

# GENDER AND SEXUAL DIVERSITY



**Health Services  
Consultation and  
Literature Review**

**HEALTHY DIVERSE  
POPULATIONS  
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**calgary health region**  
*leaders in health - a partner in care*

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## GLOSSARY OF TERMS

*Adapted from definitions developed by McKinley Health Center, University of Illinois at Urbana-Champaign and the Halifax Rainbow Health Project*

**Gay:** A person who has physical, emotional and/or romantic attraction to people of the same gender. The term gay is usually used to describe men who form their primary loving and sexual relationships with other men, although it can be used to describe both gay men and lesbians.

**LGBT (and GLBT):** An acronym in use since the 1990s to refer collectively to Lesbian, Gay, Bisexual, and Transgender people. Its use today relates to the diversity of the Gay culture.

**LGBQITT (and GLBQITT):** An acronym used in this report to refer to Lesbian, Gay, Bisexual, Queer, Inter-sexed, Transgender, and Two-spirited. The use of the acronym in this report is an attempt to be inclusive of all groups of people who identify themselves as being gender and sexually diverse. At this time, Gender and Sexually Diverse communities have not definitively agreed on an acronym or a term to use to refer to themselves.

**Lesbian:** A woman or female-gendered person who has physical, emotional and/or romantic attraction to women/female-gendered persons.

**Bisexual:** A person who has physical, emotional and/or romantic attraction to either male or female persons. The degree to which a person has an attraction to male or female persons may vary throughout their lifetime and an individual could be more attracted to men or more attracted to women, but feel they can have relationships with either.

**Queer:** An individual whose gender identity does not strictly conform with societal norms traditionally ascribed to either male or female and who defines themselves outside of these traditional definitions.

**Intersexed:** This is a relatively new term to describe someone who is born with ambiguous genitalia or chromosomal anomalies. Some doctors and parents elect surgery for the infant and assign a gender. A person's true gender cannot be known by their genitalia, and therefore an assignment at birth can be wrong.

**Transgender:** A broad term inclusive of individuals whose behaviour, manner of dress, or identity does not strictly conform to societal perceptions of how one fits into a binary gender definition of "male" or "female." This can range from wearing the attire socially ascribed to the opposite sex, to a person whose gender and sex are in direct opposition, and may or may not be taking steps in transitioning to the opposite gender. Transgender persons may define themselves as heterosexual, gay, lesbian or bisexual.



**Transsexual:** Someone who believes that his/her gender identity is different from their biological sex, and often feels deeply that they were born into the wrong body and should be the other gender. Therefore, some people elect to use sex hormones, electrolysis, plastic surgery, or gender reassignment surgery to help them make the physical change that is more congruent with their internal identity and self-image.

**Two-Spirited:** A tradition within Aboriginal culture which denotes an individual with close ties to the spirit world and who may or may not identify as being lesbian, gay, bisexual or transgender. This varies from culture to culture in how it is interpreted and defined, but does overall indicate a duality existent in a person which may or may not include both male and female spirits in one person.



## EXECUTIVE SUMMARY

The purpose of this literature review and consultation was to identify the health issues of people in sexual minority populations (gay, lesbian, bisexual, queer, intersexed, transsexual and two-spirited), the barriers they experience in having their health needs met and explore ways these barriers can be reduced. The literature review focused on articles published since 2000. The consultation involved two in-depth interviews and four focus groups with 27 participants in total, most of whom were recruited with the assistance of community organizations. In addition, the consultant communicated (through group discussion, personal interviews, telephone and/or email contact) with staff working in a number of different areas of the Calgary Health Region and with staff and volunteers from community organizations involved with the target population.

The literature review and consultation looked at health issues for specific subgroups of the population, notably lesbian and bisexual women, gay and bisexual men, transsexual and intersexed persons and two-spirited persons. Also addressed were mental health issues of LGBTQITT persons and intimate partner abuse and violence by others.

A number of potential barriers to health services were identified and discussed, including non-disclosure, overt or perceived discrimination, deficits in provider knowledge, heterosexism, youth issues and other barriers.

Strategies to reduce potential barriers, drawn from the literature and the consultation, were grouped into four categories; policy and accountability, communication and awareness, physical environments and community collaboration:

### **Policy and Accountability**

- Ensure Regional policies are free of heterosexist assumptions and biases.
- Include gender identity and sexual orientation in a zero-tolerance discrimination policy.
- Ensure staff are held accountable for non-inclusive behaviours and know the legal requirements of human rights acts.
- Adopt position statements from professional bodies when appropriate.
- Implement a system for intermittent feedback on sexual minority inclusiveness in different situations.
- Share learnings on this issue with other health regions and professional bodies.

### **Communication and Awareness**

- Train staff on heterosexism awareness, inclusive language, gender and sexual orientation as determinants of health and other information.



- Increase staff familiarity with guidelines and standards of care that pertain to the health of sexual minorities.
- Provide training to new staff at orientation and existing staff on an ongoing basis.
- Assess diversity competence of potential staff in employment interviews.
- Incorporate more training into post-secondary programs for health service providers.
- Incorporate inclusive language into all aspects of health services.
- Avoid ‘alphabet soup’ acronyms in an attempt to capture all sexual minorities.

### **Physical Environments**

- Examine physical environments for assumptions of heterosexism.
- Modify environments to include symbols of diversity and acceptance (ensure staff have been trained and demonstrate inclusive attitudes and behaviours before symbols are used).
- Display posters, magazines and pamphlets that are inclusive of sexual minority individuals.
- Provide gender-neutral washrooms.
- Develop forms that are inclusive of clients who do not identify with gender as a dichotomous variable and are free of heterosexism.

### **Community Collaboration**

- ‘Come out’ as a health region in support of the sexual minority community, e.g., be visible at public events, distribute literature at health facilities, advertise in community publications.
- Ensure support from upper management for the Region’s gender and sexual diversity initiatives.
- Involve members of the sexual minority population on Regional diversity advisory committees.
- Build greater links with community agencies already involved with the sexual minority community.
- Develop a list of gay-friendly and trans-friendly family physicians.

The report also includes information on accessing guidelines, information sheets, toolkits, practitioner training, associations, and information for LGBQITT persons and a listing of organizations providing LGBQITT health, mental health and social services.

The literature review and consultation identified health issues, potential barriers to health services and possible strategies to overcome these barriers. The next step for Calgary Health Region’s Healthy Diverse Population team is to build relationships with the target population and to use this information to plan strategies to reduce barriers.



## A. INTRODUCTION

The Calgary Health Region defines diversity as all the ways all people are unique and different from others. Dimensions of diversity include, but are not limited to, such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual identity, ability, education, age, ancestry, place of origin, marital status, family status, socio-economic circumstance, profession, language, health status, geographic location, group history, upbringing and life experiences. Respect for diversity is fundamental and integral to the Calgary Health Region workplace and to the populations it serves. Sexual orientation and gender identity were the aspects of diversity addressed in this consultation and literature review

“...As a patient or client in the health care system, you have the right to be treated with respect and without discrimination. You have the right to be listened to carefully and to receive support throughout your healthcare experience...”

Extract from  
*Working Together: A Guide to Rights and Responsibilities for Patients and Clients in the Calgary Health Region, 2003/06*

According to the 2003 Canadian Community Health Survey, 21.8% of self-identified homosexual or bisexual Canadians, compared to 12.7% of heterosexuals, have an unmet health need (Statistics Canada, 2004a). While the share of the population served by the Calgary Health Region that self-identifies as lesbian, gay, bisexual, queer, intersexed, transgender or two-spirited (LGBQITT) is not known, a rough estimate can be calculated. According to Statistics Canada (2004b), 1.2% of the provincial population self-identifies as ‘homosexual’ or ‘bisexual,’ although the number is **very likely higher**.<sup>1</sup> If the same proportion is served by the Calgary Health Region (with a population of 1,064,254; Statistics Canada 2001 Community Profiles), an estimated 12,770 individuals would self-identify as gay or bisexual and of those, an estimated 2,784 could be said to have an unmet health need.

Another population to consider is the employee group of the Calgary Health Region. Again, using the conservative estimates above, almost 300 of the total 24,000 employees would identify as gay or bisexual.

The number of transsexuals in Calgary and area cannot be referenced to statistical data as none is available, although an estimate of “well over 100” is suggested by both a community organization connected

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<sup>1</sup> The LGBQITT population served by the Region is likely higher, given that the provincial estimate of 1.2% identifying as homosexual or bisexual excludes youth (under 18) and seniors (over 59), and excludes individuals not identifying as ‘homosexual’ or ‘bisexual’ but who may otherwise identify as a ‘sexual minority.’ Moreover, the use of the provincial estimate (of 1.2%) does not account for the higher concentration of LGBQITT individuals in the province’s urban areas.



with the transsexual population and a transsexual man who is active in a number of aspects of the transsexual community.

The purpose of this literature review is to identify the health issues of the LGBTQITT population, the barriers they experience in having their health needs met and explore ways barriers can be reduced. Studies have shown that experiences of bias, insensitivity, discrimination and inappropriate or inadequate health-related services can result in a distrust of the health care system and potentially lead to avoidance of regular and preventive health care (Ontario Public Health Association, 2000; Jackson, 2006). According to the Coalition for Lesbian and Gay Rights in Ontario, an estimated 15% of lesbian women forgo regular health checkups for fear that their sexual orientation will negatively impact the quality of their care (1997, cited in Davis, 2000), and a national study conducted in the US recently found that 75% of lesbians, compared to 54% of heterosexual women, had previously delayed obtaining health care and of those, nearly one-third (27%) cited negative past experiences as their main reason for doing so (compared to 12% of heterosexual respondents; Mautner Project, 2005; see also Bowen et al., 2004). Clearly, an understanding of the barriers to health care experienced by LGBTQITT individuals will contribute to the development of inclusive and appropriate, or 'diversity competent'<sup>2</sup>, health care environments.

Following a brief explanation of the methods used to compile this review, we present the current literature on LGBTQITT health issues and barriers to health care, key themes from interviews and focus groups with members of the LGBTQITT community in Calgary and the surrounding area and the organizations that serve them, and conclude with a summary of recommendations for creating inclusive health care environments, particularly for the Calgary Health Region.

There would be no preset assumptions as to my sexual orientation or gender identity.

Doctors and other medical people would treat me as a human being and not a fantastic science experiment.

Staff would have adequate training about sexual minority health issues.

There would be reading materials around the room that are not just for heterosexuals.

I would be able to choose for myself whether to have a male or female attendant.

My doctor would maintain my confidentiality.

*Responses (paraphrased) of youth focus group participants when asked what an inclusive health care system would look like to them*

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<sup>2</sup> The Calgary Health Region defines *diversity competency* as "the ability of systems to respond respectfully and effectively to people of all diverse backgrounds in a manner that recognizes, affirms, and values the differences, similarities and worth of individuals, families and communities and also protects and preserves the dignity of each. A diversity competent organization holds diversity and equitable services in high regard. It continually self-assesses its structures, policies, and procedures; expands diversity knowledge and resources; adapts service models to accommodate needs; and engages diverse people in all aspects of the organization".



## B. METHODS

The literature review was prepared with computer-assisted database searches (MEDLINE, PubMed, Scopus and CINAHL) with key words “access and lesbian or gay or bisexual or queer or transgender or transgendered or intersex or intersexed” to identify North American articles published between 2000 and 2007. Articles were also identified through Internet search engines (Google and Google Scholar) and through a scan of refereed journals dedicated to sexuality and to health, including American Journal of Public Health, Journal of Homosexuality, and Journal of the Gay and Lesbian Medical Association. The research included a review of grey literature identified online with a particular focus on organizations exemplifying ‘best practices’ in working with the LGBQITT population.

The consultant conducted two in-depth interviews and four focus groups (27 participants in total) with people who identified themselves as gay, lesbian, bisexual and/or transsexual and allies of this population. Interview and focus group participants included both youth and adult individuals and were recruited with the generous assistance of community organizations and through the consultant’s personal contacts. Attempts to include two-spirited persons in the interviews and focus groups were unsuccessful.

In addition, the consultant communicated (through group discussion, personal interviews, telephone and/or email contact) with staff working in the following areas of the Calgary Health Region:

- Harm Reduction
- Community Development
- Mental Health Services
- Oral Health
- Patient Concerns Office
- Sexual and Reproductive Health
- Sexually Transmitted Disease Clinic
- Southern Alberta Clinic

and with staff/volunteers from the following Community Organizations:

- AIDS Calgary Awareness Association
- Alberta Society for the Promotion of Sexual Health
- Diversity Resources Unit, Calgary Police Service

The Calgary Health Region and the project consultant are grateful to the individuals in the LGBQITT community, their allies and service providers who openly shared their experiences and opinions during the course of this research.



- Calgary OutLink: Centre for Gender and Sexual Diversity (formerly Gay and Lesbian Community Services Association)
- Calgary Sexual Health Centre (formerly Calgary Birth Control Association)
- GLBTI Health Program, Capital Health, Halifax, Nova Scotia
- Positive Space, Mount Royal College
- Sexual Health Access Alberta (formerly Planned Parenthood Alberta)

While we are confident that this review is comprehensive and representative of the literature, our understanding of LGBTQITT health issues and access barriers in a Canadian context remains limited. The majority of published studies are American and existing Canadian studies are largely community-based. The first Statistics Canada survey to identify respondents by sexual orientation, the 2003 Canadian Community Health Survey, (Cycle 3.1; Statistic Canada, 2004b), provides data on 'homosexual' and 'bisexual' health by health region, though Statistics Canada does not include the sexual orientation identifier in its public dataset for reasons of confidentiality, and to date has reported only sparingly on national-level results.

Further limitations of the available research include the use of a small sample size and convenience (non-probability) samples, which provide a depth of understanding but are not highly generalizable, and a bias in the literature toward the health issues and barriers of lesbian women and gay men. While transgender health research is beginning to emerge, the health issues and access barriers of individuals identifying as Two-Spirited are marginally present on the North American research agenda, and no studies on barriers to health care among intersexed persons were identified.



**C. LGBTQITT HEALTH ISSUES**

**I Health Issues of Lesbian and Bisexual Women**

Research has sought to determine whether lesbian and bisexual women are at a disproportionately high risk for cancer, cardiovascular disease, and poor health generally as a result of a greater prevalence of nulliparity, smoking, obesity and alcohol consumption.

Just because she identifies as a lesbian, that doesn't mean that she only has sex with women

*Service provider*

Recent studies have found lesbian women three times and bisexual women two times more likely than heterosexual women to report nulliparity (Case et al., 2004), which has been associated with breast cancer (Cochran et al., 2001) and ovarian and endometrial cancer (Davis, 2000). Tobacco use, associated with cardiovascular disease and cancer, is also more prevalent, with 19% to 37% of lesbian and up to 50% of bisexual women reporting current smoking behaviour, compared to about 10% of heterosexual women (Case et al., 2004; Cochran et al., 2001; Gruskin et al., 2001; Diamant et al., 2000a; Tang et al., 2004; Aaron et al., 2001; Roberts 2001).

Lesbian and bisexual women are also more likely than their heterosexual counterparts to be overweight or obese (Cochran et al., 2001; Valanis et al., 2000; Aaron et al., 2001, Mravcak, 2006). A national American study recently found a 50% greater prevalence of obesity among lesbian women and a 40% greater prevalence among bisexual women (Case et al., 2004). Greater participation in vigorous physical activity, however, has also been observed (Mravcak, 2006; Aaron et al., 2001; Case et al., 2004).

There is some evidence that lesbian and bisexual women are more likely than heterosexual women to regularly consume alcohol. Research in the US indicates that approximately two-thirds of lesbian and bisexual women report daily alcohol intake (61.8% and 66.9%, respectively), compared to 54.9% of heterosexual women (Case et al., 2004; see also Aaron et al., 2001; Cochran et al., 2001; Diamant et al., 2000a; Cochran and Mays, 2000b; Gruskin et al., 2001). Whether lesbian and bisexual women are more likely to engage in heavy alcohol use is debated; defining heavy consumption as 60 or more drinks per week, Aaron et al. (2001) found 4.7% of lesbian women compared to 1.1% of the general American female population to report heavy consumption, though



others (Roberts, 2001; Gruskin et al., 2001) have found little difference and conclude that the vast majority of lesbian and bisexual women do not report problematic use of alcohol.

Finally, sexually transmitted infections (STIs) can occur between women who are sexually active with women (Mravcak, 2006; Davis, 2000; Fethers et al., 2000), with the Canadian Health Network (2006) reporting the most common STIs to be bacterial vaginosis, human papilloma virus, trichomoniasis, and herpes simplex virus. However, lesbian women can also experience any other types of STIs such as HIV, Chlamydia, gonorrhea, syphilis, etc.

There is concern that lesbian and bisexual women are less likely than heterosexual women to undergo routine preventive screening, in part because of a reduced need for birth control leading to fewer opportunities for routine gynecological care. Research conducted by Aaron et al. (2001) confirms that while lesbian women are as likely as heterosexual women to have ever had a Pap smear test (94.2% and 93.8%, respectively), they are less likely to be tested regularly, with 74.9% having had a Pap smear test within the previous two years, compared to 80.3% of heterosexual women (see also Valanis et al., 2000; Mrazzozzo et al., 2001; Mrazzozzo, 2004; Bowen et al., 2004).

In the focus groups, several lesbian and bisexual participants said they were told by physicians they did not need to have a Pap test because they were not currently having sex with a man. A few of these women had to be quite adamant before their physician would agree to do a Pap test. With respect to STIs, one focus group participant explained how she and her female partner went for STI testing early in their relationship but their doctors questioned why they were doing so and were reluctant to do the testing until “forced.”

Research is inconclusive on the use of mammography, with some studies reporting significantly lower lifetime mammography screening rates among lesbian and bisexual women (Cochran et al., 2001; Valanis et al., 2000) and others reporting similar (Diamant et al., 2000a) or slightly higher (Aaron et al., 2001) rates.

Whether the health risks identified here are associated with a higher prevalence of chronic disease and other health problems among lesbian

My partner had to force her doctor to test for HIV, chlamydia, gonorrhea and syphilis. All the things, if a woman had a male partner, would be a no brainer. And here we were trying to be responsible and we have to justify why we want to take care of our health.

*Female participant  
in a focus group*



and bisexual women is largely unknown. Tracking systems generally do not include a measure of sexual orientation, identity or behaviour, and studies that correlate risk behaviours with health status tend to be localized and to rely on convenience samples (Aaron et al., 2001; Cochran et al., 2001; Fields and Scout, 2001). Still, there is consensus in the literature that preventive screening should be conducted at the same rate as for heterosexual women, and that lesbian and bisexual women should be included in prevention strategies that encourage the reduction of risk behaviours (Cochran et al., 2001; Davis, 2000; Mravcak, 2006; Marrazzo et al., 2001; Case et al., 2004).

This said, care must be taken to avoid making assumptions about health behaviour based on sexual orientation and gender identity. As one gay woman explained, “The GLBT community is painted with one brush – that we engage in higher risk activities, that we are more likely to have substance abuse issues, more likely to smoke. While lots of that is true, and is undoubtedly connected to society’s view of being GLBT, it is not fair to make assumptions.”



## II Health Issues of Gay and Bisexual Men

HIV/AIDS remains a significant health issue for gay and bisexual men. An estimated 56,000 Canadians were living with HIV/AIDS by 2002 and of those, 58% of cases were among men who had sex with men (Myers and Allman, 2004); in the US, 45% of the incident cases of HIV infection occur in men who have sex with men (Pathela et al., 2006; see also Catania et al., 2001). The Ontario Men's Survey, a cross-sectional survey of 5,080 self-identified gay and bisexual men, examined the risk behaviours associated with the prevalence of HIV and found that 42.1% of gay and 30.7% bisexual men reported at least one episode of unprotected anal intercourse in the previous three months. A significant minority (24.6%) of the sample indicated that they were not tested for HIV on a regular basis (Myers and Allman, 2004).

Other health issues for which gay and bisexual men are believed to be at greater risk are urethritis, proctitis, pharyngitis, hepatitis A and B, syphilis, gonorrhoea, chlamydia and herpes due to lower rates of preventive screening (Peterkin and Risdon, 2003) and for stroke, coronary artery disease and myocardial infarction due to a greater prevalence of smoking (Tang et al., 2004). There is also some indication of high rates of illicit drug use among gay and bisexual men; just 34.5% of gay and bisexual men participating in the Ontario Men's Survey for example had *not* used recreational drugs within the previous year (Myers and Allman, 2004). Finally, gay and bisexual men may be at greater risk than heterosexual men for eating disorders (Lee, 2000a).

It was suggested by some focus group participants that bisexual men might be a more isolated group than other sexual minorities and therefore less likely to have their health needs met. This could be related to the fact that they may be more secretive about their sexual orientation and therefore less likely to seek or be given the health information they require.

“A good relationship is one in which they [health care providers] ask me questions and I can ask them questions.”

*Male participant  
in a focus group*



### III Health Issues of Transgender and Intersexed Persons

HIV/AIDS is a significant health issue for transgender<sup>3</sup> individuals (Clements-Nolle et al., 2001), with reports of HIV prevalence among American transgender individuals ranging from 14% to 47% (National Coalition for LGBT Health, 2004). HIV prevalence among the Canadian transgender population is unknown, though 8% of respondents in Goldberg et al.'s (2003) study of transgender individuals in British Columbia had used health services related to HIV/AIDS in the past, and 12% anticipated doing so in the future.

“Gender identity is different than sexual orientation. Gender is between your ears and sex is between your legs.”

*Transsexual person  
in an interview*

Transgender health issues also include medical interventions meant to masculinize or feminize the body, including hormone therapy and gender reassignment surgery (Bockting et al., 2004; Feldman and Bockting, 2003); the majority of transgender individuals surveyed in British Columbia for example indicated a current or anticipated need for hormone therapy (87%) and gender reassignment surgery (79%; Goldberg et al., 2003; for an overview of specific health risks associated with male-to-female and female-to-male sex-reassignment surgery, see Berreth, 2003).

There is some indication of a greater prevalence of substance abuse-related health concerns among transgendered individuals, with 16% of participants in Goldberg's (2003) study of transgender British Columbians identifying a need for substance addiction services, and one-third of transgender respondents in a study conducted in Washington, DC self-identifying as having a substance addiction; of the latter, 36% had sought alcohol-related and 53% had sought drug-related health services (Xavier, 2003).

There is a lack of health studies to identify health issues or specific concerns for intersexed individuals, other than references to the controversial nature of sex assignment of intersexed infants.

<sup>3</sup> A clarification of terminology used in this section is as follows: Transgender is a broad term inclusive of individuals whose behaviour, manner of dress, or identity does not strictly conform to societal perceptions of a binary gender definition of “male” or “female.” This can range from wearing the attire socially ascribed to the opposite sex, to a person whose gender and sex are in direct opposition (transsexual), and may or may not be taking steps in transitioning to the opposite gender. Intersexed describes someone who is born with ambiguous genitalia or chromosomal anomalies.



#### **IV Health Issues of Two-Spirited Persons**

While the health issues of Two-Spirited persons are not significantly different from the health issues of GLBQIT persons, disparities in health status among Aboriginal Canadians generally are believed to exemplify the health concerns of this population (Teengs and Travers, 2006). Notably, Aboriginal Canadians are at a disproportionately high risk of HIV/AIDS; by 2002, Aboriginal Canadians comprised 3% of the national population, but 12% of new HIV infections and by 2003, one-quarter of individuals testing positive for HIV were Aboriginal (Teengs and Travers, 2006; see also McKay-McNabb, 2006; Monette and Albert, 2001). It is not known if gender and sexual diversity play a role in the prevalence of HIV / AIDS in the Aboriginal population.

Unfortunately, personal opinions of Two-Spirited persons have not been captured in this report as attempts to include Two-Spirited individuals in the interviews and focus groups were unsuccessful.



## V Mental Health Issues of LGBTQITT Persons

LGBTQITT individuals tend to be at higher risk for depression and suicide, resulting from lived experiences and internalization of heterosexism and homophobia and experiences with discrimination, stigmatization, social isolation, HIV-related grief and anti-gay violence (Mravcak, 2006; Case et al., 2004; Gilman et al., 2001; Meyer, 2003; Cochran et al., 2003; Bockting et al., 2004). Of 90,823 American women surveyed by Case et al. (2004), 18.8% of lesbian and 22% of bisexual women, compared to 13.3% of heterosexual women, reported recent depression. Mills et al. (2004) found the seven-day prevalence of depression<sup>4</sup> to be 17.2% higher among gay men compared to heterosexual men, and studies conducted by Cochran and Mays (2000a, 2000b) found gay men twice as likely as heterosexual men to experience recurrent depression. A recent survey of gay, lesbian, bisexual and transgender persons in Ottawa revealed that more than one-third (37%) of the total sample cited depression as a health concern, and more than one-half (52%) of transgender respondents did so (Pink Triangle Services, 2001).

Depression is also related to an increased risk of suicidal ideation and suicide attempts. Among American men aged 17 to 39, Cochran and Mays (2000a) report that gay men are five times more likely than heterosexual men to have attempted suicide (19.3% compared to 3.6%, respectively), and among men who have sex with men, Paul et al. (2002) found 21.3% had made a suicide plan and 11.9% had attempted suicide; HIV-positive gay men were more likely to have made a suicide plan, but were no more likely than non-positive gay men to have made a suicide attempt. Suicide is a significant health risk among transgender persons as well; of 252 transgender persons surveyed in Washington, DC, 35% had experienced suicidal ideation and of those, 47% had made one or more suicide attempts (Xavier, 2003, and of transgender persons surveyed in Ottawa, 20% indicated that they had experienced suicidal feelings (Pink Triangle Services, 2001; see also National Coalition for LGBT Health, 2004; Clements-Nolle et al., 2001).

Challenges associated with the emergent recognition of same-sex interests and difficulty coping with stigmatization and anti-gay hostility

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<sup>4</sup> (Definition of seven-day to be added in final paper)



are believed to put LGBTQITT youth at a particularly high risk for depression and suicide (Paul et al., 2002; Lee, 2000a; Garofalo and Katz, 2001; Dobinson, 2003; Frankowski, 2004). While the sexual orientation or identity of youth who commit suicide is often not known, D'Augelli et al.'s (2001) study of 350 gay, lesbian and bisexual youth revealed that 42% had contemplated suicide, 33% had made at least one attempt, and over one-quarter had made an attempt by age 16. Paul et al. (2002) also reports that nearly three-quarters (70%) of gay men participating in an American survey (n=2,881) who had made a suicide attempt had done so before age 25, and among GLBT teens interviewed in Ottawa, 62% indicated that depression and 36% indicated that suicidal feelings were of concern (Pink Triangle Services, 2001).

Mental health issues emerged in discussions with interview and focus group participants as well. A few participants said they or a LGBTQITT friend had experienced suicidal ideation and/or attempts. Some identified their friends in the LGBTQITT community as one of the strongest sources of support when dealing with emotional or mental health issues. A few had received counselling from mental health professionals.

There is evidence in the literature of greater mental health service utilization among LGBTQITT individuals (Roberts, 2001; Pachankis and Goldfried, 2004). Cochran and Mays (2000b) report that 75-80% of lesbian and bisexual women utilize mental health services, and that lesbian women with at least one psychiatric syndrome are twice as likely as their heterosexual counterparts to use such services (48% compared to 22% of heterosexual women). In a later study, Cochran et al. (2003) found lesbian and bisexual women three times more likely than heterosexual women to have seen a mental health provider in the previous year (33.0% versus 10.7%), more likely to have attended a self-help group (27.8% versus 8.3%) and more likely to have taken psychiatric medication (19.2% versus 13.5%). Gay and bisexual men were also more likely than heterosexual men to have seen a mental health provider in the previous year (19.4% versus 7.5%), to have seen a general physician to address an emotional issue (45.0% versus 15.4%), to have attended a self-help group (15.3% versus 3.9%), and to have taken psychiatric medication (24.8% versus 5.6%). Of 179



transgender persons interviewed in BC, 42% indicated that they had previously utilized mental health services (Goldberg et al., 2003).

While greater mental health service utilization is unexplained, it may be associated with positive community norms and entry to mental health services through HIV-related counselling (Cochran and Mays, 200b). Still, the higher prevalence of depression and suicidal ideation, and early onset, suggests the need for mental health screening, particularly among LGBQITT youth.



## VI Intimate Partner Abuse and Violence by Others

Intimate partner abuse and anti-gay violence constitute significant health risks for LGBTQITT persons. According to the 2004 General Social Survey (GSS), 15% of Canadians self-identifying as homosexual have experienced partner violence (compared to 7% of heterosexuals; Statistics Canada, 2006a). A recent review of the literature led Helfrich and Simpson (2006) to conclude that within the United States, 41-68% of lesbian women experience intimate partner violence, and the National Coalition of Anti-Violence Programs (2001) estimates that 15-20% of gay males experience domestic violence. Despite these high proportions, just 2.5% of the incidents of spousal violence reported to police, in this country, are reported by persons in same-sex relationships (Statistics Canada, 2006b).

Reluctance to report abuse may be associated with fear of disclosing sexual orientation or identity, a lack of awareness of and sensitivity to abuse in same-sex relationships among professionals and within shelters, and the normative views that gay men are not abusive and that men in general are seldom victims of spousal violence (Ontario Public Health Association, 2000; Kirkland, 2004; Helfrich and Simpson, 2006; National Coalition of Anti-Violence Programs, 2001).

LGBTQITT individuals are also at risk of victimization by anti-gay violence (National Coalition for LGBT Health, 2004; Duncan et al., 2000). Of 252 transgender individuals surveyed in Washington, DC, 43% indicated that they had been a victim of violence or crime and of those, 75% felt their victimization was related to transphobia or homophobia (Xavier, 2003). A survey of 405 self-identified gay, lesbian and bisexual adults residing in 15 American cities found that 39% of participants worried they would be the victim of anti-gay violence, with lesbian women the most likely to indicate concern (59%), followed by gay men (40%) and bisexual persons (22%; Kaiser Family Foundation, 2001). Notably, about one-quarter of LGBTQITT youth are believed to experience physical abuse at home (Lee, 2000a; Garofalo and Katz, 2001; see also Saewyc et al., 2006).

Violence in lesbian relationships is rarely talked about or acknowledged...One reason shared by most “battered women” is that abuse in our society generally has been hidden. The assumption is often made that women interact in a caring and supportive manner and therefore cannot be abusers. As a result, abuse is thought to only occur in straight relationships and always by men to women. Other issues relate to stereotypes and prejudices about lesbians. There is often fear among lesbians that open discussion about abuse will generate even broader negative images regarding the community.

*Extract from  
You Don't Deserve to be Abused  
pamphlet produced by Peer Support  
Services for Abused Women  
(Calgary)*

A survey done in Calgary by VIGOR (Violence in Gay Male Relationships) in 2002 found 36% of the gay men reported experiencing/perpetrating domestic violence in their relationships. The same survey done in 2003 and 2004 indicated 41% had experienced / perpetrated abuse.

*Same-Sex Domestic Violence:  
The Hidden Danger  
article by Jane Oxenbury  
in Calgary Unity Pages 2006-2007*



In the transsexual population, a few individuals who participated in the interviews and focus groups said they have feared for their safety in healthcare situations when their gender, which did not match their outward appearance, was made public through the behaviour of staff, e.g., loud comments that could be overheard by others in a waiting room or by staff insisting that the transsexual person be seen by a same-gender attendant.



## D. BARRIERS TO ACCESSING HEALTH CARE SERVICES

The preceding discussion of health issues, though not exhaustive, provides insight into the most common physical and mental health challenges of LGBTQITT persons. The greater prevalence of unmet health needs among LGBTQITT populations (Statistics Canada, 2004a) and reduced likelihood of utilizing routine, preventive health care services together signify the importance of understanding the barriers to adequate and appropriate health care.

It shouldn't be that I have to go seeking a gay friendly doctor. I should be able to go and walk into any doctor and it shouldn't matter who I am or what I am or how I identify.

*Male participant  
in youth focus group*

In this section we identify such barriers, including reluctance to disclose LGBTQITT orientation, identity or behaviours to health care practitioners; overt and perceived discrimination in health care environments; lack of appropriate and relevant health information; and deficits in health care provider knowledge on health issues of relevance to LGBTQITT populations. The literature strongly suggests that these barriers result in large from the prevalence of heterosexist bias in health care organizations, including the 'default' assumption that consumers of health care are heterosexual, and in some cases, assumptions of heterosexual superiority. Because heterosexism is itself a social determinant of health, heterosexist bias in health care environments is of particular concern (Fields and Scout, 2001; Barbara et al., 2001; Duncan et al., 2000; Jackson, 2006).

### I Barriers to Disclosure

Reluctance to disclose or to be open with practitioners about sexual orientation, identity or behaviours is a salient barrier to accessing appropriate and adequate health care. The studies reviewed indicate that between 38% and 72% of LGBTQITT individuals have reservations about disclosing their sexual orientation to health care providers (Mautner Project, 2007; Fields and Scout, 2001; Marrasso et al., 2001; Eliason and Schope, 2001; Bowen et al., 2004). There is some indication that lesbian and bisexual women and LGBTQITT youth and seniors have greater difficulty communicating with health care providers (Heck et al., 2006; Pink Triangle Services, 2001; Stein and Bonuck, 2001), and that individuals who are open about their sexual identity or orientation in other areas of their lives are more likely to be open with health care providers (Eliason and Schope, 2001; Mitchell, 2006; van Dam et al., 2001).



Open communication may be particularly difficult for bisexual and transgender individuals, as a survey of 826 GLBT individuals in the Ottawa area revealed that just 57% of bisexual and 73% of transgender persons had disclosed their sexual identity or orientation to their regular health care provider, compared to 82% and 84% of lesbian women and gay men, respectively (Pink Triangle Services, 2001). A particularly poignant story was told by a transsexual person during an interview with the consultant. He went to a walk-in clinic complaining of a sore throat. The clinic had just opened for the day and no one was in the waiting room. He provided his health care card by which the clinic staff could tell he was transgendered. The staff clarified the information on the card with the patient, took the information back to the doctor and then returned and told the patient the doctor was “unable to see me today.” The patient left the clinic and did not take the issue any further.

Non-disclosure is associated with a heightened risk of inappropriate testing, misdiagnoses and inappropriate treatment or referral (Lucas, 1992 and Carroll, 1999, cited in Ontario Public Health Association, 2000), while individuals who are comfortable discussing their sexual orientation, identity or behaviours with health care providers are more likely to seek general and preventive health care services (White and Dull, 1997 and Bradford, Ryan and Rothblum, 1994, cited in Barbara, 2001; Lekas et al., 2005). A survey of 56,935 self-identified lesbian women in the US for example found that those who had disclosed their sexual orientation to their regular health care provider were significantly more likely to have received a Pap smear test within the past two years (82% compared to 64% of those who had not disclosed; Diamant et al., 2000b).

The literature suggests that the majority of LGBTQITT individuals recognize the importance of open communication with health care providers. Research conducted by the Coalition for Lesbian and Gay Rights in Ontario, for example, found that while 51% of lesbian women had chosen not to disclose their sexual orientation to a health care provider, the vast majority (91%) felt that it was important to do so (cited in Davis, 2000). Factors contributing to reluctance to disclose include overt, perceived or anticipated discrimination and/or substandard care, and heterosexist assumptions/biases of the health care environment and of health care providers and staff, including the use of non-inclusive

I got a list [from the Calgary Health Region] of physicians who were taking new patients and phoned everyone on the list to see if they would be willing to take transgendered patients. Only five said they would.

*Transsexual person  
in an interview*

Many years ago I felt a negative reaction from old family doctor [because I was gay]. That would have been 20 years ago...Since I've been going to my current doctor, there are no problems...Nothing has ever been lacking in my health care.

*Male participant  
in an interview*

I lived as straight person and my experience with the health care system was straight but false, and now I live as a gay woman and I feel great, in my head and in my life, and I think my health care is strained.

*Female participant  
in a focus group*



language, inappropriate questioning, and failure to demonstrate an understanding of LGBTQITT health issues. Each of these barriers is discussed later in this section.

Participants in the focus groups and interviews described how they will test a new environment to determine how accepting the provider is and if it is safe to disclose. Clues come from language (e.g., several people said the term 'homosexual' suggested the provider was not comfortable with the gay community), nonverbal behaviour (e.g., several people noticed a decrease in eye contact after they told their provider they were gay) and the physical environment (e.g., several people said a pamphlet or a poster that did not make heterosexist assumptions would give them a message of openness and inclusion).

Several focus group participants suggested that disclosure would be more likely if the health care provider asked neutral questions, such as, "Are your sexual partners men, women or both?" rather than, "Are you gay or lesbian?" It was thought by participants that some people would not identify as gay but would respond affirmatively when asked if they had sex with partners of the same gender.

A few participants in the focus groups and interviews felt quite strongly that disclosure was inappropriate unless their health issue was related to their sexual orientation or gender identity, such as with relationship issues and sexual issues. For example, if they went to a walk-in clinic because of a minor injury, they felt it was inappropriate to disclose.

Signs from the health care professional are subtle but cold. ...rush out of room...not thorough care...the assessment gets speeded up...you can tell they can't focus... limits my willingness to share with them. If you can tell they can't handle the idea [of your sexual orientation], how do ask them questions about other things you need to ask.

*Female participant  
in a focus group*



## II Overt / Perceived Discrimination and Substandard Care

Negative prior health care experience, including experiences of overt discrimination and/or substandard care, can reduce the willingness of LGBTQITT individuals to openly discuss their sexual orientation, identity or behaviours, and contribute to lower rates of service utilization (Fields and Scout, 2001; Marrazzo et al., 2001; Hutchinson et al., 2006; van Dam et al., 2001; Mimeault, 2003). Recent Canadian research has found 28% of GLBT individuals in Vancouver and 11% in Ottawa to have experienced negative treatment for hospital emergency services (Pink Triangle Services, 2001), and 16% of GLB persons to have experienced negative treatment when utilizing public health services in Ontario (CLGRO, 1997, cited in Ontario Public Health Association, 2000). American research reveals that between 27-30% of lesbian and bisexual women and one-third of transgender persons indicate having experienced a negative reaction (such as anger or hostility, discomfort, disgust, embarrassment or shock) or received substandard care from their health care provider upon disclosure of their sexual orientation (Smith et al., 1985, cited in Mravcak, 2006; Lehmann, Lehmann and Kelly, 1998, cited in Fields and Scout, 2001; Xavier, 2003), and a study of 524 lesbian women from across the US found one-third (36%) had delayed utilizing health care services for fear of a negative reaction (van Dam et al., 2001; see also Mautner Project, 2005, Barbara et al., 2001, and Eliason and Schope, 2001).

Another aspect of discrimination related to assumptions that impacts the LGBTQITT population is overt or perceived discrimination against people who are living with, or perceived to be living with, HIV/AIDS. AIDS Calgary Awareness Association has developed a set of eight Human Rights Fact Sheets (2004) providing information on a range of topics related to stigma, discrimination and HIV/AIDS, accessing services and filing a human rights complaint. Fact Sheet #7, *HIV/AIDS and Accessing Services* explains, “It is illegal for a service provider (e.g. doctor, dentist etc) to refuse to serve you based on any of the protected grounds for discrimination. This means they cannot refuse to serve you based on your HIV status. If the service provided is ‘accepting new patients’ or ‘accepting new clients’ that means they cannot refuse to serve you due to your HIV status” [or perceived status].

There’s blatant homophobia and there’s reactionary discomfort. I feel a chill in the exam room as soon as I say to the nurse or physician, ‘gay.’ It’s really subtle but it’s still very obvious to me the patient. And then my care is different. Before we were chatty and we were friendly, it was very engaged. And then suddenly it’s quite sterile and very cold and very quick and no eye contact... That to me signals there’s a lack of comfort on the health care professional’s part with a diverse population. They know gay people are out there but when I’m sitting right next to the doctor or nurse, you know they’re uncomfortable.

*Female participant  
in a focus group*

It’s not specific words. It’s how they talk, eyes, body position.

*Male participant  
in a focus group*



The extent to which health care providers hold discriminatory attitudes toward LGBTQITT individuals is generally unknown. A recent survey of physicians in one US state found just 8% of male physicians and less than 2% of female physicians to self-identify as homophobic (Eliason and Schope, 2001), while a survey of GLBT physicians revealed that two-thirds (67%) of respondents knew of cases where a GLBT client was denied treatment or given substandard care on the basis of their sexual orientation (Schatz and O'Hanlan, 1994, cited in Fields and Scout, 2001).

In the Calgary Health Region, the Patient Concerns Office has received only a couple of concerns over the past number of years related to sexual identity or gender orientation. The Region responds to each concern on an individual basis with a staff member from the Patient Concerns Office taking a lead role in facilitating an internal review process that focuses on client relations, information sharing and conflict resolution. While patients are encouraged to first discuss their concerns directly with their care provider or Patient Care Manager, the Patient Concerns Office provides another point of entry into the system for patients or their advocates to express concerns, complaints or messages of thanks regarding patient care. Concerns may be expressed over the phone, through a website form or in writing. Any information provided by a patient/client is kept confidential and used only with the patient/client's permission to investigate their concern.

My doctor has said to me a couple of times, you're not having sex very often, and I thought what are you talking about. Well she's just assuming that there has to be a penis involved for it to be sex...She'd joke around that you're going to break my speculum here...Then she turns around and says don't be afraid to be yourself around me. I'm getting very confused and mixed messages from her.

I never avoided using health care services because of my [gay] sexual orientation... Getting information has not been a problem. My family doctor is quite good.

*Male participant  
in an interview*



### III Heterosexism

Heterosexist assumptions, reflected in the exclusion of LGBTQITT persons in health promotion material, inappropriate verbal and written questioning, and the use of non-inclusive language are the norm in mainstream health care environments; a study by Eliason and Schope (2001) for example found that less than 10% of GLB respondents, in their most recent health care visit, saw a pamphlet, poster or magazine that was GLB-inclusive, and just 14% felt their intake form was inclusive of their sexual identity.

Experiences of heterosexism and homophobia in society more generally result in an acute awareness among LGBTQITT persons of cues in health care environments that might indicate whether practitioners are sensitive and receptive to persons of LGBTQITT sexual orientation (Barbara et al., 2001), and heterosexist bias in the physical environment and the use of exclusive language can foster feelings of invisibility, exclusion and marginalization (Eliason and Schope, 2001).

Moreover, the 'default' assumption of practitioners that clients are heterosexual is also prevalent, and can result in missed opportunities to identify health care concerns specific to LGBTQITT individuals. Assumptions of heterosexuality often go unchecked, as health care practitioners fail to inquire about clients' sexual orientation or behaviours (Hutchinson et al., 2006; van Dam et al., 2001). A survey of 424 bisexual and 1,921 lesbian women receiving gynecological care in the US for example found that just 9.3% of respondents had ever been asked by their health care provider about their sexual orientation (Smith et al., 1985, cited in Mravcak, 2006), and of 575 gay and lesbian individuals surveyed in New York, just 29% had been asked (Stein and Bonuck, 2001). Likewise, just 32% of gay and lesbian participants in a survey conducted by the Coalition for Lesbian and Gay Rights in Ontario had been asked by their physicians about their sexual orientation and just 13% had been given an opportunity to disclose their sexual orientation on an intake form (cited in Davis, 2000; see also Banks, 2001).

In addition to heterosexist biases in physical health care environments and assumptions of client heterosexuality among practitioners, heterosexist bias also permeates substance addiction treatment

I went in for my annual exam...They gave me a handout on perineal care and it said don't have sex with your partner when he has sores on his penis. I wrote on it and handed it to the nurse can you just put when your partner has sores on their genitals because my partner's female and she doesn't have a penis...It was so exclusive. How hard would it have been to just think outside the box...With that one word, it negated 10% of the patient base.

*Female participant  
in a focus group*



programs; the National Coalition for LGBT Health (2004) points out that programs often exclude transgender persons through strict gender segregation (thereby excluding persons who do not identify exclusively as male or female) and by prohibiting the use of hormone therapy, considered drug use, while in treatment.

Heterosexist biases, assumptions and policies contribute to feelings of invisibility and marginalization, and ultimately, can lead to reluctance on behalf of LGBQITT persons to utilize health care services (Mitchell, 2006; van Dam et al., 2001; Duncan et al., 2000). A participant in this research explained heterosexual lack of awareness and how it impacts her: “I don’t think that heterosexual people recognize the vulnerability of GLBT people throughout our lives. I am a lesbian who has a lot of privilege in our society. And yet, I always dread having to come out to people when I first engage with them. For me, this has been especially true when accessing medical services than anywhere else. I may have to come out several times as I work through a particular medical issue and I am always afraid that, if that person is not open, it could negatively impact the care I receive.”

The participants in the focus groups and interviews spoke repeatedly of frustration with heterosexist and gender binary language (language that allows for male or female genders only) on health related forms and in information material distributed in health settings. Many participants felt the use of less discriminatory language on forms and health material was absolutely essential for a more inclusive system.

Transsexual individuals who took part in the focus groups expressed a desire to be referred to by the name and gender they request rather than what it says on their birth certificate or medical records. As one female to male transsexual explained, “In the clinic they shout out my full legal feminine name. What about privacy? There’s no respect. I go up to the counter and say can you please call me my shorter [androgynous] form of the name, but they don’t. They say but that’s your name on record. It’s a big deal to me but they think I’m being so petty.” Another transsexual person described a negative experience with laboratory services: “They called my old name...I went to the front and said I’ll explain to you why the name is different if we could just go around the corner because the waiting room was full. They refused. They were unwilling for me to explain to them someplace private. I said can I just have my requisition back and I will go

I had an accident [at home]...I didn’t want to go to the hospital but I passed out and my partner insisted. My name had been changed but my gender hadn’t. I ended up going...They were fabulous...They came over quietly and asked ‘has your name changed since the last time you were here?’ I said yes. She went back and updated the information in her computer.

*Transsexual person  
in an interview*



somewhere else.” It is important to note that not all experiences with the health system for this population have been negative. For example, a transsexual person described how he picked up a prescription for testosterone at a pharmacy and was delighted to see they wrote down his male name on their clinic records. Likewise, another transsexual reported a positive experience in the emergency area of a local hospital.

Another area of concern for transsexuals was gender-specific washrooms. Transsexual participants said the washrooms in health care facilities and elsewhere pose problems for them and they would prefer gender neutral washrooms. They do not feel it is appropriate that the handicapped washroom be used as a substitute for a gender neutral washroom.



#### IV Deficits in Provider Knowledge of LGBTQITT Health Issues

There is little Canadian research on the extent to which health care professionals are adequately prepared to meet the health care needs of LGBTQITT individuals, though a survey of pediatric residents at the University of Ottawa revealed that the majority of participants felt they had not received adequate professional training to address the health care needs of homosexual youth (Lena et al., 2002), and of 200 health and social service providers interviewed in another Ottawa study, greater training in GLBT sensitivity and in transgender issues was cited as necessary by 64% and 57% of the sample, respectively (Pink Triangle Services, 2001). In the US, a review of four-year family medicine training curricula revealed that an average of 2.5 hours of training was dedicated to homosexual and bisexual health (Tresar and Rovi, 1998, in Fields and Scout, 2001), and in another study, just 40% of American medical students felt they had received sufficient training in gay male health and 68% in lesbian health (McGarry et al., 2002).

Training deficits in transgender health are particularly problematic, resulting in inconsistent applications of the guidelines for the provision of hormone therapy, and more generally, in long wait times for access to practitioners with adequate transgender health care training (Lombardi, 2001; Goldberg et al., 2003; Nemoto et al., 2005; JSI Research & Training, 2000).

Inadequate training contributes to misperceptions about LGBTQITT health, such as the misperception that that lesbian women are not at risk of cervical cancer, leading some physicians to suggest that same-sex partnered women do not require regular Pap smear testing (Mravcak, 2006; Diamant et al., 2000a; Hudspith, 2001; Mautner Project, 2007). A study of same-sex partnered women in Seattle, Washington found that one in ten had reportedly been told by a physician that Pap smear testing was unnecessary because the participants were lesbian (Marrazzo et al., 2001). Another common misperception is that sexual identity is a reliable predictor of sexual behaviour, leading health care providers to draw inaccurate conclusions about the likelihood that their clients engage in risky sexual behaviours (Fields and Scout, 2001; Ontario Public Health Association, 2000; Pathela et al., 2006; Hutchinson et al., 2006). Practitioners may assume, for instance, that lesbian women are at lower risk for certain



STIs or do not require information on safe sex with opposite-sex partners because they are not sexually active with men, when in fact lesbian identity does not exclude opposite sex relationships; of 6,935 American lesbian women surveyed by Diamant et al. (2000a), three-quarters (77%) reported that they had previously been sexually active with men, and 6% had been sexually active with men within the previous twelve months.

Many of the participants in the interviews and focus groups felt health care providers lacked knowledge about appropriate ways to communicate with the LGBTQITT population and, in some cases, about information specific to this population's health issues. As one person explained: "One of the biggest barriers I encounter...as a lesbian is a lack of understanding among medical professionals about the unique circumstances of GLBT people. Either there is obvious discomfort or a need to justify that everyone is treated the same. Both scenarios create a less open environment for a patient."

However, it must be emphasized that not all participants felt providers lacked information and exhibited heterosexist attitudes. Several spoke quite adamantly about their positive experiences in the health care system, with one remarking, "Calgary is perceived to be quite gay friendly." He went on to say that while the gay and lesbian community in Calgary is small compared to large urban centres in North America, it does not mean that gay and lesbian people are mistreated. Another gay man said he has found the health care in Calgary to be positive and non-discriminatory. He disclosed to his physician the first time they met: "I put down on my form that I was a single male. He asked the question if I was gay. Said he didn't want to insult me, he just thought it was something he should know." This individual states that his doctor has always been able to provide the information he needs and that his gay friends have had similarly positive experiences in the health care system.

Several community organization representatives said one of the most significant barriers to health care for the LGBTQITT population was the lack of related education for health care providers. One individual said their community organization hears frequent complaints that Pap tests are not offered or are discouraged for lesbians and that providers do not know about transsexual health issues. Interestingly, this organization



has noticed an increase in the number of health care providers calling for information about sexual minorities in the last year or two, sometimes related to physical health issues but primarily related to mental health issues. In response to these calls, they provide the necessary information or refer callers to other resources.

An issue that arose only once in the focus groups but that should be noted is related to people who identify as asexual. One participant expressed concern that asexual people (people who do not experience sexual attraction although may experience romantic attraction), are assumed by health care providers to have a sexual disorder. “When they talk to a doctor for another issue, doctors assume there is something wrong...and start testing them for a bunch of things. They assume they have a sexual disorder such as hypoactive sexual disorder...If you say asexual, they won’t believe you. The doctors look at you like you’re insane and they try to fix you. The other side of it is what kind of health care do asexual people need. No clear guidelines.”



## V Barriers among Youth

There is little empirical research on the extent to which the health care needs of LGBQITT youth are unmet, though a study of GLBT persons in Ottawa found that among teens indicating that depression was a significant health issue, the majority (55%) were not accessing appropriate health services (Pink Triangle Services, 2001). More generally, the literature cites barriers to health care among LGBQITT youth as including a reluctance to discuss emerging questions about sexual orientation or identity, difficulty managing social stigma and social isolation more generally, and a prevalence of homelessness and related barriers to health care access (Ryan et al., 2000; Ontario Public Health Association, 2000; Ray, 2006; Duncan et al., 2000).

Youth who participated in the LGBQITT focus groups spoke about some of the same issues identified in the literature as well as others. More specifically, a number of participants had concerns about lack of health provider knowledge around LGBQITT issues, contradictory information around testing for sexually transmitted infections and barriers to disclosure such as fear of breached confidentiality.

Much of the discussion with youth focused on their experiences with family physicians, which ranged from very positive to very negative. For example, one young male said, “Whenever I’ve been to see a nurse or doctor, their response has been ‘how can I help you?’ so it’s not that forbidding to go – it’s a warm atmosphere.” When this individual came out to his family doctor as a gay male, his doctor asked if his parents knew. When the youth replied that they did, the doctor said, “Then we’re good.” Another participant, a female to male transsexual, described a less positive experience. When he came out to his family doctor, the doctor remarked, “So you’re a sexually aggressive lesbian?” And the young man replied, “I told him I’d find a new doctor.” And finally, another participant described a more indirect situation at his physician’s office that made him feel uncomfortable: “At my doctor’s clinic, I was requested next time you come in you should ask for this person. I think they were saying it was the gay friendly doctor but I could also tell the nurse and doctor I was talking to were uncomfortable with the conversation I was having with them. It was more of a shift of we don’t want to deal with you, that person will.”

It would nice to have something you and your doctor could go over together that...talks about your responsibilities to each other...Like on the patient’s side, to be honest about a lot of things, and on the doctor’s side, to preserve your confidentiality. That kind of makes it explicit...

*Female participant  
in youth focus group*

My doctor said ‘you know what you’ve told me is confidential.’ I didn’t believe him. Even when my dad came into the room and asked questions, the doctor didn’t tell.

*Male participant  
in youth focus group*



Some service providers who participated in the interviews and focus groups felt youth were less likely to disclose in a health care situation. The youth who participated in the interviews and focus groups felt disclosure was important only in certain situations, e.g., when going in for “mental anguish” or when there was to be a long-term relationship with the care provider. When the issue was “just sewing your finger up,” they thought disclosure was unnecessary.

Youth participants also said they had received conflicting information about the need for Pap tests. One young woman explained her experience: “I went to my doctor when I was 19 and asked for a Pap test. When she found out my partner was female, she told me if I never had sex with a man I would never need a pap smear...I questioned her on it and she finally did it because she found out my partner had been with a man. But she said my risk was so low it wasn’t really important.” Another young woman said when her physician told her she did not need a Pap test, “I went home and read up on what the specific strain of HPV that is contracted by women through women. I had to go back and force her to give me a Pap test...It was very hard for me to have to force something that I didn’t want in the first place but I knew I needed.”

Youth participants expressed concerns around breaches, or potential breaches of confidentiality. Since they often see the same family physician as their parents, many did not trust their physician to keep their sexual orientation or gender identity confidential. One young female expressed her concerns this way: “If it’s a family doctor, you can’t always rely on them to keep it to themselves, implicitly or explicitly, especially when they’ve treated your whole family for years and years...there’s loyalty to your parents...[This] gets in the way of telling them things.” One young male had direct experience with a breach of confidentiality when he asked his physician about sexually transmitted infection testing one day, and then his mother questioned him about it the next day. Another young male described his experience as this: “I haven’t found a safe place yet. I don’t like going for physicals with my family doctor. When he asks if I’m sexually active he means with the opposite sex. I don’t want my entire family knowing. It’s bad enough that my mother knows.” Several youth found a workable solution by seeing two separate physicians – their family physician (to whom they have not disclosed) and the physician at their post-secondary institution (to whom they have disclosed). Even so, one participant said he was worried

My doctor makes jokes about me not having a penis every time I’m in there, directed to me. In order to get treatment I need to see a doctor to be regulated because it’s dangerous not to...Testosterone is a prescribed substance. I want to go through a doctor and make sure it’s done properly.

*Transsexual person  
in youth focus group*

If I ask this question [of my family physician], who else is going to know I’ve asked this question?

*Male participant  
in youth focus group*



about “file transfer from one doctor to the other.” Another problem with this solution is that the physician at the post-secondary institution is not available year round. One young woman said she used a tele-health service for some of her medical support while living in another province. She liked the fact that it preserved some anonymity and, “You get practically the same amount of attention as you get in a clinic.”

For young transsexuals, access to psychiatry services has been a challenge. To find a psychiatrist, they have researched on the Internet, sought recommendations from community organizations and asked other members of the LGBTQITT community.

Other concerns raised by the youth participants in interviews and focus groups were related to sexual health education in high school. More specifically, some felt sex education in high school assumes everyone is heterosexual, does not teach that novelty condoms may not protect against STIs, and presents little information on oral sex.



## VI Barriers to Mental Health Care

Despite the comparatively high rates of mental health care service utilization by LGBQITT persons noted in the previous section, research suggests that LGBQITT persons are more likely than heterosexual persons to express dissatisfaction with the availability of appropriate mental health care and to indicate that they have unmet mental health needs. Research conducted in New York for example found GLBT individuals more likely to report dissatisfaction with the mental health services they had received (17.6% compared to 8% of heterosexual respondents; Avery et al., 2001), and a study of 826 GLBT persons in Ottawa found that 13% had received negative treatment when pursuing mental health services (Pink Triangle Services, 2001). Of those indicating that depression was a health concern, 46% of transgender, 30% of gay, and 23% of lesbian participants indicated that they were not accessing appropriate mental health services (Ibid.). As with physical health care, negative prior experience can reduce the likelihood that LGBQITT persons will seek mental health care in the future.

Additional barriers to mental health care include difficulty locating mental health care providers who are knowledgeable of and experienced with mental health issues of LGBQITT persons (Arnold et al., 2002; Willging et al., 2006; National Coalition for LGBT Health, 2004; Bockting et al., 2004; Eliason, 2000), and reluctance on behalf of professionals to discuss gender- or sexually-related concerns (Willging et al., 2006). As well, there is some indication that LGBQITT persons face unique barriers accessing mental health support when experiencing intimate partner abuse, including an unwillingness to disclose sexual identity, diminished self-esteem resulting from internalized homophobia, and in cases where an abusive partner has a long-term illness, such as HIV/AIDS, a moral obligation to support that individual regardless of abuse (Kirkland, 2004).

Some focus group participants expressed frustration with counsellors and how they addressed their sexual orientation or gender identity. For example: "Counsellors, I've seen several. They don't always have the language to ask the right questions. They don't understand the language. One psychiatrist looked at my form and asked how I would identify my sexual orientation. I said bi. He said how are you with that? I



said good. He said okay we won't spend time on that but other counsellors thought it was the root of all my problems."

Some service providers who participated in focus groups and interviews said members of the LGBTQITT population in Calgary may not know how to locate counsellors who specialize in working with sexual minority populations, despite the fact that some LGBTQITT websites list providers of sexual minority friendly psychological services, e.g., Safety Under the Rainbow<sup>5</sup> has developed a resource booklet for Alberta that includes listings of counselling services and shelter, and Youthsafe.net<sup>6</sup> includes on their website a listing of psychological services friendly to the LGBTQITT community. Another service for the LGBTQITT community is "OUT IS OK," a phone line that provides 24-hour support, information and referral to members of the LGBTQITT community, their family and friends and provides peer support during select hours of the day. This telephone line is the result of a partnership between the Distress Centre and Calgary OutLink - Centre for Gender and Sexual Diversity.

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<sup>5</sup>Resources and information intended primarily for service providers to raise awareness about and increase understanding of same-sex domestic violence and homophobic youth bullying.

<sup>6</sup>A website developed by the Youthsafe Resource Committee, a multi-agency group formed to address the gaps in violence prevention services offered to gay, lesbian, bisexual, transsexual, transgendered and questioning youth.



## VII Financial Barriers

While there is no evidence that LGBTQITT persons are, on the whole, economically disadvantaged, discrimination-induced joblessness and poverty are cited as barriers to health care service utilization among transgender individuals (Xavier, 2003; National Coalition for GLBT Health, 2004; Banks, 2001; Shaffer, 2005). According to Goldberg et al (2003), three-quarters (72%) of transgender persons seeking transition health services in British Columbia cite difficulty accessing health care services and of those, 55% attribute their difficulty to financial considerations (Goldberg et al., 2003). Financial cost is of particular concern among transgender persons seeking gender reassignment surgery in jurisdictions where the procedure is not covered by provincial health care plans (Government of Ontario, 2003). While in Alberta the cost of gender reassignment surgery is generally covered, transsexuals in interviews and focus groups said they end up paying for various other expenses related to gender reassignment.

Financial barriers associated with difficulty obtaining health care insurance are particularly salient in the United States, where LGBTQITT persons are disproportionately unlikely to hold adequate insurance coverage (Mautner Project, 2005; Diamant et al., 2000a; Marrazzo et al., 2001). Barriers to obtaining adequate health care insurance coverage are under-examined in the Canadian context, though a recent survey of GLBT persons in Ottawa found three-quarters of gay and lesbian respondents to hold health insurance in addition to OHIP, though just 48% and 66% of transgender and bisexual respondents, respectively, did so (Pink Triangle Services, 2001). The exclusion of alternative or non-Western health care therapies from health insurance plans, though unexamined in the literature, may further constitute a financial barrier to desired health care service utilization<sup>7</sup>.

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<sup>7</sup> While this review did not identify any research on LGBTQITT access to alternative or non-Western health care services, the literature does suggest that alternative or non-Western health care is preferred by some LGBTQITT persons (Mimeault, 2003; Scherzer, 2000); a study of 826 GLBT individuals residing in the Ottawa area for example found that 18% of participants had ever utilized alternative health care services (Pink Triangle Services, 2001).



## VIII Other Barriers

For some LGBTQITT persons, social stigma, discrimination, and isolation related to sexual identity or orientation is compounded by exclusion from Aboriginal, visible minority, disabled, youth and senior communities. The unique health care barriers experienced by individuals with 'multiple marginalizations' are discussed in this section.

Two-Spirited Individuals: While Two-Spirited persons were once widely-accepted in Aboriginal culture, the historical colonization of Aboriginal peoples and the ensuing entrenchment of homophobia in Aboriginal societies have resulted in Two-Spirited individuals' estrangement from their families, home communities and culture (Thoms, 2007). In addition to social isolation resulting from heterosexism and homophobia within Aboriginal communities, barriers to health care experienced by Two-Spirited persons include:

- an absence of health services geared toward Two-Spirited persons generally
- a lack of sensitivity to and awareness of Aboriginal-specific health issues in mainstream health care environments specifically;
- disparities in health status typifying Aboriginal Canadians (including poverty, inadequate housing, substandard living conditions, disintegration of traditional ways of life, and high rates of substance abuse, addictions and suicide; see Brotman et al., 2007); and
- a tendency of Two-Spirited individuals toward attitudes of passivity, resulting in reluctance to advocate for inclusive and appropriate health care services (LGBT Health Association of B.C., 2003; Brotman et al., 2002; Ryan et al., 2000).

Visible Minority LGBTQITT Individuals: There is a virtual absence of Canadian research on the health care experiences of LGBTQITT persons of racial and ethnic minority (Myers and Allman, 2004), though American research has found visible minority LGBTQITT more likely to experience their cultural or ethnic communities as homophobic, and thus to experience exclusion from both LGBTQITT communities (on the basis of visible minority status) and from ethnic/racial/cultural communities (on the basis of sexual orientation/identity; Ryan et al., 2000; Kennamer et al., 2000).

Exclusion from LGBTQITT communities can pose a significant barrier to health care service utilization, as the social networks formed among



individuals of similar sexual orientation or identity can be a source of health information, referrals and support (Dobinson, 2003)<sup>8</sup>.

LGBQITT Persons with Disabilities: LGBQITT persons with disabilities also commonly experience exclusion from both peers with disabilities and LGBQITT communities, resulting in reduced opportunities for health-related networking (National Disability Authority, 2005). Additional barriers of LGBQITT persons with disabilities include misperceptions among health practitioners about the sexual needs/feelings of persons with disabilities generally, assumptions of practitioners that their clients with disabilities are heterosexual, and the invisibility of LGBQITT persons with disabilities in public health campaigns (Canadian Federation for Sexual Health).

LGBQITT Older Persons: Contributing to unmet health needs among older LGBQITT persons are ageism within LGBQITT communities, compromising the ability of older individuals to access health information and referrals from peers, and a cultural silence about aging and sexuality more generally, reducing the likelihood that health practitioners will initiate discussions about sexual behaviours with older LGBQITT clients (Ryan et al., 2000; Hudspith, 2001; Cahill et al., 2000; Clover, 2006). The literature also suggests that older LGBQITT persons may be more reluctant to discuss their sexual identity, orientation or behaviours with health care providers, having already endured a lifetime of concealment of their sexual identity/orientation (Cahill et al., 2000; Clover, 2006).

In a recent Canadian study, Brotman et al. (2003) conducted focus groups to explore the experiences of gay and lesbian seniors in accessing health and social services, and found the most common barriers include:

- mistrust of health and social services, due to life-long experiences of marginalization,
- homophobia and discrimination,
- the invisibility of older gay and lesbian persons in mainstream service environments, and

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<sup>8</sup> Research conducted by Eliason and Schope (2001), for example, found that one-third of gay, lesbian and bisexual individuals had consulted peers about a health practitioner's receptivity to gay, lesbian and bisexual clients prior to making an appointment, and of 575 gay men and lesbian women interviewed in New York, nearly one-half (43%) had used a referral from a partner, friend or relative for the selection of their current health care provider (Stein and Bonuck, 2001).



- discomfort exhibited by service professionals when discussing sexuality with older clients or upon observing displays of affection among same-sex couples in residential health care settings.

Participants also expressed fear and anxiety in anticipation of becoming dependent on long-term health care institutions, perceived as typified by heterosexism and homophobia.



## E. REDUCING BARRIERS TO HEALTH CARE SERVICES

In this final section, we summarize the recommendations found in the literature and identified in the consultation for enhancing health care service utilization among LGBTQITT persons and present exemplars of inclusive and accessible LGBTQITT health care approaches. The information was compiled through the review of academic literature and from publicly-available guidelines and standards of care, toolkits and information sheets (Appendix A) and through interviews with representatives from organizations exemplifying best practices in the provision of LGBTQITT health services. Additionally, suggestions from participants in focus groups and interviews have been incorporated into this section. Highlights from this section have been summarized in Figure 1: Summary of Strategies to Reduce Barriers to Health Services for LGBTQITT Populations.

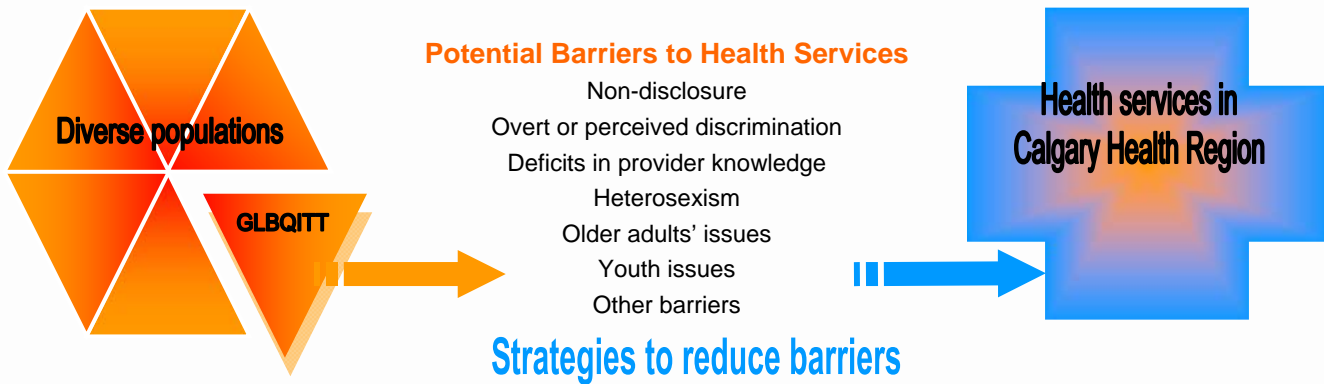
The best way to change prejudicial attitudes is to create familiarity.

*Service provider*

There is general agreement in the literature that health care service utilization is enhanced when the policies and practices of health care organizations are premised on a model of ‘culturally competent care,’ including “(1) an understanding of population-specific health-related cultural beliefs and values, (2) knowledge of disease incidence, prevalence and mortality rates and (3) an understanding of population-specific treatment outcomes” (Schilder et al., 2001: 1657), but also including linguistic competency and sensitivity, respect and inclusion. Cultural competence in health care environments increases access, but also enhances practitioner-client communication and rapport and results in greater disease prevention, more accurate diagnoses, and greater treatment adherence (Mautner Project, 2007; Fields and Scout, 2001).



**Figure 1. Summary of Strategies to Reduce Barriers to Health Services for LGBQITT Populations**



**Policy and Accountability**

- Ensure all Regional policies are free of heterosexist assumptions and biases.
- Include gender identity and sexual orientation in a zero-tolerance discrimination policy.
- Ensure staff are held accountable for non-inclusive behaviours and know the legal requirements of human rights acts.
- Adopt position statements from professional bodies when appropriate.
- Implement a system for intermittent feedback on the sexual minority inclusiveness of different situations.
- Share learnings on this issue with other health regions and professional bodies.

**Communication and Awareness**

- Train staff on heterosexism awareness, inclusive language, gender and sexual orientation as determinants of health and other information.
- Provide training to new staff at orientation and existing staff on an ongoing basis.
- Assess diversity competence of potential staff in employment interviews.
- Increase staff familiarity with guidelines and standards of care that pertain to the health of sexual minorities.
- Incorporate sexual minority diversity training into post-secondary programs for health service providers.
- Incorporate inclusive language into all aspects of health services.
- Avoid 'alphabet soup' acronyms in an attempt to capture all sexual minorities.

**Physical Environments**

- Examine physical environments for assumptions of heterosexism.
- Modify environments to include symbols of gender and sexual diversity and acceptance (ensure staff are trained and demonstrate inclusive attitudes and behaviours before symbols are used).
- Display posters, magazines and pamphlets that are inclusive of LGBQITT individuals.
- Provide gender-neutral washrooms.
- Develop forms that are inclusive of clients who do not identify with gender as a dichotomous variable and are free of heterosexism.

**Community Collaboration**

- 'Come out' as a health region in support of the sexual minority community, e.g., be visible at public events, distribute literature at health facilities, advertise in community publications.
- Ensure support from upper management for the Region's gender and sexual diversity initiatives.
- Involve members of the sexual minority population on Regional diversity advisory committees.
- Build greater links with community agencies already involved with the sexual minority community.
- Develop a list of gay-friendly and trans-friendly family physicians.



## I Policy and Accountability

Diversity competent care requires that health care organizations examine their policies for implicit, but exclusionary heterosexual assumptions and biases. In addition to a zero-tolerance discrimination policy that includes sexual identity, orientation and behaviours, policies should be modified to ensure recognition of non-traditional family formation, to allow, for example, same-sex partners to participate in health care decision-making. With respect to older LGBTQITT persons, policies should incorporate homophobia as a form of elder abuse, particularly within long-term care facilities (Brotman et al., 2003).

Participants in the interviews and focus groups emphasized the need for a clearly stated Regional policy with respect to sexual orientation and gender identity. And, even more importantly, participants stressed the importance of holding staff accountable for discriminatory behaviours and attitudes and contacting professional bodies as incidents occur. One focus group participant who felt strongly about this issue stated: “Marginalized people know when they’ve been dismissed. And that’s what is at play here – individual providers, clinicians choosing to do that. Nobody calls them on that behaviour. And there’s no reprimand.”

This diversity thing, it’s not a love-in anymore. There’s a problem. Everyone that’s involved is part of the solution...Why do you accept the premise that there’s someone in the Calgary Health Region that *isn’t* safe [for sexual minorities]?

*Male participant  
in a focus group*

It was also suggested by focus group participants that the Region adopt the College and Association of Registered Nurses of Alberta’s Position Statement on Vulnerability (September 2005) as a guideline on care. Additionally, it was suggested that health service providers be educated about the Alberta Human Rights, Citizenship and Multiculturalism Act and be reminded that they are required by law to follow the act, which protects people from being discriminated against by those who provide public services, which includes health care. As one service provider said, “This isn’t just about being nice. Just as we have anti harassment policies, the principles apply when dealing with patients and [should say] none of our staff our allowed to discriminate. It’s about carrying out our legal responsibilities.” And taking it a step further, this provider suggested the Calgary Health Region be a leader in the area of inclusive practices and share what they have learned with other health regions and professional bodies.



Written policy is important for accountability. One service provider pointed out that while people can be informed how to make an official complaint, systems must be put in place to prevent complaints from being necessary. She explained: “If I rely on people who are vulnerable and marginalized to be the ones who have to police me, I’m not going to get policed. If I rely instead on systems to keep me in check, I’m more likely to aspire to be the best practitioner I can be.”

Some focus group participants felt the complaint process at the Region was limiting, e.g., “Clients may drop complaints when they are asked over and over what the issue was.” Several suggested an intermittent feedback mechanism would be more useful than waiting for complaints to be made because “a lack of complaints does not necessarily mean a system is working.” Feedback could be provided through survey forms (e.g. ask “Did you feel respected” or “How would you measure this experience in the health system”), either on paper or through an online system. One person suggested a “mystery shopper” approach whereby members of the LGBTQITT community would go to health care providers or facilities for a service and then complete a rating of the service afterwards.



## II Communication and Awareness

Health care practitioners, administrators and staff should examine their personal assumptions for heterosexist biases, and be encouraged to participate in training on the impact of heterosexism. Training in the use of inclusive, non-heterosexist language, and trans-positive language (including sensitivity to pronoun use), as well as training in taking nonjudgmental, detailed and open-ended sexual histories is recommended (Ryan et al., 2000; for suggestions see Mravcak, 2006). Some participants in the interviews and focus groups recommended using a checklist to assess how inclusive the Region is to the LGBTQITT population (some checklists have been developed by community programs – see Appendix).

Familiarity with guidelines and standards of care that pertain to LGBTQITT health, and awareness of heterosexism and homophobia as social determinants of health more generally should be promoted (Fields and Scout, 2001; Duncan et al., 2000). Explicitly ensuring confidentiality and ensuring that sexual health information and discussions are relevant to clients of all sexual orientations can further enhance the delivery of inclusive and relevant health care services.

One community service provider explained it this way, “It would be so helpful for medical professionals to have some form of diversity training to develop a deeper understanding of this client / patient group. It is important not to make assumptions based on commonly held, although not necessarily accurate, facts. For example, to assume that lesbians would not want to engage in a conversation about birth control is not necessarily appropriate. In fact, there was research recently done that concluded that sexually active gay, lesbian or bisexual teenagers in B.C. are up to three times more likely to be involved in a pregnancy than their heterosexual counterparts. This is one fact that is really important for health care providers to understand, but how do they access this type of information?” However, the need goes beyond simply having the information available – health care providers must be willing to have conversations with their clients about these issues.

Most of the community agencies and service providers who spoke with the consultant felt provider training was important, particularly anti-homophobia training with a focus on raising the provider’s awareness of

More [sexual minority diversity training] happens in high schools and with the general population than health care providers.

*Service provider*

If we started the education process before they were nurses and doctors, we’d be ahead of the game.

*Female participant  
in a focus group*

their own heterosexism. The training could be incorporated into post-secondary education programs, into orientation for new staff at the Region and provided to Regional staff on an ongoing basis. Questions about inclusive attitudes could be included in employment interviews. Some people suggested the training be made mandatory, e.g., “The [Region’s] diversity assessment tool is good but we need to make it mandatory.” One provider said he had offered sexual diversity education as concurrent sessions at a couple of conferences for health care providers and they were poorly attended.

Even having one staff member who is educated and proactively supportive of sexual diversity can have a ripple effect on the rest of the staff group, noted one provider.

A number of programs developed by a variety of organizations are listed in the appendices of this report and may be possible resources in diversity training, e.g., Sexual Attitude Reassessment Workshop by the Alberta Society for the Promotion of Sexual Health, Anti-Homophobia Workshop by the Calgary Sexual Health Centre, Same Sex Domestic Violence by Safety Under the Rainbow and education programs by AIDS Calgary Awareness Association. Some focus group participants stressed the value of a desensitization approach, either through panel discussion or group education sessions: “If people sit in a room and talk with people who are different than them, the effect is profound. Face-to-face is more powerful than online. It’s that personalization of it that can’t be done online. That’s what goes on in the anti-homophobia sessions with high school students.”

We cannot expect others to fully understand the experiences of marginalized populations unless they are given the opportunity to hear from a person who lives those experiences.

*Service provider*

A few gender and sexual diversity resources are available on the Calgary Health Region website and through related links. The Sexual Diversity page on the Sexual and Reproductive Health website, defines sexual orientation, sexual identity and sexual behaviour, and provides a tip sheet “How to talk about sexual health with health professionals,” and for health professionals, a tip sheet “How to talk about sexual health with patients/clients.” A link is provided to Calgary OutLink: Centre for Gender and Sexual Diversity and another to [www.youthsafe.net](http://www.youthsafe.net), an Alberta website providing resources and links on sexual orientation and gender identity issues for youth. ([www.calgaryhealthregion.ca/hecomm/sexual/sexualorientation.htm](http://www.calgaryhealthregion.ca/hecomm/sexual/sexualorientation.htm)) Also, an excellent fact sheet about homophobia and sexual orientation



developed by Dr. Gene Flessati at the Calgary Health Region is available at [www.calgaryhealthregion.ca/clin/adultpsy/flessati/homophobia.htm](http://www.calgaryhealthregion.ca/clin/adultpsy/flessati/homophobia.htm).

Inclusive language must be incorporated into all aspects of health services. As one service provider said, “If all of the language as a pre-natal class is about a husband and wife, this clearly is not going to be a safe, open place for a lesbian couple. Services are only really accessible when the client sees her or himself represented. Having brochures in the waiting area, and a receptionist that is open, is the key as this is the first contact a client will have.” Terminology was an area of much discussion in the interviews and focus groups. While not all people agreed on the exact phraseology, some suggestions from participants for inclusive terminology in questioning about sexual history were:

- Are your partners predominantly male or predominately female?
- Do you have sex with men, women or both?
- Have you had male sexual partners? Had female sexual partners?

An example of an inclusive language resource is the Inclusive Language booklet developed by Healthy Diverse Populations and the Aboriginal Health Program, which is available on line at [www.calgaryhealthregion.ca/hecomm/diversity/diversity\\_reources\\_sub.htm](http://www.calgaryhealthregion.ca/hecomm/diversity/diversity_reources_sub.htm). The purpose of this booklet is to encourage Calgary Health Region staff, volunteers and Board members to actively think about the language they use, to be aware of current inclusive and discriminatory language, and to encourage consistent use of inclusive language when interacting with clients/patients, families and staff at work. This booklet also provides practical examples of how to use inclusive language and examples of non-inclusive language that should be avoided.

Several participants mentioned the universal domestic violence screening being done in many areas of the Region as an example of inclusive questioning, e.g., “I was first asked if I had a partner, then asked if my partner was male or female, then questioned further around potential violence.”

As for gender, health care providers should not always assume a person is either male or female. Gender is fluid; for example, some

Professionals using the term partner...goes a long way in terms of reducing barriers. It is much more than using politically correct language, it is again a way to be open to populations.

*Service provider*

I get the impression that health care professionals step very gingerly around language, they're quite afraid of offending. I think the challenge to our community is to ease up a little bit. Because there is so far to go...So they used the wrong label, or a label...and that's not great. But I think there's so much fear on their part of using the wrong term that that's a shame because that actually stops the dialogue. So I challenge us to maybe make it a little bit easier for dialogue.

*Female participant  
in a focus group*



people see themselves more as transsexual or gender queer. Generally, participants recommended that providers ask the individual how they identify their gender and to avoid limiting them to only two choices. They also cautioned against trying to use “alphabet soup” acronyms to capture all sexual orientations because different people define the groups in different ways and there is a good chance of overlooking a group in the listing. Indeed, there was much inconsistency in the gender and sexual diversity acronyms seen in the course of this research.



### III Physical Environments

Physical environments should be examined for ways they communicate assumptions of heterosexism, and modified to include symbols of diversity and acceptance. Inclusive physical environments can be created by:

- posting a non-discrimination statement that includes sexual orientation,
- developing intake forms that are inclusive of clients who do not identify with gender as a dichotomous variable and allowing clients to indicate a significant non-heterosexual relationship,
- displaying posters, magazines and pamphlets that are inclusive of LGBTQITT individuals, and
- having gender-neutral washrooms.

Focus group and interview participants had a number of suggestions related to changes in the physical environment to make health care facilities communicate greater inclusiveness:

- Just one thing in the rack or one thing on the wall that suggests a sexual orientation or gender identity other than heterosexual male or female.
- Anything with a rainbow on it (the rainbow signals that this organization honours gender and sexual diversity).
- Lab jacket pins that say 'safe space' and have a rainbow or a rainbow sticker on the clipboard of individual providers who have taken gender and sexual diversity training or who otherwise support inclusivity.
- Make health care facilities and providers earn their pins or stickers by fulfilling specified criteria, just like breastfeeding friendly places.

One service provider described an initiative she was involved in several years ago, which focused on training of service providers to be more open to GLBT clients. Once trained, the participants received a poster entitled, 'Come In and Be Out'. This poster was a way to let sexual minorities know immediately that the place was a safe environment.

Another suggestion made by focus group and interview participants was to provide single washrooms not specific to gender, which might be modeled after open designs seen in some European cities. The non-gender washrooms should be for general use and not specified as for

In the waiting rooms I see lifestyle, weddings and other stuff but it would be nice to see literature that is not just assuming hetero normative reading – articles, ads, I'd like to see some stuff that I can read and not be bored out of my mind.

*Male participant  
in a focus group*



handicapped use or offering baby changing facilities. A participant noted that the Peter Lougheed Centre has a few washrooms with both male and female figures on the door.

Finally, with respect to enhancing service utilization by Two-Spirited persons, health care delivery, including education and prevention programs, should be culturally relevant, utilizing for example the model of the Medicine Wheel, oral traditions of Aboriginal culture, and the use of storytelling, visual aids and gatherings (Monette and Albert, 2001).



#### IV Community Collaboration

While interview and focus group participants were generally pleased at the Region showing an interest in taking action to reduce barriers for the LGBTQITT population, many were curious and some even skeptical as to why the Region has decided to address the issue at this time. One person asked, “Why now? Was it provincially mandated?” Another said, “I challenge the true involvement the CHR in this process...Saying we support diversity is different than saying we have zero tolerance for people who are marginalizing in our service or show disrespect.”

One service provider suggested the LGBTQITT community was reticent because the Region has not reached out to it before. It was recommended that the Region “come out” in a public way and become a more visible supporter of the LGBTQITT community, e.g., advertise in publications, sponsor events and conferences. The Region could also state publicly the steps that will be taken to address sexual minority discrimination. By being explicit, the Region will build trust within the community.” Service providers also advised that, to be successful, the Region must take a ‘top down’ approach and create a climate where discrimination is not acceptable.

Participants also suggested that the Region involve members of the LGBTQITT population on Regional diversity advisory committees and said there was a willingness among members of the LGBTQITT population to participate in committees or in other ways. Certainly this has been the experience of the Calgary Police Service, where several volunteers have been involved in their sexual and gender diversity committee for 10 years.

Building greater links with community agencies would also increase the distribution of information about health issues and resources for the LGBTQITT population. Participants suggested more information about LGBTQITT health and resources be included on the Regional website (while some information is currently available on the Region’s website, it is hard to locate). Print materials on community resources for the LGBTQITT population could also be distributed a health facilities.

Many participants talked about the need for a list of gay-friendly and trans-friendly family physicians who understand patients’ issues. Lists



like this have been put together by some community groups and individuals and are provided upon request. There may be an opportunity for the Calgary Health Region to assist in this area.



## V Exemplars of Diversity Competent Care

The following section highlights examples of diversity competent care (underway or in development) in relation to sexual minority health issues and access to care, either. Hard copies of resources from these programs are included in the appendices of this report.

**Halifax Regional Municipality, Capital Health Gay, Lesbian, Bisexual, Transgender and Intersex Initiative:** Information for GLBTI people and their families, friends and health care providers; their project creates networks for health care providers; conducts research of health needs; creates educational information and learning opportunities for providers; organizes community outreach through education sessions in Halifax to raise awareness of health and wellness in the GLBTI community  
<http://www.cdha.nshealth.ca/programsandservices/GLBTI/index.html>

**Challenging Heterosexism Project of Newfoundland and Labrador:** This research project is intended to counter the heterosexism permeating rural Newfoundland through the development of a website which provides a questionnaire through which individuals and organizations may test their heterosexist assumptions (see [www.mun.ca/the](http://www.mun.ca/the); also Bella and Yetman, 2001).

**Eliminating heterosexism and homophobia from public health and community agencies:** Ontario Public Health Association (2000) has a comprehensive statement on the role of public health in eliminating heterosexism and homophobia from the public health units, community agencies and populations they serve, developing accessible and inclusive quality services, ensuring the support and appreciation of diversity, providing health services that support individuals in coming out and addressing issues of self-esteem and self-confidence, loneliness and isolation and family problems related to sexual orientation (Ontario Public Health Association, 2000).

**Queer Women's and Trans Health Series:** Initiated in Vancouver in 2001 and coordinated by The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and their Allies, the Queer Women's and Trans Health Series sought to promote and celebrate health, and included a health and education project to



promote awareness of STD and Pap test screening, including clinics and social activities. Entitled “Papalooza: The Smear Campaign,” this program is a unique model for outreach, education and community-building emphasizing collaboration between the LGTB communities and the mainstream health care system (see <http://cwhn.ca/network-reseau/4-3/4-3pg1.html>).

**Hasslefree Clinic:** Although there are no clinics in the Calgary Health Region that specifically serve the LGBTQITT population, there are clinics in larger urban centers that tailor some services specifically to sexual minority populations, such as Hassle Free Clinic, a community-based clinic in Toronto providing medical and counselling services in sexual health, the largest anonymous HIV test site in Canada, and one of the country’s busiest STD clinics (see <http://www.hasslefreeclinic.org/>).

**Bisexuals, Gays, Lesbians and Allies in Medicine** (Michigan). A medical student association at the University of Michigan Medical School, organized a series of public events in 2006, including lectures and resource material distribution, to raise awareness of GLB health needs ([www.med.umich.edu/opm/newspage/2006/lqbthaw.htm](http://www.med.umich.edu/opm/newspage/2006/lqbthaw.htm)). In Calgary, the consultant for this Calgary Health Region project heard from participants in focus groups and interviews that medical students at the University of Calgary organized an education session for fellow medical students on the topic of sexual minority issues, although this information has not been confirmed with the medical school. This session was held once in the last few years but, as far as the participants knew, has not been repeated.

**Healthcare Equality Index Survey by the Gay and Lesbian Medical Association in the United States:** The recent launch of the Healthcare Equality Index Survey will provide a quality indicator for health care related to GLBT clients; it will provide a baseline understanding of existing hospital policies and will measure improvement annually. As well, it will enable the identification of existing policies that may be used as a guide that other hospitals can adopt to promote policies of equality. The survey is being sent to hospitals between October 2006 and January 2007 (see <http://www.gлма.org/index.cfm?fuseaction=Page.viewPage&PageID=789&CFID=6141218&CFTOKEN=62452676>).



**GLBT Health Access Project:** This project, funded by the Massachusetts Department of Public Health, seeks to eliminate health care barriers experienced by the GLBT community, to foster the development of culturally appropriate health promotion policies and health care services, and expand data collection on GLBT health, including a qualitative study of health issues and barriers experienced by transgendered / transsexual individuals in Boston. Outcomes include the development of “Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients” and the development and delivery of a health access training curriculum (see [www.ajph.org/cgi/reprint/91/6/895.pdf](http://www.ajph.org/cgi/reprint/91/6/895.pdf); also Clark et al., 2001).



## G. CONCLUSION

This paper has sought to sensitize health care providers to some of the more common health issues of LGBTQITT persons. Though not exhaustive, and not of relevance to every LGBTQITT individual, identification of health issues can assist practitioners in developing an awareness of and sensitivity to certain health concerns for which LGBTQITT persons may be at heightened risk. More importantly, this paper has identified barriers LGBTQITT persons may experience in accessing services for physical and mental health care, including heterosexism and homophobia; inadequacies in knowledge of LGBTQITT health issues among health care providers; and 'multiple marginalizations,' leading, for some, to a reluctance to participate in open communication with health care providers, delaying health care utilization, and in some cases, systematic avoidance of the health care system.

This review illustrated that an inclusive, accessible health care environment is one that is free of heterosexist bias, intolerant of discrimination, inclusive of LGBTQITT individuals and their experiences, and is one in which non-traditional family formation is acknowledged and respected, where health care providers have current and relevant knowledge of LGBTQITT health issues, and are sensitive to and aware of heterosexism and homophobia as social determinants of LGBTQITT health. With its size and multifarious nature, The Calgary Health Region has an opportunity to become an influential role model in providing inclusive service for people of diverse sexual orientations and gender identities.

It is important that the process continue through to implementation after this initial research is complete.



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**APPENDIX A: GUIDELINES, INFORMATION SHEETS, TOOLKITS, PRACTITIONER TRAINING, ASSOCIATIONS, AND INFORMATION FOR LGBTQITT PERSONS**

**Guidelines, Handbooks and Standards of Care Documents**

- Lesbian Health Guidelines of the Society of Obstetricians and Gynecologists; see Davis (2000), or a summary provided by the Canadian Health Network: <http://www.canadian-health-network.ca/servlet/ContentServer?cid=1148760087306&pagename=CHN-RCS/CHNResource/CHNResourcePageTemplate&c=CHNResource>;
- Guidelines for Care of LGBT Patients of the Gay and Lesbian Medical Association: [http://ce54.citysoft.com/ data/n\\_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf](http://ce54.citysoft.com/ data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf);
- Standards of Care of the Gay, Lesbian, Bisexual and Transgender Health Access Project (see Clark et al., 2001);
- Guidelines for Addictions and Mental Health Therapists and Counsellors provided by the Centre for Addiction and Mental Health: [http://www.camh.net/Care\\_Treatment/Resources\\_for\\_Professionals/ARQ2/index.html](http://www.camh.net/Care_Treatment/Resources_for_Professionals/ARQ2/index.html);
- Caring for Lesbian Health: A Resource for Canadian Health Providers, Policy Makers and Planners: <http://www.health.gov.bc.ca/whb/publications/caring.pdf>;
- The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health (2006) published by The Haworth Press Inc. and edited by Michael D. Shankle;
- The American Academy of Family Physicians policy statements relevant to lesbian and bisexual women (see Mravcak, 2006);
- Caring for Lesbian and Gay People: A Clinical Guide (Peterkin and Risdon, 2003); endorsed by the College of Family Physicians of Canada; may be ordered online from: [http://www.cma.ca/index.cfm/ci\\_id/18218/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/18218/la_id/1.htm);
- Caring for Transgender Adolescents in BC: Suggested Guidelines (2006): <http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-adolescent.pdf>;
- Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia (2006): <http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-primcare.pdf>;
- Counselling and Mental Health Care of Transgender Adults and Loved Ones (Bockting et al., 2006): <http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-mentalhealth.pdf>;
- American Psychological Association Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients: <http://www.apa.org/pi/lgb/guidelines.html>;



- Being Nice is Not Enough: Developing Clinical Competence in Trans Care: <http://www.rainbowhealth.ca/documents/english/handouts-trans.pdf>;
- Care of the Patient Undergoing Sex Reassignment Surgery (2006): <http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-surgery.pdf>;
- Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines (2006): <http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-endocrine.pdf>;
- Asking the Right Questions 2: Talking with Clients about Sexual Orientation and Gender Identity in Mental Health, Counselling and Addiction Settings: [http://www.camh.net/Care\\_Treatment/Resources\\_for\\_Professionals/ARQ2/arg2.pdf](http://www.camh.net/Care_Treatment/Resources_for_Professionals/ARQ2/arg2.pdf);
- The Canadian Federation for Sexual Health provides an example of an LGBT-inclusive policy for individuals providing services to persons with disabilities: <http://www.tash.org/resolutions/res02sexuality.htm>;
- Recommendations for the provision of health care to non-heterosexual youth are provided in Frankowski (2004);
- Model Standards Project (MSP) provides a model of professional standards governing the care of LGBT youth in out-of-home care; an overview by Wilber et al. (2006) includes examples of and recommendations for the implementation of the model in organizations serving youth in care, and which may also serve as a guide for enhancing health care service utilization among LGBTQITT youth;
- Beemyn (2003) provides an overview of practices meant to facilitate service provision to transgender college students, many of which are transferable to the health care environment.

### Information Sheets

- On sexual orientation and cancer: <http://www.cancer.org>;
- Pamphlets are produced by The Centre (Vancouver) for consumers and providers:
  - Bisexual Health Matters: [http://www.lgtbcentrevancouver.com/pdf\\_s/bisexual\\_health.pdf](http://www.lgtbcentrevancouver.com/pdf_s/bisexual_health.pdf);
  - Gay Men's Health Matters: [http://www.lgtbcentrevancouver.com/pdf\\_s/gay\\_health.pdf](http://www.lgtbcentrevancouver.com/pdf_s/gay_health.pdf);
  - Lesbian's Health Matters: [http://www.lgtbcentrevancouver.com/pdf\\_s/lesbian\\_health.pdf](http://www.lgtbcentrevancouver.com/pdf_s/lesbian_health.pdf);
  - Transgender Health Matters: [http://www.lgtbcentrevancouver.com/pdf\\_s/transgender\\_health.pdf](http://www.lgtbcentrevancouver.com/pdf_s/transgender_health.pdf);
- Social Justice Framework for GLBTT-SQ Wellness (Canadian Rainbow Health Coalition): <http://www.rainbowhealth.ca/documents/english/Social%20Justice%20Framework.pdf>;
- A Lesbian Health Fact Sheet is produced by the Office on Women's Health (Washington, DC): <http://www.4woman.gov/owh/pub/factsheets/Lesbian.htm>.



## Toolkits

- The Mautner Project for Lesbians with Cancer “Tools for Caring about Lesbian Health Kit:” [www.mautnerproject.org](http://www.mautnerproject.org);
- The Halifax Rainbow Health Project has produced a package that health care organizations can use to assess the inclusiveness of their environment, intake and assessment procedures and policies and services; it includes an Assessment Tool, guidelines for developing standards of care as well as a sample standards of care document, a comprehensive glossary and links to websites on LGBTQITT community health issues: <http://www.rainbowhealth.ca/documents/english/halifax%20rainbow%20health%20project.pdf>;
- A Positive Space is a Health Place: Making Your Community Health Centre or Public Health Unit Inclusive to those of all Sexual Orientations and Gender Identities, produced by The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgender, Two-Spirit, Intersex, Queer and Questioning Equity, a workgroup of the Ontario Public Health Association. Includes background information on sexual orientation and gender identity, information about Positive Space programming, tools to assess the workplace, policies and practices and the need for further training in cultural competency related to LGBTTTTIQQ inclusivity and examples of activities that can be used in delivering a Positive Space Workshop. See: <http://www.opha.on.ca/resources/SexualHealthPaper-Jun06.pdf>.

## Training / Education for Practitioners

- Gender and Health Collaborative Curriculum Project, online module on Gender, Sex and Sexuality; sponsored by the Council of Ontario Faculties of Medicine: <http://www.genderandhealth.ca/en/modules/>;
- Removing the Barriers: Providing Culturally Competent Care to Lesbians and Women who Partner with Women (Corexcel, 2006): <http://corexcel.com/rtb/>;
- Lesbian Health: Tip Sheet for Health Care Providers (Canadian Women’s Health Network): [http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/lesbi\\_e.html](http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/lesbi_e.html);
- Abuse in Lesbian Relationships: Information and Resources (Ministry of Health): [http://phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/femlesbi\\_e.html](http://phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/femlesbi_e.html);
- Caring for Lesbian Health: A Resource for Canadian Health Care Providers, Policy Makers and Planners, Revised Edition (Lesbian and Bisexual Women’s Health Project, BC Centre of Excellence for Women’s Health): <http://www.cwhn.ca/PDF/lhp-infosheetEN.pdf>;
- Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirit People (Brotman and Ryan, 2001; an educational module for professionals): [http://www.rainbowhealth.ca/documents/english/critical\\_issues.pdf](http://www.rainbowhealth.ca/documents/english/critical_issues.pdf);
- Health Matters: An Education and Training Resource for Health and Social Service Sectors (The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgender,



Bisexual People and Their Allies, Vancouver):

[http://www.lgtbcentrevancouver.com/pdf\\_s/theManual\\_vFinal.pdf](http://www.lgtbcentrevancouver.com/pdf_s/theManual_vFinal.pdf);

- Rainbow Health Educational Toolkit (Rainbow Health Network):  
<http://www.rainbowhealth.ca/documents/english/RHET%20Section%201%20-%20Intro%20and%20Workshops.pdf>;
- What Health Care Providers Can Learn: A History of 2-Spirited People:  
<http://www.2spirits.com/AHistoryof2SpiritedPeople.pdf>;
- Transgender and Intersex Health Information links compiled by Hawaii AIDS Education and Training Center AIDS Education Project, John A. Burns School of Medicine, Department of Medicine: [http://www.hawaii.edu/hivandaids/links\\_transgendered.htm](http://www.hawaii.edu/hivandaids/links_transgendered.htm);
- Lee, Rita. 2000b. How to talk about sex with patients who are not heterosexual. *Western Journal of Medicine*. Vol. 172(6): 401-02.
- The Lesbian and Gay Aging Issues Network (LGAIN) works to raise awareness about the concerns of lesbian, gay, bisexual and transgendered (LGBT) elders and about the unique barriers they encounter in gaining access to housing, healthcare, long-term care and other needed services: <http://www.asaging.org/networks/LGAIN/about.cfm>

#### Sample of Associations and Interest Groups

- Intersex Society of North America: <http://www.isna.org/>;
- The 2-Spirited People of the First Nations: <http://www.2spirits.com/>;
- National Coalition for Lesbian, Gay, Bisexual and Transgender Health:  
<http://www.lgbthealth.net/>.

#### Sample of Information for LGBQITT Individuals

- Health care information for gay, lesbian and bisexual individuals: <http://www-hsl.mcmaster.ca/tomflem/gay.html>;
- Information on lesbian health: <http://www.ssmu.mcgill.ca/lbqtm/info/women.html>;
- Planned Parenthood Federation of America: <http://www.plannedparenthood.org/sexual-health/sexual-health-relationship/lesbian-health.htm>;
- Sexual Health for Lesbians: Risks and Realities (Canadian Health Network):  
<http://www.canadian-health-network.ca/servlet/ContentServer?cid=1148760087306&pagename=CHN-RCS/CHNResource/CHNResourcePageTemplate&c=CHNResource>);



- As a lesbian, how do I get good health care? (Canadian Health Network): <http://www.canadian-health-network.ca/servlet/ContentServer?cid=1001994&pagename=CHN-RCS%2FCHNResource%2FFAQCHNResourceTemplate&lang=En&c=CHNResource>
- The Lesbian and Gay Aging Issues Network (LGAIN): <http://www.asaging.org/networks/LGAIN/about.cfm>



**APPENDIX B: ORGANIZATIONS PROVIDING LGBTQITT HEALTH, MENTAL HEALTH AND SOCIAL SERVICES**

**A. Local Organizations**

**AIDS Calgary Awareness Association**

To come

**Calgary Health Region** (<http://www.calgaryhealthregion.ca/hecomm/sexual/sexualorientation.htm>): Sexual and Reproductive Health: Sexual Diversity website defining sexual orientation, sexual identity and sexual behaviour, and providing a tip sheet “How to talk about sexual health with health professionals,” and for health professionals, a tip sheet “How to talk about sexual health with patients/clients.” Link is provided to Calgary OutLink: Centre for Gender and Sexual Diversity and another to [www.youthsafe.net](http://www.youthsafe.net), an Alberta website providing resources and information links on sexual orientation and gender identity issues for youth. Methods for contacting a CHR Sexual Health Specialist are provided.

**Calgary OutLink: Centre for Gender and Sexual Diversity** (formerly Gay and Lesbian Community Services Association)

(<http://www.glcsa.org/services.php>): Offers peer support and crisis line, 24-hour information line, library, drop-in centre, and a directory of GLBT-friendly services. Health services are not provided.

**Calgary Police Services, Diversity Resources Unit, Sexuality and Gender Diversity Portfolio**

(<http://www.calgarypolice.ca/sections/dru/cru.html>): Builds understanding, trust, and communication between the community and police through involvement in committees, commissions, and agencies that provide service to Calgary's sexuality and gender diverse community.

**Calgary Sexual Health Centre** (formerly Calgary Birth Control Association)

([www.cbca.ab.ca](http://www.cbca.ab.ca)) Provides a wide range of services including an anti-homophobia education in schools, and in the community, to help to reduce barriers for the GLBT population, and to develop a better understanding among the heterosexual community about the unique experiences of that population. The program has been provided for over 10 years. A cornerstone of the program is in involving a member of the GLBT community to tell their personal story. This reduces barriers significantly as it gives participants an opportunity to ask questions directly and to hear first hand the experiences of that individual. A committee at the Centre has developed a teacher's guide to human rights, sexual orientation and gender identity. While a lot of the focus of this book is in legal rights, it also covers in depth the issues for GLBT youth in schools and may be a useful reference for the Calgary Health Region.

**Sexual Health Access Alberta** (formerly Planned Parenthood Alberta)

Supports opportunities for healthy sexual development through comprehensive sexual health education, information and a variety services. Gender identity and sexual orientation are presented as simply part of the range of normalcy. Programs and resources include, wontgetweird campaign (youth-friendly website and other media pieces), a sexual health resource centre and video productions.



**B. Western Canadian Organizations**

**The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and their Allies (Vancouver, BC)** (<http://www.lgtbcentrevancouver.com/main.htm>): Bute Street Clinic at The Centre: HIV/STD outreach clinic for the lesbian and gay communities; free, confidential testing; Hepatitis A and B immunization and STD treatment; needle exchange. LGBT Health Matters Project: with health and social service providers and their educators set an LGTB Health agenda; raised awareness through the development and distribution of “Health Matters: An Education & Training Resource for Health and Social Service Sectors” aimed at educators in the health and social service field (available for download on the website); offers a document on developing LGTB Health policy in smaller health and social service agencies, “Preparing an LGTB Policy for Health and Social Service Organizations.”

**Pride Health Services (Vancouver):** Provides direct clinical services (primary health care and counselling) to LGBT individuals; offers LGBT health education to service providers and the LGBT community; a partnership of AIDS Vancouver, The Centre, Three Bridges Community Health Centre and the Transgender Health Program.

<http://www.vch.ca/transhealth/resources/directory/listings/pridehealth.html>

**British Columbia Health Ministry:** Ministry’s Advisory Council on Women’s Health operated between 1994 and 2002 and produced “Caring for Lesbian Health: A Resource for Health Care Providers, Policy Makers and Planners” (1999; 2001). <http://www.health.gov.bc.ca/whb/publications/caring.pdf>; website has link to a document on human rights that addresses sexual orientation and homophobia:

<http://www.ag.gov.bc.ca/human-rights-protection/pdfs/SexualOrientationDiscrimination.pdf>

**Vancouver Island Health Authority:** Provides information and links to supports and services including SEXY: Victoria YMCA Youth Program for questioning, gay, lesbian, bisexual youth and their allies; PFLAG of Greater Victoria (Parents, Families and Friends of Lesbians and Gays); mental health care practitioners specializing in GLBT needs; Transgender Health Program at Three Bridges Community Health Centre, Vancouver; North Community Health Centre (Vancouver) offers addictions counselling program for GLBTQ community. <http://www.viha.ca/>

**Interior Health Region (British Columbia):** in 2005 developed “Proposed Framework for GLBT Youth Suicide and Abuse Prevention;” website contains link to Gay and Lesbian Association of Kamloops; and the 2004 Strategic Plan for Injury Prevention refers to GLBT population risks.

<http://www.interiorhealth.ca/default.htm>

**Fraser Health Authority (British Columbia):** Provides website links to GLBT-friendly physicians, surgeons, psychologists, associated clinical consulting and counselling services.

<http://www.fraserhealth.ca/Home/Default.htm>

**Capital Health Region (Edmonton):** provides online information sheet on sexual orientation for youth.

<http://www.capitalhealth.ca/default.htm>

**Peace Country Health Region (Northern Alberta):** offers consultations on sexual orientation issues including an online Q & A and in-person consultations. <http://www.pchr.ca/>



**C. Eastern Canadian Organizations**

**Halifax Regional Municipality – Capital Health: Gay, Lesbian, Bisexual, Transgender and Intersex Initiative** (<http://www.cdha.nshealth.ca/programsandservices/GLBTI/index.html>): Information for GLBTI people and their families, friends and health care providers; creates networks for health care providers; conducts research of health needs; creates educational information and learning opportunities for providers; organizes community outreach through education sessions in Halifax to raise awareness of health and wellness in the GLBTI community.

**Toronto: The 519Community Centre** ([www.the519.org](http://www.the519.org)); see also Harmer (2000)

Anti-Violence Programme: Objectives are to increase the support available to victims of hate-motivated violence based on sexual orientation; to increase GLBT community awareness of services available; to increase support available to victims of same-sex partner abuse; and to increase GLBT community knowledge of how to respond to potential/actual violence. Services for individuals experiencing violence on the basis of sexual or gender orientation; individuals experiencing violence/abuse in same-sex relationships; resource for health care providers and for LGBTTQ communities. Offers services to victims (e.g., assists with making police reports, provides court support, assists with applications for Criminal Injuries Compensation); offers self-defense courses for LGT individuals; provides training to service providers on issues related to hate motivated violence and same-sex partner abuse; public information on hate crimes and same-sex partner abuse; workshops, public forums; participates in related coalitions and committees.

Anti-poverty and homeless services: including Clothing Programme, Health Bus, ID Clinic, Meal Trans Programme (multi-service drop-in for lower-income and street-active transsexual and transgender individuals), and Sunday Drop-In.

Community Counselling Programme: short-term counselling services and referrals for longer-term services; counsellors are familiar with gay, lesbian, bi and trans agencies, therapists, doctors, lawyers and other professionals.

Groups: Lesbian and gay friendly Alcoholics Anonymous and other Anonymous Peer Support Groups; Deaf Outreach Programme (interpretation and advocacy for deaf people with HIV and workshops on HIV/AIDS and deaf culture); 2-Spirited Circle (starting March 2007, intended to bring together 2-Spirited people for meetings including a talking circle and guest speakers); Bisexual Women of Toronto (safe place for bisexual women to discuss and listen to various perspectives on bisexual issues, offering support, social network, information and referral; associated with the Toronto Bisexual Network); Coming Out Being Out Discussion Group (GLBT people aged 25-40 discuss coming out and being out: relationships, self-esteem, activism, homophobia in the workplace, coming out to families and being GLBT parents); Prime Timers (discussion, support and social activities for older gay men); The Space Between (support group for people assigned the gender of female at birth who feel that this does not best describe their gender identity; intended to create a space for people who fall in between female and FTM or who are questioning their gender, or who consider themselves genderqueer); The Time of Day (social group for LGBT people with disabilities); queer parenting programs.



TS/TG 101 for Service Providers: An Introduction to Transsexual and Transgendered Issues for Service Providers in Toronto: 3-hour workshop for social service providers to increase agency staff knowledge about common TS/TG issues, identity barriers to access, build tools for service providers to move toward further inclusion, reduce stigma, eliminate stereotypes, and address issues of marginalized trans communities including sex workers, low-income trans people, homeless and street-involved trans people.

Older Adult Services: Opening the Closet on Aging: A Day of Learning and Sharing (workshop in March 2007 sponsored by Toronto's Senior Pride Network held at the 519 focusing on the special issues and needs of lesbian, gay, bisexual, trans and two-spirit people in the areas of housing, self advocacy, legal issues, leisure planning and dealing with loss; open to service providers wishing to serve LGBTT people to learn about the kinds of services and programs older LGBTT people want and how they want them delivered); LGBT Seniors Resource Centre; Older LGBT Programme (programme to discover and begin to meet the needs of older LGBT people).

**Southern Ontario Gay and Lesbian Association of Doctors** ([www.soglad.ca](http://www.soglad.ca)): Toronto-based group of physicians and medical students who are interested in the health issues of particular concern to gay, lesbian, bisexual and transgendered people; addresses issues through professional, educational, social and political activities; maintains a list of gay and gay-positive physicians in Toronto area.

**Ontario HIV Treatment Network** (<http://www.ohntn.on.ca/index.html>): Originally established to help meet the care and treatment needs of people with HIV; has a Community Network designed to address the changing challenges of living with HIV and a Health Care Provider Network to develop and implement strategies to support the efforts of health care providers in the treatment and care of people with HIV/AIDS.

**AIDS Committee of Toronto (ACT)**

(<http://www.actoronto.org/website/home.nsf/pages/home!opendocument>): Delivers community-based HIV support services and education, prevention, outreach and fundraising programs that promote the health, well-being, worth and rights of individuals and communities living with, affected by and at risk for HIV/AIDS, and increases awareness of HIV/AIDS; provides free supportive and practical services to individuals living with HIV/AIDS and information and support to their friends, families and partners.

**Central Toronto Youth Services Pride and Prejudice Community Counselling Program**

(<http://www.ctys.org/programs/prideprejudice.htm>): Programs for lesbian, gay, bisexual, intersex, transgender, transsexual and questioning youth 25 and under; individual counselling, group counselling.

**Hassle Free Clinic (Toronto)** (<http://www.hasslefreeclinic.org/>): Community-based clinic providing medical and counselling services in all areas of sexual health; largest anonymous HIV test site in Canada and one of the country's busiest STD clinics.

**2-Spirited People of the 1<sup>st</sup> Nations** (<http://www.2spirits.com/>): Toronto-based social service organization for Aboriginal gay, lesbian, bisexual and transgender people in Toronto; services include HIV/AIDS education, outreach, prevention and support and counselling for 2-spirited people living with and affected by HIV/AIDS.



**D. National Organizations (North American)**

**Canadian Rainbow Health Coalition** ([www.rainbowhealth.ca](http://www.rainbowhealth.ca)): National organization to address health and wellness issues including networking and advocacy for those working in gay, lesbian, bisexual and transgendered health and wellness; clearinghouse for projects and literature.

**Gay, Lesbian, Bisexual and Transgender (GLBT) Medical Students of Canada**

([http://www.utoronto.ca/diversity\\_in\\_medicine/qlbtmeds/](http://www.utoronto.ca/diversity_in_medicine/qlbtmeds/)): National professional organization dedicated to address the issues and concerns of GLBT medical students and physicians in Canada; represents the voices of over 250 GLBT medical students and residents. Purpose is to allow for networking between GLBT medical students, physicians, and other supportive health care groups, to create a forum to discuss GLBT issues and their relation to health care, to provide support for GLBT medical students and trainees during their career, to organize social events and coordinate advocacy activities, and to promote the visibility of the estimated 800 GLBT medical professionals in Canada.

**Callen-Lorde Community Health Centre** (<http://www.callen-lorde.org/>): New York primary health care center dedicated to meeting the health care needs of LGBT communities regardless of ability to pay. Services include primary health care by providers with expertise in LGBT health concerns, lesbian health services including gynecological care, mammography referrals, health education and health counselling; HIV/AIDS services; health outreach to teens including medical and mental health services for LGBT and street youth; senior health services; and primary care, including hormone therapy, counselling and education and referrals to support services for transgender persons.



**Please Note:**

**If you have difficulties reading this document, it is available in alternative formats by contacting:**

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Calgary Health Region  
10101 Southport Road S. W.  
Calgary, AB T2W 3N2  
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