often defined and treated differently in RFPs.

As the focus of the research, LGBTQ references were disaggregated into groups by specific population group, such as lesbians, as well as references to behavioral categories, such as men who have sex with men.

This report analyzed the text of 22 requests for proposals (RFPs) issued by 8 different organizations (Appendix A). Of the 21 priority populations coded in RFPs and interviews, 20 were present in at least one RFP. Private RFPs contributed 12.36% of all references to priority populations. Public RFPs contributed 87.64%. This discrepancy may be due to the fact that private RFPs in the sample averaged 8 pages in length, whereas public RFPs in the sample averaged 81.5 pages of text.

Nine interviews were conducted; five interviews were conducted with individuals at funding organizations and four interviews were conducted with individuals at organizations that receive funds (Appendix B). Only 15 of the 21 priority populations were mentioned in interviews.

After analyzing the requests for proposals and interviews, three themes emerged: labeling, intersectionality, and data. This project sought to determine how populations of LGBTQ people are defined and included or excluded in grants. As such, how groups of people were labeled was important. In addition to labeling, in order to understand how target populations were set, intersectionality became an important theme. Intersectionality looks at the interactions between different identities, for example how the lived experience of an African American gay woman may be different than an African American bisexual man. Finally, the need for data and lack of knowledge of available LGBTQ health equity data was important to understand how LGBTQ populations were prioritized for funding.
Findings and Discussion

Labeling

As seen in Figure 2, RFPs most often mentioned people of color as a priority population. References to people of color make up 24% (n=198) of all priority population references in requests for proposals. In comparison, all references to lesbian, gay, bisexual, transgender, queer, LGBTQ, men who have sex with men, sexual orientation and gender identity only added up to 10.88% (n=88).

As referenced earlier, this category was not disaggregated, which may account for the size of the category. However, 15 of 22 RFPs referenced people of color as a priority population. One additional RFP referenced American Indians in comparison to other communities of color as a priority population; meaning only 6 RFPs (27%) made no reference at all to communities of color.

Unlike in RFPs, people of color made up a large, although not the largest, proportion of references to priority populations in interviews (Figure 3). The 25 references made up 19% of all references to priority populations. References to American Indians as a priority population for health equity work constituted an additional 4% of references in interviews.

The second most referenced priority population in RFPs (see Figure 2), also an aggregate category, was “age.” The category includes prioritizing youth, seniors, and generic age categories. Like the people of color category, distinguishing between age groups was not the focus of this research so the references remained combined. Age made up 17% (n=140) of all priority population references in requests for proposals. Eighteen (82%) RFPs in the sample use age as a priority population category. While age was not referenced the most times, it was referenced in the most RFPs.

Being LGBTQ and a person of color, or of a certain age group, are not mutually exclusive. Both age and people of color are potentially opportunities to include references to the LGBTQ people by prioritizing LGBTQ people within those categories. Because “aging services [for LGBTQ people] haven’t caught up with what needs to be” PFund’s LGBT Aging Initiative targets at the intersection of age and sexual orientation (Kayva Yang, PFund). Older LGBT people often experience poor health outcomes due to isolation or returning to the closet in an assisted living facility or nursing home.

“As this competitive grant program provides funds to close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota compared with Whites…” (Eliminating Health Disparities Initiative (EHDI), 2012)

“Describe any racial/ethnic and other health disparities related to adolescent pregnancy and sexually transmitted diseases that exist in your community. Describe any cultural considerations given to assure adequate programming for your target population.” (PREP Teen, 2012)
“LGBTQ” was used as a label whenever the RFP or interview did not distinguish between lesbian, gay, bisexual, transgender, or queer populations. It was the most used priority population definition related to sexual orientation or gender identity. There were 25 references to LGBTQ as a priority population in RFPs which made up only 3% of all references to priority populations in RFPs.

Figure 4 shows the priority population references in RFPs excluding categories that aren’t related to sexual orientation and gender identity. Only looking at sexual orientation and gender identity populations, LGBTQ was the most used definition, making up 29% of those references. Even though it was the most used category, only eight of the 22 RFPs use the term. One additional RFP referenced a disaggregated group within the LGBTQ label, meaning 13 of 22 RFPs did not explicitly make any reference to LGBTQ groups.

For both public and private funders, LGBTQ was used not only as an umbrella category, but was listed among other priority categories. Rarely was “LGBTQ” found prioritized alone. Being included in a list of populations implies a level of similarity between different priority groups that may deserve culturally-specific treatment.

As three of the interview questions explicitly asked about LGBTQ funding and many interview participants were selected because of their work in LGBTQ health equity, it was unsurprising that sexual orientation and gender identity references dominated the priority population references in the interviews.

As an umbrella category, “LGBTQ” comprised 31% (n=41) of all references to any priority population in interviews. Excluding priority populations that were not sexual orientation or gender identity related, the composite category of LGBTQ made up 67% of references (Figure 5). Even though many interview participants discussed their work with specific populations under the LGBTQ umbrella, more often LGBTQ was referenced as one category.

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“The Social Change Fund of Headwaters Foundation for Justice, provides support for a wide range of change strategies and is committed to supporting the inclusive advancement of disenfranchised constituencies (low-income, people of color, women, LGBT, people with disabilities, immigrants, etc.).”

(Headwaters Foundation Social Change Fund Planning Grant Application, 2013)

“African-American, American Indian, Hispanic Latino, SE Asian, Lesbian Gay Bi-sexual Transgender (LGBT), new immigrants, multi-cultural or other underserved communities are encouraged to examine and ‘explain’ the dynamics within their communities surrounding alcohol and drug use, abuse and addiction and to develop and present a culturally infused service model for early intervention and/or recovery support."

(Culturally-Based Early Intervention Recovery, 2011)
The second most frequently used way to define sexual orientation or gender identity in RFPs was the phrase “sexual orientation.” Out of all priority populations, sexual orientation took up 2% (n=18) of RFP coding references (Figure 2). That amount was 21% of all RFP sexual orientation and gender identity references (Figure 4). Although, like LGBTQ, sexual orientation was an umbrella category, it was often used in RFPs as a way to ward against discrimination against sexual minorities within other populations, such as in the PREP Teen example. This usage potentially creates space for intersectional work by ensuring that sexual minorities within racial or ethnic minorities will be reached by grant funded projects. Unfortunately, only eight of 22 RFPs used that language.

Unlike the LGBTQ and sexual orientation coding categories, the next largest way of defining a priority population in RFPs was a very specific group defined by their sexual behaviors rather than self identification. While “men who have sex with men” (MSM) and “non-gay identified men who have sex with men” (non-gay MSM) were coded separately during the analysis of RFPs, they are similar enough to merit being explored together.

Both groups were relatively large. MSM contributed 21% (n=16) of all sexual orientation and gender identity priority population references (Figure 4). Non-gay MSM contributed another 9% (n=8) to the sexual orientation and gender identity priority population references.

Interestingly, 100% of references to both men who have sex with men and non-gay identified men who have sex with men came from public funders’ RFPs (Figure 6). This may be explained by the historic use of “MSM” in public health that eschews sexual orientation in favor of behavioral risk factors (Young, 2005).

No interview participant used the “men who have sex with men” language.

Combined, MSM and non-gay MSM constituted 27% of the sexual orientation and gender identity references in RFPs but 0% in interviews. The MSM language was also only found in RFPs put out by public grantmaking institutions. In the Minnesota Department of Health’s HIV/STD Prevention Project RFP, MSM language was used throughout but there were never priority populations defined as gay, bisexual, or queer men. This is problematic because it “(1) undermines the self-determined sexual identity of members of sexual-minority groups, in particular people of color; (2) deflects attentions from social dimensions of sexuality that are critical in understanding sexual health; and (3) obscures elements of sexual behavior that are important for public health research and intervention.” (Young, 2005, 1114) By defining a priority population as “men who have sex with men” it reduces the target population to one aspect of their behavior.

The separated categories of lesbian, gay, bisexual, transgender, and queer are relatively nonexistent in the text of RFPs. Naming the discrete groups matters as the health needs of each population are different. Lesbian, gay, bisexual, transgender, and queer people have unique health experiences and disparities. Lesbian, gay, bisexual, and queer were each referenced as a standalone category only once, all within the same RFP, put out by PFund, which only does LGBTQ philanthropy. Transgender as a discrete group is only referenced in one additional RFP, meaning that of the 22 RFPs in the sample only two (9%) separate LGBTQ identities. The additional RFP that referenced transgender people as a priority population identifies transgender individuals primarily as associated with high risk behavior, such as intravenous drug use and survival sex.
While it is important to ensure that transgender individuals with high risk behavior receive culturally competent treatment, there were no references to prioritizing health issues specific to transgender people within the sample of RFPs. This problem was expounded upon in interviews.

The largest amount of references in interviews to any specific LGBTQ population was also the transgender population. References to transgender people as a priority population made up a full 7% (n=10) of all references in interviews (Figure 3). Among only sexual orientation and gender identity priority populations, references to transgender people make up 16% of all references in interviews (Figure 5). Interviews, unlike RFPs, focused on the need to prioritize the health needs specific to transgender people, not on risk factors correlated with transgender people.

Lesbian and queer were the only other population groups, besides transgender, that were isolated apart from LGBTQ in interviews. Both were referenced in only two interviews.

While interviews only amounted to 14.21% of all references to priority populations, they constituted 40.94% (n=61) of all sexual orientation and gender identity related references (Figure 7). Even though interview participants were asked explicitly about LGBTQ health equity funding issues, their answers did not require use of that language. The way in which interview participants shaped their answers and the wording of RFPs illuminates different perspectives on LGBTQ health equity.

Furthermore, only 14.21% of all coding came from interviews, but 62.12% (n=41) of references to the umbrella label “LGBTQ” came from interviews. Even though this category was the most coded sexual orientation and gender identity category in RFPs, as shown earlier, still only eight RFPs even used it as a priority population. People on both the funding and receiving side of health equity understand the importance of LGBTQ health and understand the need for inclusion, especially of more specific populations, in more opportunities.

While these representatives acknowledged the gaps in funding, this was not reflected in requests for proposals that are being issued.

Beyond the mislabeling of priority populations and equating the health needs and experiences of all LGBTQ groups, RFPs include language for underserved populations that weren’t named in addition to specific named groups that are eligible for the funds.

“There are gaps in funding for all of it, in terms of LGBTQ, trans people definitely and there’s a focus on gay men’s health, so queer women fall through the cracks. People say LGBTQ but often they just mean gay men.”
(Erin Wilcox, Family Tree Clinic)

“A single issue [like same-sex marriage] overshadows other issues, like trans issues or aging service sector. [LGBTQ] aging services haven’t caught up with what needs to be.”
(Kayva Yang, PFund)
While this language potentially creates opportunity to apply for populations who weren’t included in the RFP, it relegates them to secondary status. LGBTQ organizations may be eligible to apply for funding as an underserved population, however the language does not invite them to apply. Adding catchall language potentially allows for funding to go to LGBTQ groups. It does not however acknowledge that health disparities exist. When the funding organization does not include LGBTQ populations as a priority group, the onus is on the organization applying to justify the need, even more than for other populations that are applying. By labeling a group as a priority population in an RFP, the funder acknowledges that health disparities exist for that population. By applying as an “undeserved population” that population is responsible for proving that they experience health disparities. Explicitly labeling LGBTQ groups as a priority will not only encourage groups to apply for funding, but would create an environment that acknowledges that health disparities rooted in sexual orientation and gender identity exist.

**Intersectionality**

The RFPs in this sample made virtually no reference to the way in which a population may be defined by multiple identities. In fact, most RFPs used language that separated potentially overlapping identities into discrete categories. This language identifies populations as inherently separate. A person who is young, a racial/ethnic minority, with a mental illness who is LGBT and poor could potentially be targeted for programming based on five separate parts of their identity, but not based on their identity as a whole. The few examples of acknowledging intersectional identities are primarily found in RFPs to fund direct service and not policy, systems, and environmental change work.

“Determine if there are underserved or un-served high-risk populations in your area and identify those who are at high risk for unintended pregnancy.”
*(Family Planning Special Projects Grant Program Application, Minnesota Department of Health, 2013)*

“It doesn’t invite you to apply if other groups are listed and you’re not.”
*(Joann Usher, Rainbow Health Initiative)*

“If you didn’t name us, you didn’t invite us.”
*(Sarah Senseman, Blue Cross Blue Shield Center for Prevention)*

“We know that poverty is amplified by race and ethnicity, they work in tandem—you can’t separate them out. You can’t separate out being trans from race and ethnicity from your class status...so much funding seems contingent on one identity...this is...why things are inequitable. It’s not about one facet—it’s not about being LGBTQ, it’s also about race—it’s also about class—it’s also about income. [To receive] grant funding...you really have to tailor to just one facet.”
*(Dylan Flunker, Minnesota Transgender Health Coalition)*

Unlike most other RFPs that only allowed a program to target one discrete population, these references acknowledged that they fund programs that serve clientele whose identity is made up of more than one label. Targeting groups that are potentially the most marginalized due to the intersections of their identity could be more effective by targeting more efficiently.

Throughout many interviews, participants referenced the need for more intersectional funding.

“These groups include, but are not limited to: youth and young adults; racial/ethnic minorities; people with severe and persistent mental illness; people with low socio-economic status; lesbian, gay, bisexual, and transgender populations”
*(Tobacco Free Communities, 2012)*

“All applicants will adhere to relevant regulations and policies that govern provision of Syringe Services Programs and will ensure that services are appropriate to the client’s culture language, sex, sexual orientation, gender identification, age, and developmental level.”
*(HIV/STD Prevention Projects, 2012)*
Both funders and recipients echoed the same idea that funds are currently targeted based on one facet of identity. Six of the nine interviews (67%) referenced either a lack of intersectional funding or a desire to increase the amount of intersectional funding. PFund’s unique community based structure, focused on LGBTQ issues, was the only organization that actively engages grantmaking from an intersectional standpoint. The fact that LGBTQ people cross all other communities is a potential point of intersection for health equity work.

Language in RFPs has the power to define and invite groups to apply; RFPs currently define groups as separate, exclusive groups. It is worth noting that the structure of analysis of labeling populations in RFPs and interviews for the purpose of this research used the same method of defining populations as exclusive from one another. This language implies that one’s sexual orientation or race or gender, etc. may influence health outcomes. That structure makes it difficult to understand the way the multiple intersecting identities compound to influence health outcomes.

The current funding system treats each identity group as separate, while in reality all genders cross with all racial and ethnic groups; all socio-economic status groups exist in all gender identities; all levels of ability are possible in any geographic location and any possible combination of factors. It may be impractical to focus funding on every possible combination of priority groups; however groups which are intersectionally marginalized could be met by articulating the importance of reaching them within the target population, such as focusing on lower socio-economic status individuals within a project for LGBTQ smoking cessation. This would allow for more targeted use of resources to the groups with the highest need.

“We want to fund organizations that work at the intersection of multiple communities and issues.”
(Kayva Yang, PFund)

“We’re also missing the intersection of multiple marginalized identities, and explaining the compounding effects of racism and homophobia. We need to be pulling in more of that because the more you experience the worse your health outcomes are.”
(Sarah Senseman, Blue Cross Blue Shield Center for Prevention)

“The LGBT community crosses all areas and all communities.”
(Karen Christensen, Department of Human Services)

“We talk about our work as intersectional with racial and ethnic groups and also as multiplicative... you experience the disparities of your racial ethnic group as well as of the LGBT group.”
(Joann Usher, Rainbow Health Initiative)
**Data**

“Six percent of the US population is estimated to identify as Lesbian Gay Transgender Bisexual. This year the treatment data will begin collecting information for this population as well.”

“No Evidence Based Practice (EBP) models have been researched on behalf of communities of color or American Indians in the area of recovery, however, and if minorities did participate in the research, the numbers were so low as to not be representative.”

(Christensen, 2011)

“We can talk about how trans/gender non-conforming people of color aren’t being served in a lot of ways …. but there’s not research about the community, the little quantitative research shows there’s big disparities and anecdotal research shows huge gaps.”

(Dylan Flunker, Minnesota Transgender Health Coalition)

“There’s not the data that backs up the need. Grant applications need statistics and data, that stuff doesn’t exist for trans health yet. So if you’re trying to have a competitive proposal based on research and data, that’s just not possible.”

(Erin Wilcox, Family Tree Clinic)

“They’re the invisible people. Until recently when it’s a lot more acceptable to come out they were completely invisible to us. I went through all of our data and talked to the state demographer and all of our data has no mention of anything related to sexual orientation or gender identity.”

(Karen Christensen, Department of Human Services)

Of the 22 RFPs in the sample, 17 (77%) RFPs specifically required use of evidence-based strategies, statistical data, or used data about health disparities in the RFP. Nearly all of the references to data required the use of existing data to justify the need for programs. For populations where little data is collected, this is a challenge. Only one RFP noted this.

One additional RFP noted which populations the funder’s approved systems had been tested in. Beyond those two cases, the rest of the references to data focus on already established disparities. Data on LGBTQ health is relatively new and has been covered in little research.

Based on interviews, much of the exclusion of LGBTQ groups from RFPs seemed to originate from the lack of data on health disparities for the groups. This is a cyclical problem, as the exclusion from funding means that generating the data that would show the existence of disparities is likely to remain unfunded. The lack of data stems from multiple problems. As referenced by Christensen, LGBTQ people are, for the most part, invisible to data collectors. Many sources used to collect health equity data do not include questions about sexual orientation or gender identity. “…only six of the 12 federal information systems used to monitor [health disparities among LGBTQ people] have experience collecting sexual orientation data” (Bowleg, 2008, 322). Health disparities facing LGBTQ people will not receive priority until data is being collected as regularly for sexual orientation and gender identity as for other priority populations. Looking back at Figure 1, the feedback loop for nonprofits in general, the cycle shows that data about LGBTQ health equity is not being collected because it’s not being funded. It’s not being prioritized because there’s not data on the disparities. Without breaking that cycle, funding will continue to be scarce for LGBTQ health equity.

“Six percent of the US population is estimated to identify as Lesbian Gay Transgender Bisexual. This year the treatment data will begin collecting information for this population as well.”

“No Evidence Based Practice (EBP) models have been researched on behalf of communities of color or American Indians in the area of recovery, however, and if minorities did participate in the research, the numbers were so low as to not be representative.”

(Christensen, 2011)

“We can talk about how trans/gender non-conforming people of color aren’t being served in a lot of ways …. but there’s not research about the community, the little quantitative research shows there’s big disparities and anecdotal research shows huge gaps.”

(Dylan Flunker, Minnesota Transgender Health Coalition)

“There’s not the data that backs up the need. Grant applications need statistics and data, that stuff doesn’t exist for trans health yet. So if you’re trying to have a competitive proposal based on research and data, that’s just not possible.”

(Erin Wilcox, Family Tree Clinic)

“They’re the invisible people. Until recently when it’s a lot more acceptable to come out they were completely invisible to us. I went through all of our data and talked to the state demographer and all of our data has no mention of anything related to sexual orientation or gender identity.”

(Karen Christensen, Department of Human Services)
Recommendations

Labeling
Requests for proposals should use the same language to define priority populations as groups themselves use. Men who have sex with men can describe gay men, bisexual men, queer men, men on the down low, among other labels, none of which are captured by the MSM label. The communities affected by funding should be able to speak for themselves. Using labels that are culturally appropriate will help create services and policies that more accurately reflect the needs of different communities.

Requests for proposals should specify whether projects are expected to focus on lesbian, gay, bisexual, transgender, or queer health. The largest portion of references to sexual orientation and gender identity in RFPs in the sample were aggregate categories (Figure 4). Lesbian, gay, bisexual, and transgender health needs and disparities are different and need to be treated as such in RFPs and programs.

Intersectionality
Proposal reviews should prioritize projects that show genuine ways of addressing communities that are intersectionally marginalized. The little data on health outcomes for LGBTQ populations that is available show that health disparities become worse with every level of marginalization. Targeting groups that are multiply marginalized would allow for better efficacy of resources.

“If the CDC can use the phrase LGBT, you can too.”
(Sarah Senseman, Blue Cross Blue Shield Center for Prevention)

“Language is just really important… all of the letters [LGBTQ] are just lumped together which sets up an expectation that the health experience and the health needs are the same”
(Joann Usher, Rainbow Health Initiative)

“LGBT funding is normally just LGB funding. It’s hard to find something trans health that’s not lumped into LGBT stuff.”
(Erin Wilkins, Family Tree Clinic)

“We really like to hear from the community.”
(Chris Tholkes, Minnesota Department of Health)

“Recommend that people don’t think of LGBT as one identity that’s separate and think about reaching multiple communities based on issues not on a single identity”
(Sarah Senseman, Blue Cross Blue Shield Center for Prevention)
Data
Requests for proposals should require data collection on gender identity and sexual orientation for grant recipients. Data collection based on sexual orientation and gender identity is not included as routinely as other demographic data. Requiring data collection of sexual orientation and gender identity as demographic data for all funded projects, even those not related to LGBTQ issues, will broaden the scale of data collection. It will also show where potential intersections for targeting populations lie.

Conclusions
Anecdotal evidence of funding gaps facing LGBTQ health equity nonprofits prompted this research. The analysis of RFPs and interviews supported those claims. The analysis showed that funding gaps potentially stem from lack of data on LGBTQ health experiences, low prioritization of LGBTQ people as priority populations, and missed opportunities to target LGBTQ people within other populations. After conducting interviews and reviewing requests for proposals, it seems that most exclusion from funding lies not in overt discrimination, but in a systemic need for data that is unavailable.

The results from this analysis were limited in scope and showed that there is a need for more research. This research provides a framework that could be scaled larger within Minnesota or nationally.

The sample of RFPs was limited to the past five years. Developing the historic evolution of priority population labeling will give better background to where LGBTQ populations have fit and currently fit in funding systems. This project did not attempt to quantify funding that was not available to LGBTQ groups, either due to exclusion on RFPs or because of a lack of quality data. Future research quantifying losses will help more fully understand what the impact of lost funding is.

“I hate just repeating ‘there are inequities.’ We need more local data. We have plenty of national data but we’re not using it. We need to pull all of the national data together and present it better. You need to collect data when political will is missing.”
(Sarah Senseman, Blue Cross Blue Shield Center for Prevention)

“The question remains, should we require treatment programs to ask [about gender identity or sexual orientation], is that too intrusive, is it required, for people coming in to treatment [to disclose] either their gender or orientation? How do you treat someone when you only have half the deck? …how do you tailor treatment to the people you’re serving if you don’t know the whole story? I can see that someone is black but I can’t see their orientation or gender identity.”
(Karen Christensen, Minnesota Department of Human Services)
## Appendix A: Requests for Proposals

<table>
<thead>
<tr>
<th>TITLE</th>
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<th>YEAR</th>
<th>SECTOR</th>
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## Appendix B: Interview Participants

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<th>ORGANIZATION</th>
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<td>Christensen, Karen</td>
<td>Minnesota Department of Human Services, Alcohol and Drug Abuse Division</td>
<td>Principal Planner</td>
<td>Funder</td>
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<td>DuBois, Diana</td>
<td>WellShare International</td>
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<td>Funding Recipient/General Health Equity</td>
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<td>Flunker, Dylan</td>
<td>Minnesota Transgender Health Coalition</td>
<td>Board Member</td>
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<td>Hoffman, Megan</td>
<td>Center for Health Equity</td>
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<td>Senseman, Sarah</td>
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<td>Tholkes, Chris</td>
<td>Minnesota Department of Health, Alcohol and Tobacco Prevention and Control</td>
<td>Supervisor</td>
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<td>Usher, Joann</td>
<td>Rainbow Health Initiative</td>
<td>Executive Director</td>
<td>Funding Recipient/LGBTQ Health Equity</td>
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<td>Wilkins, Erin</td>
<td>Family Tree Clinic</td>
<td>Program Director</td>
<td>Funding Recipient/Sexual Health, LGBTQ Programming</td>
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<td>Yang, Kayva</td>
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<td>Program Officer</td>
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Appendix C: Interview Scripts

Grantmaker Interviews
“Thank you for taking the time to meet with me today. My name is Liv Anderson. I am a Master’s in Public Policy student at the Humphrey School at the University of Minnesota and an employee of the Center for Regional and Urban Affairs (CURA) hired to work on a research project with Rainbow Health Initiative. The focus of this research is to assess the impact of funding on LGBTQ health equity work. I expect this interview to take about 30 minutes.”

1. Date

2. Location of Interview

3. Funding Organization

4. Person Being Interviewed

Background Information
5. What is your title?

6. How long have you been working for [funder]?

7. I want you to feel comfortable speaking with me. When I am writing a report of these findings, are you comfortable with me using your name or would you prefer I simply cite “a representative from [funder]”

General Funding Questions
8. What is the focus of your organization’s grant making (specific health issues, regions, etc.)? [Follow up: How many years have you been doing this kind of grant making? How many times per year do you put out RFPs? What is the volume of your funding streams?]

9. When you are putting out an RFP, do you name specific groups or populations who should apply? [If yes, follow up: What is the process for determining target populations? Does this process change from RFP to RFP, or are specific groups tied to specific issues?]

10. I know that the office of minority and multicultural health focuses their health equity work on racial and ethnic minorities. Does the OMMH influence the health equity work that you do?

11. When you are designing RFPs, are funds more likely to be allocated by issue or by population?

12. What factors are most important when you evaluate proposals (addressing specific issues, populations, working in coalitions, etc.)?

LGBTQ Questions
13. As I mentioned, this research project is examining LGBTQ health equity work. Have LGBTQ people played a role in the design of RFPs, the evaluation of proposals, or as grant recipients?

14. What may make it more likely for an LGBTQ organization to receive a grant?

15. What populations do you think have the greatest gaps in funding?

Closing
Thank you so much for your time. If you have any questions, please feel free to contact me or to contact John Salisbury at Rainbow Health Initiative.

16. Is there anything else I should know?
Appendix C: Interview Scripts

Grant Recipient Interviews

“Thank you for taking the time to meet with me today. My name is Liv Anderson. I am a Master’s in Public Policy student at the Humphrey School at the University of Minnesota and an employee of the Center for Regional and Urban Affairs (CURA) hired to work on a research project with Rainbow Health Initiative. The focus of this research is to assess the impact of funding on LGBTQ health equity work. I expect this interview to take about 30 minutes.”

1. Location of Interview
2. Date
3. Organization
4. Person Being Interviewed

Background Information

5. What is your title?
6. How long have you been working for [organization]?
7. I want you to feel comfortable speaking with me. When I am writing a report of these findings, are you comfortable with me using your name or would you prefer I simply cite “a representative from [organization]”

General Funding Questions

8. What is the focus of your organization’s work that receives grants (specific health issues, regions, etc.)? [Follow up: How many years have you been doing this kind of work?]
9. When you are designing a grant proposal, how do you name specific groups or populations who will be affected? [Follow up: What is the process for determining target populations? Does this process change from RFP to RFP, or are specific groups tied to specific issues?]
10. I know that the health equity work often focuses on disparities between racial and ethnic minorities. Does that influence the health equity work that you are able to do?
11. When you look for RFPs, do you apply based on issue or by population? [Follow up: Which have you had more success in the past?]
12. What issues or populations have you had trouble getting funded? [Follow up: How do you manage funding issues/populations that aren’t prioritized?]

LGBTQ Questions

13. As I mentioned, this research project is examining LGBTQ health equity work. Have LGBTQ people played a role in the design of your proposals or the way you design programs?
14. What may make it more likely for an LGBTQ organization, or any population, to receive a grant?
15. What populations do you think have the greatest gaps in funding?

Closing

Thank you so much for your time. If you have any questions, please feel free to contact me or to contact John Salisbury at Rainbow Health Initiative.
16. Is there anything else I should know?
Appendix D: Priority Population Labels

- Age
- Disability
- Drug Users
- Gender
- Geography
- LGBTQ
  - Bisexual
  - Gay
  - Gender Identity
  - Lesbian
  - Men Who Have Sex with Men
  - Non-Gay Identified Men Who Have Sex with Men
  - Queer
  - Sexual Orientation
  - Sexuality
  - Transgender
- People of Color
- American Indian
- Sex Workers/People Engaged in Survival Sex
- Socio-Economic Status
  - 18-24 Year Old Straight to Work

Health Issue Coding:

- Tobacco Use
- Mental Health
  - Substance Abuse
  - Suicide
- Sexual Health
  - HIV/AIDS
  - Pregnancy
  - STIs
- Lifestyle
  - Active Living
  - Healthy Eating

Strategic Theme Coding:

- Cross Cultural
- Culturally Appropriate
- Data
- Discrimination
- Disparity
- Equity
- Partnership
- Policy
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Lambda Legal. (2010). When health care isn’t caring: Lambda Legal’s survey on discrimination against LGBT people and people living with HIV. New York, NY.


Legacy (2012). Tobacco Control in LGBT Communities. Washington, DC.
For information on LGBTQ health disparities and how Rainbow Health Initiative is Advancing Health Equity, contact: Rainbow Health Initiative, 612.206.3180, www.rainbowhealth.org.