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## Trans Health Project

**A position paper and resolution adopted by the  
Ontario Public Health Association (OPHA)**

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Sponsored by the Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spirit, Intersexed, Queer and Questioning Equity (an OPHA workgroup)

*“Transpeople in Ontario need to have input into health care so we can control our own destinies.” -- M.S.*

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## Executive Summary

### Background & Rationale

The Trans Health Project is sponsored by a workgroup of the Ontario Public Health Association (OPHA): The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spirit, Queer and Questioning Equity. In June 2000, the OPHA workgroup wrote a position paper: Improving the access to and quality of public health services for lesbians and gay men. This paper identified a need to investigate the specific needs, unique barriers and existing gaps in service for transpeople in Ontario, in terms of access and equity around health care. A call for researchers went out in August 2002 and two investigators from the trans community were subsequently hired in October 2002 for the 14-month Trans Health Project.

### Literature Review & Research Results

#### *General Health*

Access and equity around overall (transpositive) health care and social services for transpeople poses numerous challenges/barriers for this highly-marginalized community. The research reveals a substantial lack of supports/services for transpeople.

#### *Physical Health*

In the study several categories of physical health are discussed: Access & Equity; re: Transpositive Care; Gender Dysphoria/"Gender Identity Disorder" [sic]; Puberty-Suppressant Agonists for adolescents; Hormone Replacement Therapy for adults; Cancer (Breast, Cervical, Vaginal, Prostate); Polycystic Ovarian Syndrome (transmen & transgendered female-to-males).

*Sex-Reassignment Surgery (SRS)*: Within the category of physical health, SRS is highlighted because given the powerful need for transsexual people to resolve their intense gender discomfort, sex-reassignment surgery (SRS) is very often the treatment of choice, and therefore, should be accessible – both financially and geographically for Canadians which require this form of medical treatment. In 1998 SRS was de-listed in Ontario as a medical service covered under the Ontario Health Insurance Plan, leaving a glaring gap in service for many transsexuals in this province, many of whom cannot afford to pay for this costly procedure.

#### *Mental Health*

Topics discussed under the mental health heading include: Depression & Anxiety, Anger & Stress; Substance Use & Eating Disorders; Early Childhood Trauma & Adult Assault; Self-Harm & Suicidality; and Family & Relationship Issues. In addition, under Access & Equity, re Transpositive Care, the research results of the Trans Health Project indicated there was a serious lack of *transpositive*, *trans-inclusive* and *trans-responsive* clinical services and supports available across the province.

#### *Social Health*

In this section: Access & Equity re: Social Services; Poverty/Low Income;

Homelessness/Underhoused/Shelters/Hostels; Discrimination (Transphobia) & Violence (Trans bashing); Isolation; Unemployment/Underemployment are discussed.

### *Sexual Health*

Under the heading Sexually-Transmitted Diseases (STDs) & HIV/AIDS, Hepatitis, it is noted that a high percentage of transsexual/transgendered individuals are living with one or more STDs and/or HIV/AIDS, Hepatitis A, B, C.

### *Spiritual Health*

A number of transpersons are religious and/or spiritual and might experience religious discrimination around their trans identification and/or their decision to undergo SRS, making spiritual support and/or pastoral counseling an important need for both trans-identified individuals and their loved ones.

### *Specific Trans Populations*

Several specific populations were identified during this study: Trans Families; Two-Spirit People; Transwomen; Transmen; Trans Parents; Transpeople on Low Income; Genderqueers; Transgendered People; Transqueers; and Trans Francophones. Additionally, in the Toronto area, a number of trans-supportive clinical services, and community resources are available for Trans Youth, however, these continue to be exceeded by the increasing demand. Also, Trans Seniors presented with concerns of facing elder abuse and/or neglect.. Additionally, a number of transwomen, trans youth, and transmen engage in sex work to help save money to pay for the costs of sex-reassignment surgeries, hormone therapy, electrolysis treatments, and related costs incurred throughout the pre-, post- and transition process. Sex work also helps pay for food and rent. Additionally, this work helps to provide personal affirmation for those who desire to be seen and accepted sexually as either women or men.

Added to their pre-existent condition of gender dysphoria (transsexualism), one or more physical, mental and/or sexual health issues can cause layers of complexity and multiple medical and psychosocial barriers to overcome for transpeople with disabilities. In addition, transpeople of colour, immigrants and refugees commonly face especially challenging barriers (e.g., transphobia, homophobia, racism), both within their own families and ethnic/religious communities, as well as within the straight, queer and trans communities. Transpeople in prison typically face blatant discrimination, as well as overwhelming barriers when attempting to access medical and other services and supports.

## Methodology

### Theoretical Framework

Two theoretical frameworks were employed in this study: **Community Based Participatory Action Research (CBPAR)** and **reflexivity**. The goal of CBPAR is to produce results that empower the community being investigated. Additionally, reflexivity is an effective tool for understanding the lives of transpeople as they access, or are denied, health care in Ontario. Reflexivity further informs us as to how transsexual/transgendered people see themselves as they seek appropriate health care. Transpeople's identities are a reflection of the interactions they encounter in their *everyday* lives, and thus, require health care services that treats them in a respectful, sensitive and caring manner. Consequently, reflexivity and CBPAR create a firm partnership in research methodology concerning the trans community.

### Data Collection

The method used in the Trans Health Project for soliciting participation from the community is “snowball sampling,” and relies upon community members inviting others they know into the process. The research data was collected by two means: focus groups and self-administered questionnaires. In addition, an (oral) semi-structured interview for focus group participants was utilized. Finally, a (written) self-administered questionnaire was disseminated to interested individuals who were unable to attend a focus group.

## Data Analysis

A (written) demographic questionnaire was distributed to all participants/respondents to complete and return. In terms of the overall **response summary**, several **over-arching themes** (needs and recommendations) emerged from the responses of research participants, as set out in the following three perspectives:

- Health Care Consumers (transpeople) need to be/have: trans-empowering/self-empowering; meaningful input into health care; patient/client choice; and be part of a participatory process.
- Health Care Providers need to be/become: transpositive; properly educated (basic core knowledge and ongoing training); and culturally competent around and clinically sensitive to the diversity and complexity of the broader trans community.
- Health Care Services need to be/become: trans-inclusive; comprehensive; holistic; and use a community health model.

### General

A summary of the participant responses, highlighting some common threads, is indicated: a comprehensive facility based in Toronto with satellites across Ontario – role model in Toronto & educate around province; trans health clinic OR community centre for transpeople, providing relevant resources; client-driven (place where TSs can choose own program); a harm reduction model; anti-forensic environment (no pedophiles); alternative resources to gender identity programs; and open to all people regardless of class.

Additional findings are included under the sections: information, education, medical and clinical support, community supports, funding (SRS), research and development, community development, housing, employment, and advocacy.

### **Limitations**

The limitations of the present study involved challenges around obtaining a representative sample of the very broad and diverse trans community across Ontario. These challenges were largely due to resource limitations (i.e., money, time and human resources), in particular, a lack of funds to travel to northern Ontario and to rural areas across the province.

### **Recommendations**

A series of recommendations have emerged from the data, and are proposed for follow-up using a CBPAR approach. They include: the funding of further research of trans populations (northern Ontario and rural areas; honoraria for Regional Networkers and research participants; advocacy of the Ontario Health Insurance Plan (OHIP) to re-list sex-reassignment surgery (SRS) and electrolysis treatments for transpeople in Ontario; widely-accessible information for transpeople, family members, partners, health care and social service providers, teachers, employers, and the public; a central medical information source (including various geographic locations in Canada and abroad where SRS is available); transpositive training across Ontario for all medical/health providers employed by Ontario Public Health Units (including basic core knowledge and ongoing professional development); a comprehensive facility (combined community health centre and community centre) for transpeople, based in an urban setting, with satellite locations across Ontario; partnering with various community organizations (including those which serve or support transpeople) and trans peer-support groups throughout Ontario creation of opportunities within Ontario public health units for volunteer involvement of members of the trans community(ies) across the province; and targeted hiring practices within Ontario public health units with a view towards actively recruiting trans-identified candidates for paid positions.

### **Conclusion**

It is evident that issues of diversely situated transpeople and their communities are complex. Despite the increasing visibility of transpeople and their health concerns in research literature, there is a gap in transpositive care for transpeople. This paper is a call for action for the Ontario Public Health Association to disseminate this paper and advocate on behalf of trans communities for the education of health providers and communities, more inviting services and multi-level action across sectors which will support the health and well-being of transpeople.

## **Background**

The Trans Health Project is sponsored by a work group of the Ontario Public Health Association (OPHA): The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spirit, Queer and Questioning Equity ([www.opha.on.ca/workgroups/pha.html](http://www.opha.on.ca/workgroups/pha.html))<sup>1</sup>.

An independent organization, the OPHA is instrumental in advocating around selected health issues and, in the past, has successfully lobbied the Ontario Ministry of Health. In June 2000, the OPHA workgroup wrote a position paper: Improving the access to and quality of public health services for lesbians and gay men ([http://www.opha.on.ca/ppres/2000-01\\_pp.pdf](http://www.opha.on.ca/ppres/2000-01_pp.pdf)), and subsequently, a resolution was adopted at the 2002 OPHA Annual General Meeting: Ethical research and evidence-based practice for lesbians and gay men ([http://www.opha.on.ca/ppres/2002-01\\_res.pdf](http://www.opha.on.ca/ppres/2002-01_res.pdf)). These recommendations are currently in the process of implementation.

## **Rationale**

This paper identified a need to investigate the specific needs, unique barriers and existing gaps in service for transpeople in Ontario - in terms of access and equity around health care - was identified in 2002. A call for researchers went out in August 2002 and two investigators from the trans community were subsequently hired in October 2002 for the 14-month Trans Health Project.

The definition of health we are using to frame this study is much broader than the traditional usage and is based on definitions, which focus on the LGBTT community (i.e., Saskatoon Declaration of LGBT Health and Wellness, 2001; United Nations Platform for Action, Beijing, 1995; Rainbow Health Network, 2002 – see Appendix A). Our definition encompasses five dimensions of health and wellness: physical, mental, sexual, social and spiritual. With regards to improving the access to and quality of public health and community health services for transpeople, a review of the research literature in Canada and the USA reflects multiple issues, challenges and service gaps for this highly-diversified population, as outlined below.

## **Literature Review & Research Results**

### General Health

Access and equity around overall (transpositive) health care and social services for transpeople - an “invisible” population (Namaste, 2000a) - poses numerous challenges/barriers for this highly-marginalized community. The research reveals a substantial lack of supports/services for transpeople (Burnham, 1998; Feinberg, 2001; Goldberg, 2003; Lombardi, 2001; Munson, 2001; Namaste, 1995; Northridge, 2001; Raj, 2002b).

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<sup>1</sup> The complexity of terminology within the transsexual and transgender communities requires close referencing to the definitions located within Appendix A of this report.

## Primary (Physical) Health

### **Access & Equity; Transpositive Care**

Accessing equitable health care for transpeople in Ontario is challenge enough (Namaste, 1995, 2000b; Raj, 2000b); accessing health care which is also *trans-inclusive*, *trans-responsive* and *transpositive* (Raj, 2000a) is a far greater challenge. The literature documents at least two sets of guidelines related to the *overall* primary health care for transpeople (Israel & Tarver, II, 1997; Meyer et al, 2001). There has been some critique from the trans community around these guidelines (Denny & Roberts, 1995).

### **Gender Dysphoria/"Gender Identity Disorder" [sic] and the Need for Sex-Reassignment Therapies**

When accessing hormonal and surgical therapies to reassign the individual's birth sex, many transsexuals and transgendered people need to obtain the approval of a government-sponsored gender identity program. Often, the strict criteria imposed by these gender programs exclude certain groups within the overall trans population (e.g., sex workers, drug users, etc.), and in other cases, erect systemic barriers difficult to overcome for certain select groups (e.g., Aboriginal people, immigrants, refugees) (Namaste, 1995; Namaste, 2000b; Raj, 2002a). Consumer satisfaction surveys which report how well the gender program is meeting the needs of transpeople (Blanchard, Dickey, Peterson, & Stephens, 1993), as well as ongoing critiques from the trans community (Denny, 1992), are imperative to ensure accountability and the need for capacity-building (i.e., trans-inclusivity, trans-responsivity and transpositivity). Input from our participants overwhelmingly indicated substantive problems in this regard (see Appendix D: Data Analysis - Response Summary).

### **Puberty-Suppressant Agonists (adolescents)**

For many teenagers who identify as transsexual or transgendered, legal access to trans-sensitive and knowledgeable physicians who will prescribe and monitor hormonal agonists to suppress the undesired secondary sex characteristics of their birth-assigned sex, is a huge challenge, and the current literature is sparse in terms of such usage. The medical technology, however, is available (Cohen-Kettenis & van Goozen, 1998; Gooren & Delamarre-van de Waal, 1996). Parental consent is mandatory for access to hormonal suppressants for young people and this consent is frequently a barrier to accessing these critical services.

### **Hormone-Replacement Therapy (HRT) (adults)**

In the case of trans-identified adults, there often exists barriers to accessing sex hormone therapy (i.e., anti-androgens, estrogens and/or progesterones for transwomen; androgens for transmen) in terms of requiring specific criteria (i.e., making the patient wait for 1-2 years, as part of a "real-life experience") before prescribing the desired medication. This wait can be problematic for transpeople who do not pass effectively as the "other" sex and who cannot afford to wait due to the intensity of their feelings of gender discomfort ("gender dysphoria") (AEGIS, 1992).



The clinical literature documents some protocols pertaining to hormone therapy for trans adults in the USA (e.g., Callen-Lorde Community Health Center in New York City, and Tom Waddell Health Center [Transgender Clinic] in San Francisco). As well, hormone protocols are currently being developed in Canada (e.g., The Transgender Health Program, Three Bridges Community Health Centre in Vancouver, and in Toronto, Sherbourne Health Centre's Trans, Two-Spirit and Intersex Primary Care Working Group, 2003).

### **Sex-Reassignment Surgery (SRS)**

Surgical intervention to medically modify the body to either a male or a female appearance (depending on whether the person identifies as a man or a woman) is the compelling drive of many transsexuals (and for some transgendered individuals, the aim might be to employ surgical means to approximate an androgynous physical presentation). Given this powerful need to resolve their chronic, intense gender discomfort, sex-reassignment surgery (SRS) is very often the treatment of choice, and therefore, should be accessible – both financially and geographically - as a guaranteed right under the Canada Health Act for all Canadian citizens who require this form of medical treatment. An additional reason why SRS should be an insured service is the simple fact that transsexualism (aka “Gender Identity Disorder”) continues to be listed in the Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revised (DSM-IV-TR) (APA, 2000) as a bona fide medical condition. In 1998 SRS was de-listed in Ontario as a medical service covered under the Ontario Health Insurance Plan, leaving a glaring gap in service for many transsexuals in this province, many of whom cannot afford to pay for this costly procedure, which ranges anywhere from \$12,000 to \$65,000 and up. **Several participants from the Trans Health Project reported SRS as a priority in their lives, and the lack of funding as a barrier to accessing this important health procedure.**

Beyond accessibility, there is also a substantial need for ongoing research and reporting of the current technical aspects of the various types of surgical procedures relating to sex-reassignment, as well as for the future development and refinement of present-day techniques (in particular, male genital surgeries for transmen: phalloplasty and metadioplasty). In terms of clinical medical research which presents an overview of several surgical options, there are several consumer reports (e.g., Cameron, 2002; Goldberg, 2001; etc), however few comprehensive medical studies have been designed to meet this need. In direct relation to the latter, there is also a need for continuing research dealing with the decision-making process related to choices and options around genital reconstructive surgery for transmen, such as the 1999 study conducted by Rachlin. Finally, more longitudinal studies are needed which report on the outcomes of post-operative transsexual patients in terms of satisfaction vis-à-vis cosmetic appearance and sexual and urinary functionality, in addition to more general outcomes pertaining to psychosocial well-being and quality of life. A scant few studies relate to the latter (Friedmann & Junge, 1998; Rehman, Lazer, Benet, Schaefer, & Melman, 1999).

### Additional Primary Health Concerns

#### **Cancer (Breast, Cervical, Vaginal, Prostate)**

A serious omission in the medical literature surrounds that of the incidence of cancer in transmen and transwomen, with the majority of reports being consumer-generated (Doherty & Green, 2001/2002; Eyler & Whittle, 2002; Green, 2002; Savage, 2002).

#### **Polycystic Ovarian Syndrome (transmen & transgendered female-to-males)**

Most of the literature on polycystic ovarian syndrome (a particular type of female infertility) pertains to lesbians and bisexual women, but fails to identify the incidence of, or address the unique needs of, transmen and transgendered female-to-males (FTMs) who present with this disease (Ross, date n/a).

### Mental Health

#### **Access & Equity; Transpositive Care**

The research results of the Trans Health Project indicated there was a serious lack of *transpositive*, *trans-inclusive* and *trans-responsive* clinical services and supports available across the province. Indeed, while the literature does include clinical references around mental health and substance use issues authored by a number of knowledgeable clinicians, who also offer *transpositive* transgender care, the bulk of these are American (e.g., Anderson, 1997; Bockting, 1997; Bockting & Coleman, 1992; Brown & Rounsley, 1996; Cole & Meyer, III, 1998; Ettner, 1999; Israel & Tarver, II, 1997; Lev, 2003; Mallon, 1999; Miller, 1996; Pollack, 1997; Rachlin, 1997; Thomas & Cardona, 1997; Vitale, 1997; Zandvliet, 2000), with embarrassingly few in Canada (e.g., Barbara, Chaim, & Doctor, 2002; Raj, 2000a). Further, while there does exist a set of guidelines geared towards counseling queer clients/patients (American Psychological Association, 2000), and a combination of queer *and* trans people (GLMA, date n/a), similar “best practices” specifically targeting transpeople are remarkably scant (e.g., Children’s Aid Society of Toronto [Transsexual/Transgendered Advisory Committee], 2001 – present; Raj, 2002a; Sherbourne Health Centre [Trans, Two-Spirit and Intersex Primary Care Working Group], 2003).

#### **Gender Dysphoria/”Gender Identity Disorder” (sic) – see PHYSICAL HEALTH**

#### **Depression & Anxiety**

Depression and anxiety are prevalent mental health issues experienced by many transpeople, and the resultant need for appropriate clinical supports are critical. Trans-supportive services exist in the way of both online (FORGE, 2002) and local, in-person (Rainbow Services Depression Group Project - Appendix H: Resources) supports. Depression and anxiety were reported by a number of our research participants.

#### **Anger & Stress**

Anger, frustration and stress typically have enormous impact on one’s health and

sense of well-being. Anger and stress, and the need for effective coping strategies to manage both, were identified by a number of participants in our study. Although both anger and stress management workshops are available for non-trans men, women and youth, none are known to exist in this province that specifically address the unique needs of transpeople. Interestingly, there was an anger management program for FTMs in Vancouver which ran out of a mental health consumer/survivor service, but funding cuts have ended this program.

### **Substance Use & Eating Disorders**

Substance use and, to a lesser extent, eating disorders, are common problems for many in the trans community, and one research participant in our study paralleled the two processes of drug use and recovery to that of transsexualism/gender dysphoria (aka “Gender Identity Disorder”) and gender “gender euphoria” - finally obtained by means of hormonal and surgical gender reassignment. While there exist at least two excellent, trans-inclusive, clinical resources for transpeople who use or have used drugs and/or alcohol in Ontario (Barbara, Chaim, & Doctor, 2002; Rainbow Services – Appendix H: Resources), and a recent work from the USA (Finnegan & McNally, 2002), the demand continues to exceed the currently available resources. A particular barrier for transpeople experiencing chronic alcohol or drug usage is that detox centres only keep people for one or two days, therefore, the idea of a transpositive infirmary (a walk-in clinic that would support clients from one day up to two weeks) (to be offered at the Sherbourne Health Centre in Toronto within the next two years) was positively valued (Miles, 2003).

In addition, trans-sensitive resources are needed to support transpersons (many of whom are youth) whose eating disorders (i.e., anorexia nervosa, bulimia) a way to cope with a negatively-perceived body image – one that is opposed to a physical presentation that would reflect their preferred gender/sex.

### **Early Childhood Trauma & Adult Assault**

A few clinicians have written about the impacts of, and interventions for, lesbians and bisexual women with respect to social/cultural trauma, sexual assault and domestic violence (Balsam, 2003, Kaschak, 2002), and gay men who are victims of same-sex partner abuse (Island & Letellier, 1991). There exists a parallel for transpeople, in general (Goldberg, J; Lev, A; The Survivor Project) including elder abuse of trans seniors (Cook-Daniels, 2002). Given that physical and sexual abuse (as a child and/or as an adult) is highly prevalent within the trans community (as noted by the number of trans clients who present at the Sherbourne Health Centre with these issues – and adult abuse was also identified by participants in the Trans Health Project), there is a critical gap in service in the way of skilled, trans-sensitive therapists.

### **Self-Harm & Suicidality**

Both self-harm behaviours (i.e., cutting, head-banging, wall-punching) and suicidal thoughts and/or attempts are prevalent in the trans community, especially, youth. This is indicated by the number of trans clients/patients with these concerns who come to the Sherbourne Health Centre for counseling/medical support (per the

clinical experience of one of the investigators who provides therapy at the centre). Trans-specific and sensitive resources are clearly indicated.

### **Family & Relationship Issues**

Problems encountered by trans youth with their family members, and those experienced by transpeople in relationships, were brought forward in the Trans Health Project, and the attendant need for effective interventions (i.e., family therapy, couple counseling) by transpositive and culturally competent clinicians. This fact has also been noted as an increasing need by one of the investigators (Rupert Raj, a counselor with a Toronto-based LGBTT program). While the literature documents a few transpositive counseling resources around family-and-youth issues (Benestad/Pirelli, 2001; Lev, 2003), there are few comparable resources for transmen, transwomen and transgendered individuals with relationship problems (Transcend). A further requirement, which is not being met, is the need for (more) skilled therapists throughout Ontario.

## **Social Health**

### **Access & Equity re: Social Services**

Overall, a substantial sector of the trans community experiences the need for varied social supports, however, marginalization, exclusion and invisibility are often encountered (Namaste, 1995; Namaste, 2000), with the resultant need for trans-responsive resources (Gapka, 2002; Raj, 2002b).

### **Poverty/Low Income**

Many members of the trans community are poor or on a fixed or low income (some of whom rely upon social assistance or a disability pension) (Burnham, 1998; Goldberg, J. et al. 2003). Some of these individuals are also people of colour and/or Aboriginal Peoples, who are also subject to racism. These people collectively make up a vulnerable sector of the trans population, with the attendant need for the appropriate supports (Tayleur, 1995).

### **Homelessness/Underhoused/Shelters/Hostels**

A large number of trans youth and transwomen, and transmen, are street-active, homeless/underhoused and/or poor or on a low income. Some of these people also engage in sex work and/or might use street drugs. Some of the youth might be running away from an abusive home life. Together, these individuals within the trans population represent a high-risk group (for possible sexual abuse, physical assault, illness, police harassment/brutality, murder or health-related forms of death, etc.). Given these substantive risks, there is a crucial need for transpositive shelters and hostels (Cope & Darke, 1999; Gapka, 2002; Miles, 2003; Namaste, 1995; Raj, 2002b; Ross, 1995; Trans Access Project – Appendix H: Resources).

### **Discrimination (Transphobia) & Violence (Trans bashing)**

Discrimination - in the form of transphobia and/or homophobia - often including violence in the form of physical and/or sexual assault - is a common occurrence for many members of the trans community (Hill, 2001; Namaste, 1993) including,

street-active youth and transwomen who might not successfully pass as a woman, and sex workers. Several transwomen in our research study reported experiencing harassment and discrimination. One of the needed social supports to help prevent such occurrences of violence and/or to help support victims of transbashing, is that of transpositive shelters, hostels and transitional housing for transpeople (Cope & Darke, 1999; Gapka, 2002; Ross, 1995; Trans Access Project – Appendix H: Resources).

### **Isolation**

One of the issues which came out of our investigation was the intense sense of isolation experienced by a number of transpeople (especially, trans seniors aged 50 and over). Such isolation included one or all of the following: rejection by family members, ex-partners, children, grandchildren, former friends, one's religious and/or ethnic communities, employers, co-workers, the queer community, and society-at-large. Given that isolation/disconnection is seen as a determinant of emotional ill health (i.e., can exacerbate depression, anxiety, substance use, self-harm, suicidality, etc.), there is a need for transpeople to feel a sense of connectedness and to have a safe place to belong, along with a desire to make a contribution to the community. This need to decrease isolation indicates the further need for opportunities for both paid work and volunteer activities, including, as well, venues for social activism within the trans and/or other communities.

### **Unemployment/Underemployment**

Unemployment and underemployment are experienced by many members of the trans community, many of whom rely upon social assistance or a disability pension. Employment in a transpositive workplace is also a challenge for many transpeople able to work but unable to find employment. This was a recurring theme which emerged from our present research study.

## Sexual Health

### **Sexually-Transmitted Diseases (STDs) & HIV/AIDS, Hepatitis**

A high percentage of transsexual/transgendered individuals are living with one or more STDs and/or HIV/AIDS, Hepatitis A, B, C. Sex workers and injection-drug users are especially vulnerable. Research studies focusing on transpeople with STDs and other viruses have been documented in Canada (Namaste, 1995b; Namaste, 1999; Namaste, LaFramboise, & Brady, 1996; Scott & Lines, 1999) and the USA (Bockting, 1998; Bockting & Kirk, 2001; Clements-Nolle, Marx, Guzman, & Katz, 2001). Most sexual health programs fail to address the complexity of transpeople's bodies and therefore fail to meet the needs of these various communities. However, at least three peer-educational, community resources exist in Toronto (Maggie's: Prostitutes Safe Sex Project; Strang & Bourgeau, 2000; Trans Brazilian Project [in partnership with the AIDS Committee of Toronto] – Appendix H: Resources).

## Spiritual Health

### **Pastoral Counseling**

A number of transpersons are religious and/or spiritual and might experience religious discrimination around their trans identification and/or their decision to undergo SRS, making spiritual support and/or pastoral counseling an important need for both trans-identified individuals and their loved ones (Bockting & Cesaretti, The Rev. Charles, in press). A number of our research participants reported exclusion and/or stigmatization on the part of their church. These individuals also identified a strong desire for connections with their religious community. In Toronto, there is available some support for the queer community (Metropolitan Community Church of Toronto – Appendix H: Resources), however, this is not trans-specific.

## Specific Trans Populations

### **Transwomen**

Transwomen (especially those who are active on the street or engaged in sex work), sometimes encounter barriers unique to their gender and sex status, whether they are post-operative transsexuals or non-surgical, transgendered male-to-females (MTFs). In some cases, this might include the right to be included in women's spaces and services (Gapka, 2002), even in those instances where transwomen/MTFs share the same vulnerability and risk that born-female women do, such as, for example, physical and/or sexual abuse and the consequent need for safe shelters (Cope & Darke, 1999; Ross, 1995, Trans Access Project – Appendix H: Resources).

### **Transmen**

Transmen also, in some instances, face distinctive challenges related to their physical status and their life situation. Two examples of this are, firstly, the prohibitive cost of “bottom” (genital) surgery (i.e., phalloplasty or metadioplasty), which can range anywhere from \$13,000 to \$65,000 and up. The fact that OHIP delisted this surgical procedure from its schedule of fees in 1998, erects a huge barrier for transmen who desire this type of surgery, and is possibly an even greater challenge for those who identify as gay or bisexual transmen, given the emphasis on penile sex. A second very common situation for some transmen - who initially identified as lesbian [prior to the later identification as a female-to-male transsexual] and who are currently involved in a relationship with a lesbian partner - is to be able to somehow meet this challenge and “save” the relationship, in open discussion/negotiation with their partner, sometimes also requiring the aid of a knowledgeable counselor.

### **Trans Youth**

Youth (26 and under) typically represent a high-risk group within the trans population (Central Toronto Youth Services [Pride & Prejudice Program], 2002). Our study received input on a series of issues from 12 (19%) self-identified trans youth. Young transpeople have been widely documented in the research literature with regards to a variety of interventions, including individual counseling (Glenn, 1999; Lev, 2003; Mallon, 1999; Pazos, 1999), family therapy (Benestad/Pirelli,

2001; Cooper, 1999; Lev, 2003), group work with sex workers (Klein, 1999), endocrine intervention (Cohen-Kettenis & van Goozen, 1998; Gooren & Delamarre-van de Waal, 1996), and sex-reassignment surgery and post-surgical follow-up (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001).

In addition to the above, references focusing on trans children and adolescents have been made from both a psychiatric perspective (Di Ceglie, 2000; The Royal College of Psychiatrists, 1998; Zucker & Bradley, 1995), and a social work advocacy approach (Burgess, 1999; Mallon, 1999; Swann & Herbert, 1999). In the Toronto area, a number of trans-supportive clinical services (LGBT Youth Program [Children's Aid Society of Toronto]; Pride & Prejudice Program [Central Toronto Youth Services]; TransFormations [Sherbourne Health Centre] – Appendix H: Resources), and community resources (Supporting Our Youth [Mentoring & Housing Program, & Trans\_Fusion Crew]; Trans Youth Toronto [519 Community Centre] – Appendix H: Resources) are available, however, these continue to be exceeded by the increasing demand.

With respect to trans-identified youth who are wards of the state and live in residential group or foster homes, this vulnerable group requires specialized supports in the way of agency advocacy and “best practices.” A local example is the work currently being conducted by the Children's Aid Society of Toronto's Transsexual/Transgendered Advisory Committee, which is developing trans-specific guidelines based on its earlier guidelines for lesbian and gay youth-in-care (Children's Aid Society of Metropolitan Toronto, 1995).

### **Trans Seniors**

The issues of trans seniors (50 and up) has only recently started to get some attention, both in the USA (Cascio et al, 2003; Transgender Aging Network – Appendix H: Resources; Witten, Eyler, & Weigel, 2000), and in Canada (Moore, 2002), and serves to flag this emerging sector of the trans community as another potentially high-risk group in terms of health care and social service issues. The Trans Health Project included (20) (31.7%) self-identified trans seniors, who also reported many concerns similar to Moore's research, (in addition to others, which are cited later on in the section on “Data Analysis: Response Summary”). One of the particular concerns faced by some older trans adults is that of elder abuse and/or neglect (Cook-Daniels, 2002).

### **Trans Parents**

Few resources presently exist for trans-identified parents and grandparents (e.g., LGBT Parenting Network – Appendix H: Resources). Rupert Raj, a clinician in Toronto, sees a growing need for this specialized type of therapeutic support.

### **Trans Families**

As more youth are coming out as trans-identified, (many of whom are as young as 11 or 12), often this trans emergence impacts on the young person's family members, frequently resulting in a request for family therapy. (Toronto

psychotherapist Rupert Raj sees a growing need for this specialized type of counseling support). Also, the children of parents who transition require appropriate counseling services throughout the parent's transition process. The existing resources (both clinical and community-based), both American (e.g., Boenke, 1999; Kaeser, 1999; Lev, 2003; PFLAG-T Net; Rosenfeld & Emerson, 1995), and Canadian (e.g., Central Toronto Youth Services, Family Pride Network, Sherbourne Health Centre) are slowly expanding, a clear indication of the increasing demand.

### **Transpeople of Colour**

Transpeople of colour, immigrants and refugees commonly face especially-challenging barriers (e.g., transphobia, homophobia, racism), both within their own families and ethnic/religious communities, as well as within the straight, queer and trans communities. There is at least one online resource (e.g., Transgendered People of Color – Appendix H: Resources) and one Toronto-based community program (Project for Newcomers – Appendix H: Resources) for transpeople of colour.

### **Two-Spirit People**

Two-Spirit people are Aboriginal Peoples who identify as having two genders, but who might or might not also identify as transsexual/transgendered, given that the latter is a White cultural concept, which is distinct from Native cultures and histories. Two-Spirit people might also be attracted to both men and women, but they do not necessarily call themselves bisexual, a non-Native term. There exists at least one peer-based community resource for Two-Spirited in Toronto [who live with HIV/AIDS], which also welcomes trans-identified Native people (2 Spirit People of the 1<sup>st</sup> Nations - Appendix H: Resources). The Trans Health Project only had one Aboriginal participant who identified as Two-Spirit. Given the nature of Native culture (considered to be a distinct society), as well as the biases of homophobia and transphobia prevalent within some sectors of the Native community, it is no surprise that Two-Spirit and Aboriginal transpeople encounter overwhelming challenges and barriers (i.e., multiple levels of discrimination: racism, homophobia, transphobia; access to available gender- and culture-affirming health care and social services).

### **Trans Sex workers**

A number of transwomen, trans youth, and transmen engage in sex work (prostitution, stripping, pornography, etc.) to help save money to pay for the costs of sex-reassignment surgeries, hormone therapy, electrolysis treatments, wigs, clothing and related costs incurred throughout the pre-, post- and transition process. Sex trade work also helps pay for food and rent. Additionally, this work helps to provide personal affirmation for those who desire to be seen and accepted sexually as either women or men. (Unfortunately, only three self-identified sex workers participated in the Trans Health Project.) The need for transpositive shelters and hostels in Ontario has been repeatedly identified (Cope & Darke, 1999; Gapka, 2002; Miles, 2003; Namaste, 1995; Raj, 2002b; Ross, 1995). Safe-sex practices are crucial for this group, which is highly vulnerable to contracting such sexually-transmitted diseases as HIV/AIDS. There are few Ontario-based resources available to support this



specialized sector of the trans community (Maggie's: Toronto Prostitutes' Community Service Project - Appendix H: Resources; Strang, & Bourgeau, 2000).

### **Transpeople on Low Income**

A high percentage of transpeople in this province rely upon social assistance (Ontario Works) or a disability pension (Ontario Disability Support Program). Many of these individuals (both those with a disability and those without) do not have the competitive employability skills needed to obtain gainful employment. Some low-income members of the trans community volunteer; others do not or cannot due to disability. As a result, their need for connection and meaning are paramount, and many seek out the community connections they so vitally need for support. Many emergency health and social service agencies which provide food and shelter for low-income individuals are gender specific (male/female) and are not transfriendly (eg. Salvation Army). Fortunately, several peer-support groups and programs exist in Toronto for the benefit of transpeople (e.g., Xpressions, FTM Peer-Support Group, Meal Trans Programme, Trans Youth Toronto, Trans\_Fusion Crew, Transition Support – Appendix H: Resources). Our research project indicated that 44.4% of our respondents considered themselves to be living in poverty, and many experienced their financial hardship to seriously compromise their quality of life and sense of well-being.

### **Transpeople with Disabilities**

Transpeople with a disability greatly overlap with those on a fixed income (as cited above), with regards to un(der)employment, financial hardship, isolation, disconnection, the need to be a functioning person and a useful member of society. etc. Added to their pre-existent condition of gender dysphoria (transsexualism), one or more physical, mental and/or sexual health issues can cause layers of complexity and multiple medical and psychosocial barriers to overcome. In our study, 38.1% of the participants reported having one or more disabilities, and many of these found their disability to negatively impact on their physical and psychosocial health and overall life situation. Not surprisingly, 20.6% reported having one or more mental health issues, while 22.2% stated they had a physical condition(s), and 1.6% identified a sexual health issue. Disabilities increase a transperson's ability to access service due to lack of appropriate supports (eg. sign language for deaf people and printed documents and web-site access for visually impaired persons).

### **Transpeople in Prison**

Incarcerated transpeople typically face blatant discrimination, as well as overwhelming barriers when attempting to access medical and other services and supports (such as clinical counseling, transition services, legal counsel, etc.), including the prevalence of HIV/AIDS (Scott & Lines, 1999), as well as those related to transitioning/gender reassignment (e.g., access to hormone therapy and/or sex-reassignment surgery) (Johnson & Castle, 1997). While there exists at least one such resource in the USA (Transgender Prison Study - Appendix H: Resources), there does not seem to be much support available in Ontario (as emphatically reported by one of our research participants, who is quoted in the section on Data

Analysis), other than a non-trans-specific, community resource for prison inmates living with HIV/AIDS (Prisoners' HIV/AIDS Support Action Network [PASAN]). However, in one noted case, the Canadian Human Rights Tribunal ordered Correctional Services of Canada to provide access to sex reassignment surgery for transsexual inmates and to revise their policy to ensure that the placement needs (male/female prisons) of transsexual inmates are identified and accommodated (*Kavanagh vs. Attorney General*).

### **Genderqueers & Transgendered People**

For the most part, genderqueers (see Genderqueers – Appendix H: Resources) and transgendered persons (as opposed to transsexuals) employ a *non-binary* paradigm with respect to gender identity, sexual identity and sexual orientation, which is in direct opposition to the traditionally-held, societal view of *binary* norms (i.e., male versus female, masculine versus feminine, heterosexual versus homosexual, etc.). The latter is an either/or perspective which conceives in terms of absolutes instead of dynamic continuums (which approximates nature). Given this conflict of a (binary) societal, cultural, medical, psychological and therapeutic viewpoint, on the one hand, and another (non-binary) perspective, on the other, genderqueer and transgendered people - who have a more fluid self-concept in terms of their gender and sexuality – often encounter unique barriers in terms of accessing the special kind of medical and therapeutic supports they require to effect a good fit. Regrettably, only a few clinical providers have addressed this challenge in the literature (Hart, 1984; Raj, 2000a; Zandvliet, 2000).

### **Transqueers**

Transqueers identify as *both* trans and queer. These individuals also include lesbian/bi/pansexual/queer. The results of a recent research study in Ottawa (Pink Triangle Services, 2001) reflected the statistical significance of the differences of transpeople and gay/lesbian/bisexual people around the need for invisibility (the former), and for visibility (the latter). In our project, however, the results indicated that while some trans participants desired *not* to disclose their trans status (i.e., they wished to be “invisible”) to health care providers, others emphatically wished to disclose their trans identity (i.e., to be or become more “visible,” – even, in one case, recommending a trans-specific coding on hospital and health insurance cards). In the case of those who identify as transqueer, some individuals might wish to disclose their sexual orientation/identity as gay, lesbian, bisexual, polysexual or simply, “queer,” while not wishing to disclose their gender identity as transsexual or transgendered, which clearly presents complex challenges for some in terms of their lives, in general, and health care in particular.

### **Trans Francophones (Ontario-based)**

The Ottawa study indicated significantly different needs of Francophone and Anglophone transpeople in terms of health care access and equity (Pink Triangle Services, 2001). A similar finding was not identified in The Trans Health Project, which included only 3 bilingual (French and English-language) participants.

## Methodology

### Theoretical Framework

Two theoretical frameworks were employed in this study: **Community Based Participatory Action Research (CBPAR)** and **reflexivity**. Emerging from the workgroup's lesbian and gay research paper, a resolution on Ethical Research and Evidence-Based Practice indicated a need for community-based participatory research (CBPAR) as evidence for practice and this informed the decision to use this approach to understand issues of access for trans communities. **CBPAR** is used to first conceptualize and then to operationalize the Trans Health Project, and was implemented as a directive from OPHA and its funding sources for the project. **Reflexivity** is an effective tool for understanding the lives of transpeople as they access, or are denied, health care in Ontario. Reflexivity further informs us as to how transsexual/transgendered people see themselves as they seek appropriate health care.

Paulo Freire, born in Brazil in 1921, first published an articulation of his methodology in 1970 (Freire, 1999, p. 12). Freire's theory and methodology underpins the participatory action research process. The goal of participatory action research is to produce results that empower the community being investigated. This method has emerged as a critique of classical social science research, which de-humanizes its research subjects and treats them as objects for study (Babbie & Benaquisto, 2002, p. 318-319). CBPAR, a modified version of Freire's method, will be implemented throughout this Project in response to the historical process of a clinical research model, which provides medical records and a justification for transsexual/transgendered people's subordination to the medical community. Consequently, CBPAR will be the mechanism for systemic change in accessing the health care which transpeople depend on.

According to George Soros, reflexivity is a process of inquiry occurring in the social science field during the observation of human research subjects and is "the relationship between thinking and reality." (Soros, 2000, p. xxii-xxiii, 41). "To a large extent, people's identity and character are built in a reflexive fashion." (Ibid, p. 12).

Transpeople's identities are a reflection of the interactions they encounter in their *everyday* lives, and thus, require health care services which treats them in a respectful, sensitive and caring manner. Namaste claims, however, that "transsexuals are *erased* in the everyday world, the concept of erasure here designates the exclusion of TS/TG people from the institutional site of health care." (Namaste, 2000, p.159). Namaste describes her own research into the experiences of transgendered and transsexual persons accessing health and social services in Ontario, "This is a reflexive approach to sociology, wherein the experiences, perceptions, and needs of the community under investigation occupy a central component of the research." (Namaste, 2000, p. 48). Consequently, reflexivity and CBPAR create a firm partnership in research methodology concerning the trans community.

CBPAR was implemented by inviting transsexual/transgendered individuals from across the province to apply as **Regional Networkers**. Six people applied from six cities across Southern Ontario and all applicants were accepted. The function of Regional Networkers

was to act as **key informants** within specific geographically-located trans communities throughout Ontario, with a specific focus on the needs of that particular community. Also, three **Research Advisors** were recruited to provide expertise on constructing the self-administered questionnaire. As well, three volunteers contributed to the Project by assisting in facilitation, the recruiting of focus group participants and the organizing of a focus group. Finally, Volunteers, Regional Networkers and Research Advisors were invited to review the Draft Report, and along with focus group and questionnaire respondents, were further invited to actively participate in a community forum to review the Final Report.

The Volunteers, Regional Networkers and Research Advisors were primarily trans-identified (i.e., self-identified as transsexual, transgendered or Two-Spirited). Two non-trans Research Advisors supported the Project by providing their expertise on the construction of the questionnaire. Additionally, one volunteer, who identified as a non-trans-identified lesbian, was inspired by a motivation to more effectively support trans clients. Through CBPAR these individuals have become engaged in a process of effecting positive change, and consequently, have the capacity to develop into leaders on future research and community projects.

### **Data Collection**

The recruitment of participants for the research study was initiated by word of mouth, e-mail lists and flyers, together with the assistance of Regional Networkers in local communities across Southern Ontario. This method of soliciting participation from a community is called “**snowball sampling**,” and relies upon community members inviting others they know into the process. Snowball sampling is an example of non-probability sampling, and therefore, is not representative of the whole population (Babbie, 2002, p. 166). It is used, rather, to investigate hard-to-reach populations for exploratory purposes, and consequently, is an ideal sampling strategy for the trans population across Ontario.

The research data was collected by two means: **focus groups** and **self-administered questionnaires**. During April through June 2003, **eight focus groups** were conducted in Ontario: in **Toronto** (6 groups of 42 participants), **Ottawa** (1 group of 15 participants) and **Guelph** (one group of 5 participants). One focus group specifically targeted trans **youth** (aged 26 and under); another focused on trans **seniors** (aged 50 and up); still another focus group was conducted at the Meal Trans Programme (a drop-in for **low-income and street-active** transpeople based at the 519 Community Centre), which 16 persons attended. (All focus groups took place in Toronto). One focus group which targeted low-income, street-involved transpeople in the west end of Toronto failed because no participants showed up for this group.

An (oral) **semi-structured interview for focus group participants** was utilized. In addition, a (written) **self-administered questionnaire** was disseminated by e-mail, regular mail and through Regional Networkers to interested individuals who were unable to attend a focus group. **Eleven** completed self-administered questionnaires were returned, **62** people participated in focus groups, and the combined number of focus group participants and individual respondents was **73**.

## Data Analysis

A (written) **demographic questionnaire** was distributed to all participants/respondents to complete and return. The total number of completed questionnaires returned was 63 out of 73 (**85.1%**). (For demographic information on these 63 participants, see Appendix C).

In terms of the overall **response summary**, several **over-arching themes** (needs and recommendations) emerged from the responses of research participants, as set out in the following three perspectives:

### Health Care Consumers (transpeople) need to be/have:

- Trans-empowering/self-empowering** (“Transpeople need to have input into health care so we can control our own destinies.”)
- Meaningful input** into health care
- Patient/client choice**
- Part of a **participatory process**

### Health Care Providers need to be/become:

- Transpositive**
- Properly educated** (basic core knowledge and ongoing training)
- Culturally competent** around and **clinically sensitive** to the diversity and complexity of the broader trans community (e.g., youth, seniors, parents, people of colour, sex trade workers, people with a disability, people living with HIV+, drug users, intersexed, ‘Two-Spirit’ people, etc.)

### Health Care Services need to be/become:

- Trans-inclusive**
- Comprehensive**
- Holistic** (“Treat the whole human being.”)
- Community health model**

A summary of the participant responses, highlighting some common threads, is presented below:

#### *General*

- Comprehensive facility based in Toronto with satellites across Ontario – role model in Toronto & educate around province
- Trans health clinic OR community centre for transpeople, providing relevant resources
- Client-driven (place where TSs can choose own program)
- Harm reduction model
- Anti-forensic environment (no pedophiles)
- Alternative resources to gender identity programs
- Open to all people regardless of class
- Open to trans allies & supporters
- Invite transpositive physicians
- Place where transpeople not afraid how they look – not rigid expectations around presentation (e.g., body image, dress, etc.)

### *Information*

- Accessible information (widely disseminated) for doctors, employers, families, the public, etc. (print & electronic resources)
- Central medical information source (including locations where SRS is available)
- Website with research on all aspects of transitioning & access to local retail facilities (e.g., electrolysis, clothing, wigs, etc.)
- Product information on puberty suppressants & sex hormones
- Information on sexual performance & orgasmic ability for post-operative transsexuals

### *Education*

- Accessible education (widely disseminated) for the public, doctors, employers, families & in public schools (print/electronic resources)
- Education & sensitivity awareness for all professionals who work with transpeople
- Transpositive training for medical students
- Cultural competency re: aboriginal transpeople, trans sex workers, etc.

### *Medical & Clinical Supports*

- Validation - not pathologizing - by medical community
- Comprehensive medical supports
- Educated & informed health care professionals
- Access to sex-reassignment surgery in Canada
- Health care re: HIV+ & STD
- Optional clinical services (e.g., drug treatment)
- Advocacy re: trans-inclusivity of hormone product information & regular updating re: medical standards (incl. potential risks)

### *Community Supports*

- Mentoring programs for transpeople (adults & youths)
- Counselling internet café with free internet services

### *Funding*

- Sex-reassignment surgery (OHIP coverage)
- Electrolysis treatments (OHIP coverage)
- Alternative medicine (OHIP coverage)
- Shelter & food for economically-challenged transpeople
- Trans Health Project under-funded - should be funded by Ontario Ministry of Health
- Research participants should be remunerated for their input by means of honoraria

### *Research & Development*

- Research to refine “bottom” surgery (phalloplastic procedures) for Transmen (FTM, TS)

### *Community Development*

- Transpeople to develop our own community programs & projects

### *Housing*

- Assisted housing for people in transition, sex workers & drug users
- Shelters & transitional housing for transpeople at risk (e.g., abuse survivors) - possibly in partnership with rape crisis centre

### *Employment*

- Skills training & employment centre for transpeople
- Jobs & employment resources (incl. information on how to transfer education, training, transcripts & degrees to new name)

### *Advocacy*

- Social political activism

In terms of the research data, we received input from **four** specific subpopulations within the overall trans community: low-income transpeople (many of whom are on a disability pension/social assistance), **trans youth** (aged 26 and under), **trans seniors** (aged 50 and over), and **incarcerated transpeople** (in a forensic institution) (see Appendix D).

## **Limitations**

The limitations of the present study involved challenges around obtaining a representative sample of the very broad and diverse trans community across Ontario (see Appendix E). These challenges were largely due to resource limitations (i.e., money, time and human resources), in particular, a lack of funds to travel to northern Ontario and to rural areas across the province. The project provided a toll-free number for participants to utilize, however this resources was used by only one participant. Additionally, communication among the Investigators, Regional Networkers, Research Advisors and participants consisted primary of e-mail communication, which seriously limited effective communication. Further, e-mail communication limited access to the very broad diversity of the trans population in Ontario, in particular, individuals on a low/fixed income, those involved in sex work and/or homeless/underhoused persons. These challenges around the limitations of the study will be addressed in the “Recommendations” section below.

## **Conclusion**

It is evident that issues of diversely situated transpeople and their communities are complex. Despite the increasing visibility of transpeople and their health concerns in research literature, there is a gap in transpositive care for transpeople. This paper is a call for action for the Ontario Public Health Association to disseminate this paper and advocate on behalf of trans communities for the education of health providers and communities, more inviting services and multi-level action across sectors which will support the health and well-being of transpeople.

## Recommendations

A series of recommendations have emerged from the data, and are proposed for follow-up using a CBPAR approach:

### 1. Research:

- a) Funding of further research (building on the results of this exploratory study) to survey the health care needs of transpeople residing in:
  - Northern Ontario
  - Rural areas across the province, as well as
  - Additional focus groups/survey questionnaires specifically targeting:
    - Transpeople of colour, immigrants and refugees
    - “Two-Spirited” people and transpeople
    - Transpersons with disabilities
    - Transpeople living with HIV+ or other sexually-transmitted diseases
    - Trans-identified survivors of sexual and/or physical abuse
    - Transpeople who are homeless/underhoused
    - Transpersons living in poverty/near-poverty
    - Trans-identified sex trade workers
    - Trans-identified alcohol/drug users
    - Transpeople who are hospitalized in a psychiatric facility
    - Transpersons who are/have been incarcerated in a penal institution
- b) Regional Networkers to be issued honoraria for their contribution to the project
- c) Increase effectiveness of communication among Investigators, Regional Networkers and research participants by utilizing phone and in-person contacts
- d) Research participants to be issued honoraria for their contribution (i.e., rich input: personal experiences, perspectives, knowledge, resources, recommendations)

### 2. Advocacy & Alliance:

- a) Overall advocacy for, and ongoing alliance-building with, the trans community (ies) throughout the province
- b) Advocacy of the Ontario Health Insurance Plan (OHIP) to re-list sex-reassignment surgery (SRS) and electrolysis treatments for transpeople in Ontario
- c) Advocacy of the Ontario Ministry of Health and Health Canada to ensure the availability of SRS surgeons/services in Ontario and other parts of Canada
- d) Advocacy of Municipalities to provide funding for transpositive shelters/hostels and longer-term transitional housing for transpeople at risk (e.g., street youth, abuse survivors, sex trade workers, drug users, HIV+ transpeople) and/or those in financial need (e.g., unemployed/ underemployed and low-income earners, welfare recipients, disability pensioners, seniors/retired pensioners, immigrants/refugees)



- e) Advocacy of research-funding agencies to fund ongoing research to refine the procedures for genital reconstructive surgery for transwomen (i.e., vaginoplasty) and transmen (i.e., phalloplasty, metadioioplasty)
- f) Advocacy of research-funding agencies to fund SRS surgeons to conduct ongoing research, and to provide accessible reports on the sexual performance (including orgasmic functioning) of post-operative transsexuals
- g) Advocacy by the Ontario Public Health Association to direct the pharmaceutical companies within the province to expand their sex-hormone product information to be trans-inclusive/responsive, and also, to regularly update such product information with regards to benefits as well as potential risks

### **3. Information:**

- a) Widely-accessible information for transpeople, family members, partners, health care and social service providers, teachers, employers, and the public
- b) Central medical information source (including various geographic locations in Canada and abroad where SRS is available)
- c) Website with research on all aspects of transitioning and access to local retail facilities (e.g., electrolysis, clothing, wigs, etc.)

### **4. Education:**

- a) Transpositive training across Ontario for all medical/health providers employed by Ontario Public Health Units (including basic core knowledge and ongoing professional development)
- b) Clinical sensitivity and responsivity towards all members of the broad/diverse trans community(ies) across the province (e.g., youth, seniors, parents, people of colour, persons with a disability, people living with HIV+, sexual/physical abuse survivors)
- c) Cultural competency, in particular, with regards to “Two-Spirited” and transpeople, trans-identified street youth, sex workers, drug users, psychiatric survivors, incarcerated/ex-convicts, etc.

### **5. Medical/Health & Clinical Supports:**

- a) Comprehensive facility (combined community health centre and community centre) for transpeople, based in an urban setting, with satellite locations across Ontario

This proposed facility to be:

- Open to all transpeople, significant others, allies and supporters
- Staffed by transpositive physicians, other primary, mental and sexual health care providers and social service providers (with a view to hiring as many trans-identified professionals and peer-providers as possible)

- Client-driven (an empowering place where transpeople can design/deliver, in collaboration with other stakeholders, their own programs/services/supports)
  - An effective example of a community health model, incorporating an anti-oppression framework and a harm-reduction approach in a non-forensic environment
  - A repository of a diverse range of relevant resources and supports
- b) Provision of transpositive, trans-inclusive and trans-responsive medical/health care professionals, who are knowledgeable in all aspects of transsexual/transgendered health care needs
  - c) Provision of transpositive, comprehensive medical/health and clinical services and supports (including primary health, mental health and addictions, and sexual health), for transpeople throughout Ontario
  - d) Where direct provision is not possible, initiation of partnerships with a variety of medical, health and clinical programs/services (as cited above) across the province

#### **6. Community Partnerships:**

- a) Combined community centre and community health centre for transpeople (see #5)
- b) Partnering with various community organizations (including those which serve or support transpeople) and trans peer-support groups throughout Ontario
- c) Creation of opportunities within Ontario public health units for volunteer involvement of members of the trans community(ies) across the province

#### **7. Human Resources:**

- a) Targeted hiring practices within Ontario public health units with a view towards actively recruiting trans-identified candidates for paid positions

## Appendix A - Definitions

**Gender Dysphoria Syndrome:** Psychological and medical condition characterized by a persisting sense of acute discomfort with one's assigned physical gender as typically experienced by transsexuals. Recently, the diagnostic classification has been replaced by "Gender Identity Disorder," as listed in the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" (4<sup>th</sup> Edition, Text-Revised) (DSM-IV-TR).

**Gender Identity Disorder:** The psychiatric classification which replaced "Gender Dysphoria" and is currently listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000).

**GenderQueer:** Slightly different from "queer," this very recent term was coined by young people who experience a very fluid sense of both their gender identity and their sexual identity/ orientation, and who do not want to be constrained by absolute (static) conceptualizations. Instead, they much prefer to be open to relocate themselves on the gender and sexual continuums. Genderqueers could potentially include anyone who identifies as other than heterosexual, and of course, includes many transpeople, especially trans youth.

**Health:** The health and wellness of Lesbian, Gay, Bisexual, Transsexual and Transgendered people holistically encompasses psychological, mental, emotional, social, spiritual, physical, environmental, economic, political and cultural states. (Saskatoon Declaration of LGBT Health and Wellness, 2001: United Nations Platform for Action, Beijing, 1995).

The achievement of health and wellness for LGBT people requires freedom from oppression and discrimination. Accessible, sensitive and equitable health and social service resources, both mainstream and specialized, are necessary for our communities to achieve health and well-being (Rainbow Health Network, 2002).

**Intersex:** Now the more common term for "hermaphrodite" (and generally preferred by intersex people). A man or woman who has a mixture of male and female gonads and/ or genitals. Listed in the DSM-IV-TR and the ICD-10 under "Other Gender Identity Disorders" or "Gender Identity Disorder, Unspecified."

**LGBTTTIQQ:** A common acronym for lesbian, gay, bisexual, transsexual, transgendered, Two-Spirit, intersex, queer and questioning individuals/population/community.

**Polysexual/Polyamorous:** In the past, known as "pansexual." An orientation that does not limit affection, romance or sexual attraction to any one gender or sex, and which further recognizes there are more than just two sexes (i.e., male, female, intersexed, transsexed) on a continuum of physical sex. Polysexuals are characteristically also polygamous (sexually involved with more than one person at a time).

**Queer:** Previously, a homophobic term of hatred used by bigots, this word has been redefined by the queer community as a celebratory word. Now used as an umbrella term to denote any sexual orientation other than heterosexual and a community comprised of non-straight: lesbians, gays, bisexuals, polysexuals, transsexuals, transgendered, “Two-Spirited” and intersexed people.

**Questioning:** Those individuals who are questioning their gender identity or sexual orientation/sexual identity and who often choose to explore other options in terms of gender and sexual identification and presentation. In some cases, confusion and/or conflict might also exist.

**Sex Reassignment Surgery:** Also known as “gender reassignment surgery.” Reconstructive genitourinary and plastic surgery performed on transsexual men and women to make the body (sex) congruent with the psyche (gender identity). For female-to-male transsexuals, SRS involves a bilateral mastectomy (chest reconstruction), pan-hysterectomy, vaginectomy (sometimes) and phalloplasty or metadoioplasty, including the scrotoplasty. For male-to-female transsexuals, SRS consists of surgical breast implants (optional) and vaginoplasty, including orchidectomy (testicular castration). Auxiliary surgery might include, shaving the vocal cords, feminizing the facial features and hair transplants.

**Transgendered:** Mostly applies to masculine dykes, but can also describe effeminate/feminine men who are androgynous psychologically and/or physically. Distinct from “transsexual” insofar as the latter desperately seek, and often obtain, a physical/sexual transformation, through medical and surgical intervention, to attain their desired level of comfort in expressing both their gender identity as men or women, as well as their sexual identity as males or females. In contrast, transgendered people, as a rule, do not desire to alter their bodies by means of hormones and/or surgery, focusing instead on expanding their gender identity mentally and expressing their gender role through non-binary (“third gender/third sex”) behaviour. In some cases, however, a transgendered person might move through the sexual-gender spectrum to subsequently identify as transsexual. And, to confuse the issue, some transsexual people also identify as transgendered.

**Transmen:** (Also known as female-to-males). Individuals who were born female but who identify as men/males/masculine. Some, but not all choose to masculinize their bodies and appearance by means of medical intervention in the form of hormone-replacement therapy (HRT) and sex-reassignment surgery (SRS).

**Transpeople:** An umbrella term which includes those persons who identify as transsexual, transgendered, Two-Spirited, intersexed, genderqueer, gender-diverse, queer and/or questioning. Also synonymous with “**trans community**” or “**trans population.**”

**Transphobia:** Similar to biphobia and homophobia, transphobia is a form of discrimination, based on fear, ignorance and hatred, directed against transsexual,

transgendered and Two-Spirit people. An extreme example of this is known as “**transbashing**” (similar to gay bashing, it involves physical and/or sexual violence directed against transpeople). Perpetrators of this form of prejudice can be straight, gay, lesbian, bisexual or polysexual. Internalized transphobia can occur when individual transpersons internalize society’s stigmatization as guilt, shame, poor self-esteem or a negative body image. The opposite of transpositive/transpositivity.

**Transpositive/Transpositivity:** Sometimes used interchangeably with “**transfriendly**,” “**trans-inclusive**,” “**trans-responsive**” or “**trans-sensitive**.” Attitudes and behaviour that are respectful of, sensitive to and supportive of transpeople, incorporating acceptance, empathy and *sometimes even understanding*, with a desire to celebrate the uniqueness of transpeople. Transpositive people are often allies of and advocates for transpeople. The opposite of transphobia.

**Transqueer:** A transsexual man or woman, or transgendered person who identifies as gay, lesbian, bisexual, transsexual, polysexual, genderqueer or queer. Sometimes used interchangeably with “genderqueer,” “transhomosexual,” “trannyfag,” and “transdyke.”

**Transsexual:** A psychiatric diagnosis listed in the DSM-IV-TR and the ICD-10 under “Gender Identity Disorder.” A transsexual man or woman has an intuitive, life-long conviction that he or she is really of the opposite gender to that assigned at birth, experiences acute gender discomfort (“gender dysphoria”) and is, thereby, driven to modify his or her body by means of “corrective” medical intervention (hormonal treatment and sex-reassignment surgery) so that the body (sex) can be in sync with the “mind” (gender). In the past - and even still now, some – transsexuals prefer not to “come out,” but instead, to blend in as “regular” men or women, as the case may be. Transsexuals can be any sexual orientation (including asexual, bisexual, polysexual or attracted to other transsexuals) and in fact, many more are now “coming out” as transqueers (gay transmen and lesbian transwomen). Distinct from “transgendered” (and much rarer), however, some transsexuals also adopt this umbrella term to describe themselves.

**Transwomen:** (Also known as male-to-female transsexuals). Persons who were born male but who identify as women/females, and who often opt to feminize their bodies by means of female hormone treatment and surgical therapy.

**Two-Spirit(ed):** Historically known as “berdache” (mostly referring to androgynous born-males but also to females) or “Amazons” (exclusively referring to androgynous born-females) by European colonists, but the term “berdache” is not embraced by the very people it purports to describe. Often these people were shamans (spiritual healers) in their communities. Many modern-day transsexual and transgendered people of African or Aboriginal origin prefer the descriptor, “Two-Spirit(ed),” to capture their true personae as two genders and two sexes, instead of the Western world’s more limiting binary perspective largely experienced by transsexuals.

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## Appendix C – Data Analysis: Demographic Summary

Of the 63 research participants, the **age** ranged from 13 through 67. The total **youths** (aged 26 and under) numbered 12 (19%); the total **seniors** (aged 50 and over) were (20) (31.7%). [Note: N/A means the question was not answered/left blank].

With regards to **birth-assigned sex**, 40 were born **males** (63.5%), 19 born **females** (19) (30.2%), 3 born **intersexed** (3) (4.8%), 1 N/A (1.6%).

Canada was the most cited **birthplace** (47/63) (74.6%). Toronto was the **residence** of most (36) (57.1%), followed by Ottawa (12) (19.0%), Guelph (5) (7.9%), Hamilton (2) (3.2%), London Area (2) (3.2%), Oshawa (2) (3.2%), Ajax (1) (1.6%), Penetang (1) (1.6%), N/A (2) (3.2%).

**Gender identity** included a whole range of mutually inclusive identities (including: Androgynous, Bigendered, Boy, Crossdresser, Drag King, Drag Queen, FTM, Gay Male, Genderqueer, Intersexed, Lesbian, Man, Pan-gendered, Questioning, She-Male, Transgendered, Transguy, Transsexual, Two-Spirited, Woman).

**Sexual orientation** included a diverse range of mutually inclusive identifications (including Asexual, Bisexual, Fag, Gay, Heterosexual, Homosexual, Lesbian, Pansexual, Polyamorous, Polysexual, Queer, Questioning, Unknown).

In terms of **race**, the majority were White (54) (85.7%), then White/Aboriginal (3) (4.8%), Latin American (2) (3.2%), Aboriginal (1) (1.6%), South Asian (1) (1.6%), White/Arabic (1) (1.6%), White/Arabic/Latin American (1) (1.6%), White/South Asian (1) (1.6%). **Ethnicity** included a very broad range, with most identifying as Canadian (25) (39.7%).

For most, the **first language learned** was English (50) (79.4%).

**Education** ranged from some Grade School to a University Graduate Degree. Only 10 (15.9%) reported they were currently **students**.

**Employment status** included: Employed Full-Time (25) (39.7%), Employed Part-Time (10) (15.9%), Unemployed (7) (11.1%), Unemployed/ODSP (Ontario Disability Support Program) (11) (17.5%), Unemployed/OW (Ontario Works) (5) (7.9%), Unemployed/ODSP & CPP (Canada Pension Plan Disability) (1) (1.6%), Unemployed/Incarcerated/Applied for Social Assistance (1) (1.6%), Unemployed/OSAP (Ontario Student Assistance Program) (1) (1.6%), Retired/Old Age Pension (2) (3.2%). **Occupation** included a highly diverse range of unskilled, semi-skilled and highly skilled forms of employment.

None identified as **homeless/underhoused**, but 28 (44.4%) stated they were living in **poverty**. Twenty-four (38.1%) stated they had a **disability**: 14 (22.2%) had **physical** health issues, 13 (20.6%) had **mental** health issues, one (1.6%) had a **sexual** health issue. Only 2 (3.2%) people considered their Gender Dysphoria to be a disability.

## Appendix D – Data Analysis: Response Summary

In terms of **LOW-INCOME** participants (who numbered approximately half of the total research participants), the following input is noteworthy:

Specific and/or especially-emphasized needs:

- Ontario Health Insurance Program coverage and/or bursaries for sex-reassignment surgery and other transition-related services (e.g., electrolysis, wigs, prostheses, etc.)
- Comprehensive, trans-specific, community health centre or combined trans-specific community health centre and community centre
- Access to transpositive shelters, hostels and transitional housing for transpeople who are homeless/underhoused, street-active and /or who have been sexually or physically-abused
- Transitional housing specifically for transpeople at risk and/or living on the street (e.g., homeless/underhoused, substance users, sex workers, youth, seniors, immigrants/ refugees, people with a disability [e.g., HIV/AIDS, emotional illness])
- Trans-friendly environment and service delivery in community health centres/public health units across the province
- Increased opportunities for community development projects for members of the trans community (including partnerships with community agencies and health organizations)
- Greater emphasis on meaningful community consultations, in addition to remuneration (i.e., honoraria), with regards to trans-specific research studies
- Job placement, career counseling and employment resources for un(der)employed transpeople in Ontario

In addition to those concerns common to the other age-group participants, the two specifically-focused homogenous groups (trans youth and trans seniors, respectively) reported particular experiences, issues, barriers, concerns and challenges unique to their respective age peers.

Trans **youth** (aged 13-26) identified the following specific experiences, issues and barriers:

- Greater incidence of trans-identified youth (including teenagers), some of whom wish to transition at an earlier age than transpeople historically have been able to do previously
- Young transpeople often discriminated by potential employers and others due to perceived or actual age
- “Genderqueer” identity not respected as valid by some psychiatrists, physicians, and parents, teachers, and society, in general
- Monetary need to access sex-reassignment surgery
- Service gaps exist for trans-identified youth, many of whom are street-active and/or homeless/underhoused



- Some trans youth experienced a lack of family support

...and made certain **recommendations** to overcome these:

- Overall focus on specific needs of trans youth
- Bursaries for sex-reassignment surgery/electrolysis for students and unemployed youth
- Inclusion of trans issues (with a particular focus on youth) in medical school curriculums
- Gender identity education in public schools to raise awareness around gender variations and options (e.g., transsexual versus transgendered, genderqueer, intersexed, Two-Spirited, etc.), and also to help prevent transphobia/transbashing
- Transitional housing for transpeople (including youth, runaways, street kids, sex workers, abuse survivors, immigrants, etc.)
- Jobs and employment resources (including information on how to transfer skills, training, transcripts and degrees/diplomas to new name)

Trans **seniors** (aged 50-67) highlighted the following experiences, concerns and challenges:

- Increasing emergence of transpeople over 50, so specific information needed for health care providers to help them meet their special needs
- Many older individuals will not disclose their trans status, thereby, making them “invisible” and more susceptible to “falling through the cracks”
- Especial vulnerability as trans seniors, particularly in terms of health care
- Higher risk for contracting osteoporosis and breast/cervical/vaginal/prostate cancer
- Concern around palliative care facilities and seniors’ homes, as outlined below:
  - Anxiety of possibly being put in “wrongly-gendered” section (Note: this concern also applies to hospital wards and non-ambulatory clinics)
  - Fear of transphobic reactions by (male) staff and/or other residents
  - Concern about privacy and dignity in terms of presentation (e.g., pre-op transwomen potentially perceived as a “bearded lady with a penis”) and personal hygiene (transwomen who have to wear a wig due to hair loss)
  - Transman with a disability (Multiple Sclerosis) prefers home care to being institutionalized to maintain his independence
- In some cases, rejection by ex-partners, children and/or other family members
- Trans-identified grandparents sometimes not permitted by their children to either see their grandchildren, or to present to same in their preferred gender (e.g., a male-born grandparent who has transitioned from male to female is not acknowledged by her child(ren) and/or grandchild(ren) as being a grandmother)
- Coming out at work aged 50+ causes apprehension over prospective employer’s potentially discriminatory attitude

...and suggested some **solutions** accordingly:

- Trans senior inclusion in health care, social services, and overall
- Education of OPHA and medical practitioners re: geriatric care for trans seniors

- Transfriendly housing and geared-to-income residential facilities for trans seniors as well as supports for assisted living (both independent and government-funded)
- Transpeople aged 50-65 need medical insurance coverage because they are especially vulnerable to unemployment and health risks
- Coverage of hormone-replacement therapy for trans seniors not on a health insurance plan as well as OHIP coverage of sex-reassignment surgery and electrolysis treatments
- Trans-specific codification of health insurance and hospital cards to identity pre-operative or post-operative status to enhance immediate medical access and facilitate “gender-appropriate” care (Note: some participants had mixed feelings around this)
- Make available transpositive sensitivity awareness training for employers and staff
- Supportive counseling for family members of transpeople

Another specialized sector of the trans community, which face exceptional barriers are those transpeople incarcerated in penal or forensic (legal and mental health-interrelated) institutions. Some of the specific barriers confronting trans **inmates** are identified (by one of our research study respondents) below.

Shauna, a 47-year-old, transwoman incarcerated in a forensic institution in Penetang, has several lawsuits pending and is currently taking legal action to obtain hormone-replacement therapy (i.e., estrogen). Shauna completed and returned a written questionnaire, in which she strongly summed up her situation in the following quote [cited here by express permission]:

“I have been incarcerated in the mental health system... [F]or a system that professes to help, I have seen great insensitivity for the Gender Identity Disordered (males who want to be females, and in one case, a female who wanted to be a man). I have personally experienced a great life setback because I did not get the help I needed for my transsexualism. I have the documentation to prove this. The mental health system needs a wake-up call in this regard. Abuses continue to occur. The matter has to be made public.”

Finally, there appears to be a number of gaps in service for many members of the trans community in terms of accessing and/or receiving effective, sensitive, supportive services from **gender identity programs**. Some of these include the following:

- Avoided GIC due to bad “rap” in trans community; GIC survivor heard “horror” stories
- “Real Life Test” (per Harry Benjamin “Standards of Care”) problematic – and GIC adheres to most conservative interpretation (i.e., two years instead of one required for approval for sex-reassignment surgery); too rigid re: idea of woman’s/female identity; inconsistency with medical standards
- Phallometric/penometer test at GIC traumatic (especially because of early sexual trauma);

- “weird” – transwoman had to lie about her sexual attraction to women
- Confusion around expectations of GIC
- Impossible standards; “I was not to their standards and had to watch what I said.”
- Lack of services and supports; not always informed of other services available at GIC (e.g., therapy group)
- Environment of GIC therapy group changed (i.e., less effective) over past few years
- Waiting list; not as much service/support during summer months
- Fear of association with “psychiatric” part of GIC
- Destructive – shame-based environment; GIC tries to discourage transpeople
- Class issues; not equipped to support sex workers and homeless people
- Need to support diversity re: trans community
- Transpeople need opportunity to explore a variety of gender identities/presentations
- Need to address multiple issues (e.g., poverty, sexual abuse, family issues)
- Transperson put on hold by GIC (“due to clinic’s negativity”) from 1992–2003, and did not get help, so taken this long to start transition; said “no” to F-M (“bottom”) surgery
- Want a transpositive health clinic in Toronto
- Not enough support; supportive only if person is emotionally grounded
- Repeated negative feedback regarding endocrinologist referred by GIC

The following two quotes reflect some of the range of responses:

“I love the Clarke [Gender Identity Clinic] because I don’t go there for hormones. I only go there for counseling. I get my hormones elsewhere.”

“They [the GIC] are a research lab... TSs [transsexuals] are ‘guinea pigs’ and we get no help with our problems.”

## Appendix E – Data Analysis: Self-Administered Survey Summary

The self-administered questionnaire was implemented to supplement the focus group data by reaching community participants who did not have the opportunity to attend a focus group. A total of 11 completed questionnaires were received from Ottawa (2), Hamilton (2), Penetang (1) and Toronto (6). The first series of questions concerned health care services.

Respondents reported being knowledgeable about regular health care services such as doctors, walk-in clinics, physical check-up, etc. 5 participants selected knowing ‘a lot’ and 3 reported knowing ‘almost everything’ about regular health care services. 8 of the 11 participants answered this question very positively. Next, knowledge about specialized health services for transpeople undergoing a gender transition (hormone therapy, electrolysis, genital surgery, chest surgery, etc.) was rated. 7 respondents selected knowing ‘a lot’ and 1 chose ‘almost everything’ for another very positive series of responses. Then, participant’s ability to get personal health care services was rated with ‘good’ = 6, ‘very good’ = 2, and ‘poor’ = 2 covering 10 of the 11 possible answers. Finally, this section measured participant’s satisfaction level with the health care provider they used the most and the results scored ‘very high’ = 4, ‘somewhat high’ = 5, and ‘somewhat low’ = 2, indicating all 11 responds for this question.

The next series of questions assessed for this report were about availability of health care services locally. 8 respondents reported ‘yes’ and 2 indicated ‘no’, while 1 wrote in “some are some aren’t”. Of those reporting ‘yes’, 1 traveled from Ottawa to Montreal for specialized surgery. Another traveled between their residence in Toronto, to Buffalo, New York and Vermont in the United States for services they did not access in Toronto. Of the 2 who stated that services were not available locally, 1 traveled from Hamilton to Toronto and the other individual traveled from Penetang to Toronto in addition getting a consultation by telephone from a gender specialist in the United States.

When asked “Is there a LGBT Health Centre in your community?” results were divided. 6 reported ‘yes’ while 5 respondents marked ‘no’. When asked if they would use a LGBT Health Centre if available in their community, 8 relied ‘yes’. There were no negative responses for this question. One participant wrote in ‘maybe’ and another wrote “would prefer this form of service.”

Finally, this report will report a series of questionnaire responses concerning gender identity programs. 10 of the 11 respondents reported needing services at a gender identity clinic. Only 7 of these 10 individuals, however, had been assessed at a gender identity program. 6 people indicated they had been assessed at the Clark Gender Identity Clinic in Toronto, and reported 1 traveling to the United States for this service. The 6 assessed at the Clarke rated the program as ‘very low’ = 4, ‘somewhat low’ = 1, and ‘undecided’ = 1. Then, an open ended question offered the opportunity to write in additional comments regarding gender identity programs and the full range of responses are included in Appendix F (Notable Quotes).

## Appendix F - Notable Quotes from Participants

### What People are Saying in Focus Groups

#### *Negative Experiences*

“They were very good as long as it was related to the issues surrounding my divorce. The minute they diagnosed me with GID they stamped [in]sane on my forehead and said we don’t deal with this. Bye bye - that was it. They couldn’t care if I wanted to throw myself off a bridge still, they didn’t want anything else to do with it. It really affected me. It made me feel like there was something so horribly wrong with me that they wouldn’t deal with it.”

“If they had been a little more sensitive and they treated me a little more like a person instead of just a file number and said look, we really aren’t equipped to handle this. We’ll refer you to some people, this person does really good work or you could contact this organization or that organization, but they didn’t do any of that. They just totally dropped the ball.”

“Apparently transsexuals in his mind are so emotionally fragile that we require an entire team of medical professionals and psychologists just to manage our process .... He said so, ‘You’re 40 years old, why do you want breast augmentation? Didn’t you already know how big you were going to be a long time ago?’ I said well actually, I’m Ts and he cut me off mid-sentence. He just went from happy to down to really sort of angry and aggressive. ‘Who sent you? I don’t deal with you people. Gender reassignments are psychologically fragile, blah, blah, blah.’”

#### *Positive Experiences*

“It was very good because he and I talked as equals, and where we had concerns and he has no problems giving us the dosage we need. He’ll trade your program and change it as your body symptoms change and how you react to drugs. He has no problem with any of the drugs, so he’s fantastic. He now has seven transsexual patients.”

“I was looking for a doctor who met certain requirements and would serve all of my needs as a human being as opposed to a very narrow focus. I settled on a doctor up at ... a very very nice guy. Apparently, I was his second Ts patient. He’s been wonderful, very very easy to talk too. Very knowledgeable, very open about listening to my questions and concerns, getting things that work for me. I recommended him to a number of people.”

“Sobering up gave me the tools to be able to transition, it really did. There are a lot of parallels between sobering up and transitioning. They are both hugely mind-altering experiences and a lot of the tools are the same. A lot of the coping mechanisms are the same. It really did help. It really did help.”

## **What People are Saying About the Lack of Trans Health Services Outside of Toronto**

### *Stories from Guelph Focus Group*

“There is not a whole lot around here [services in Guelph]. Basically, I've been traveling from Ingersol to London, and then when I moved to Guelph a year ago I travel to Toronto and that, and I also go back to Ingersol. Getting a doctor in town is very difficult, period, never mind being transsexual or transgendered.” “I travel an hour to Ingersol. It's about 110 kilometers. And I also have to see the specialist in Toronto.”

“I know this is an underserved area in terms of physicians, so actually finding a doctor is difficult. Finding a doctor who is knowledgeable on Trans issues is going to be almost as doubly difficult. My doctor has been good but has admitted that she doesn't know that much about Trans issues but she is willing to learn.” “That's positive in the sense that she is willing to learn given the fact that if she wouldn't have been willing to learn it would have been that much more difficult to find another doctor, because there are not a lot of doctors in Guelph accepting new patients”

“I was lucky enough to be going to [Guelph] University at the time and the student health centre at the University has, is always accepting new patients because there pretty [high turnover]. I found a doctor there who is willing to deal with the Trans end of things so he's become my regular doctor, and just in general they have the walk-in clinic there and I've never had any problems there since I changed my name, whatever, and for the most part, I've had not too much of a problem. I few months ago I had a physical with my regular doctor; it was the first one I had in a while. She went about it the same way as anyone, you know. It didn't really faze her, you know, she did a breast exam and she did a testicular exam. You know, that's what you have, that is what I'll examine.”

“I actually didn't end up starting on hormones until I went to see Dr. [name deleted] in Toronto, because my doctor at the University [Guelph] actually had to go on maternity leave and didn't want to leave me hanging two months into my hormone treatment and couldn't find anyone who'd be willing to take me. That's certainly of a bad thing. After about eight months or a year I transferred back to my regular doctor at the University. My doctor is on maternity leave, again, as it seems. So I've been seeing another doctor. I've been seeing another one and she's really nice too. I mean it's a lot easier to find a doctor who'll take care of you after you've been on a regimen for a while rather than when you're just wanting to start out.” “The fact is that I did have to start in Toronto, and as [name deleted] was saying, without resources I was just lucky that one of my friends online had a Trans friend in Toronto that could help me get that sort of information together, and sort of get up the courage, and Dr. [name deleted] was her doctor so that's how I got connected with him. So again it all ended up starting in Toronto.”

“When I was in Woodstock they put me on list when I was actually going through my crisis time. They put me on the list and said they were backlogged eight months. So they finally called me after eight months and said, 'Did you still need our services?' I could have been dead if I didn't have my doctor there and some of the other support

mechanisms that I established. So it's like phoning suicide hotline and being put on hold. ... I thought man, this is totally useless.”

***Stories from Guelph Focus Group: Economic Barrier to Service***

“I don't have a job or anything so I can't even begin to look into things like electro [lysis], SRS [sex reassignment surgery], or breast enhancement or whatever. Even thinking about SRS is like, you know, a pipe dream.”

***Stories from Guelph Focus Group: Lack of Supports***

“I started hormones for six months to help me sort out my feelings and see the psychiatrist to help sort out the feelings. At the end of six months I was standing alone in a room with my doctor, my G.P. in Ingersol and said, 'Well it's you and me. It's decision time. After six months it all becomes permanent.' So I said, 'It's you and me.' None of the resources from the Clarke panned out, so, again it's resource, resource, resources are very important.”

***A Volunteer from Ottawa Speaks***

“A number of the resources you have listed and discuss throughout the report are based in Toronto - primarily the downtown area. This includes the Youth initiatives as well as the Depression & Anxiety and Substance Use & Eating Disorders (Mental Health). For those of us who are not in Toronto and cannot afford to travel to and stay in Toronto, these resources provide no benefit. We need equal access to these types of resources wherever we are in the Province of Ontario. Keep up the good work!”

### Demographic Questionnaire Quotations

Questions	Answers
<p>Please add your comments about disabilities: (I don't consider myself disabled, having a disability helps me get health care, I prefer the term challenged... etc.)</p>	<p>“Disabilities are in the mind's eye.”</p> <p>“I don't consider myself disabled.” (3 responses)</p> <p>“I try not to consider myself disabled.”</p> <p>“I think I would prefer the term challenged. It is kinder sounding and with sensitivity invites understanding.”</p> <p>“Being Trans is not a disability, although needing to transition is. Also, so is social stigma that prevents getting a job.”</p>
<p>I found the choices with gender identity and sexual orientation to be (too broad, too limiting, just right, representative, not representative, etc.)</p> <p><i>Note: Offered were 14 different selections for gender identity and 11 possible selections for sexual orientation.</i></p>	<p>“Pretty reflective of the possibilities.”</p> <p>“I don't really feel that words are important to describe who I am.”</p> <p>“On a personal note the process of self-determination allows us to begin our journey. We have to be very careful we do not make too rigid a boundary as it can and often does negatively affect others approaching help.”</p> <p>“Sexual orientation does not always apply and labeling transgender people is often difficult. Self-identification doesn't always fit into any norm.”</p> <p>“Needs M2F(MtF, FtF) and f2m(ftm, mtm), needs 3rd gender. Mostly need just 'Trans' choice - am applauding the broad choices - it's great!”</p> <p>“The form is fine, but I really think that people in focus groups (especially those living in poverty) should be paid well for their time. I realize this isn't really your fault but we need to push for that in regard [to] grant budgets... the valuing of trans expertise and energy expended by those who have little and rarely benefit from research. All that being said... it's a good thing you're doing. Thank you.”</p>
<p>Is there anything else you would like to tell us about yourself?</p>	<p>“I am just at the point of coming out at work (employed 22 years) and it scares me to death.”</p> <p>“It's difficult to choose between folks thinking I'm 'M and too young to be employed' or 'F (offensive to me) and old enough to be employed'. So I'm either employed and humiliated or unemployed and broke.”</p>

### Self-Administered Questionnaire Quotations

Questions	Answers
<p>Is there anything we have missed or something else you would like to add about gender identity clinics?</p>	<p>“The Clarke and zero are the same.”</p> <p>“They [Clarke Gender Identity Clinic] judge by appearances, by antiquated stereotypes about what 'real men and women' are supposed to be, and they provided NO support at all. Thanks so much for wasting my time.”</p>



	<p>“They change. Ask about how they were and how they are.”</p> <p>“Initial appointment was too brief. Clinic is underfunded and understaffed!!! Despite my asking the Clinic to send assessment and consult note to my family practitioner Clinic needs more funding from Federal and Provincial coffers.”</p> <p>“Am glad to have avoided the Clark.”</p> <p>“I believe there should be more.”</p>
<p>Is there anything we have missed or something else you would like to add about health care services?</p>	<p>“Generally have been treated like shit. If one is depressed and trans that the legitimacy of the trans identity is questioned. Could people not realize that it's possible to be depressed for <u>other</u> aspects of my life? Or because <u>society</u> sucks when it comes to being trans? But none of that means my transness is the problem.”</p> <p>“More! Less judgmental! Less doctor God and more helping us achieve what we need.”</p> <p>“An educational panel composed of health care providers (medical and non-medical) and Trans people would be useful in enlightening medical students, nursing students, etc. at local universities.”</p> <p>“Hamilton Health Sciences Corp's four hospitals each have a health unit for their staff. None of them have info about Trans people.”</p>

## Appendix G – Limitations

Specifically, within our sample of 73 research participants, (only 63 [85%] of whom completed and returned the written demographic questionnaire):

- No one reported being homeless or underhoused\*
- Only 4 people reported physical and/or sexual assault (due to transphobia) as an adult\*
- Only 3 people identified as sex workers\*
- Only one person reported being HIV-positive\*
- No one identified as a survivor of early sexual and/or physical abuse, most likely because this question was not specifically asked<sup>+</sup>
- Only 4 individuals identified as non-White; only 6 said they were of mixed race<sup>+</sup>
- Only one respondent was incarcerated in a forensic mental health institution<sup>+</sup>
- Only 2 participants reportedly did not live in a large urban centre<sup>+</sup>
- Only one of the participants was from northern Ontario<sup>+</sup>
- Of the 12 self-identified youth (aged 13-26), only 3 were age 20 and under<sup>+</sup>
- Of the 20 self-identified seniors (aged 50-67), only 7 were age 60 or over<sup>+</sup>
- Just under a third [30.2%] (19 out of 63) were born female<sup>~</sup>
- Only 3 individuals identified as intersexed (in terms of birth-assigned sex)<sup>+</sup>
- Only 4 people identified as “Two-Spirited” (however, 3 of these did not identify as Aboriginal People so this is a misnomer as this term should be reserved only for the aforementioned indigenous peoples, per the latter)<sup>+</sup>

\*This statistic is generally known to be under-representative of the trans community in Toronto and Ontario. [This knowledge is gleaned from several sources: Rupert Raj - transactivist and therapist - through his clinical work with clients of the Sherbourne Health Centre in Toronto and his community development/activism; Susan Gapka - York University Political Science student and transactivist – through her community involvement; and Kyle Scanlon - community peer provider and transactivist – through his contact with low-income and street-active transpeople who attend the Meal Trans Programme (located at the 519 Church Street Community Centre in Toronto)].

+These individuals/groups are known to face unique barriers/different challenges when accessing health care and social services

~Many of the challenges experienced by transmen and transgendered females-to-males are different from those encountered by transwomen and transgendered males to females

## Appendix H – Resources

**2-Spirited People of the 1<sup>st</sup> Nations.** (A weekly, community drop-in centre located in Toronto for Aboriginal Two-Spirited and trans-identified youth). (Contact: Doe O'Brien: 416-944-9300; [doe@2spirits.com](mailto:doe@2spirits.com) or Terry Sands: 416-944-9300 or [terry@2spirits.com](mailto:terry@2spirits.com)).

**Genderqueers.** (E-mail: [genderqueers@hotmail.com](mailto:genderqueers@hotmail.com); Listserv: [vicgenderqueers@yahoogroups.com](mailto:vicgenderqueers@yahoogroups.com)). (A Canadian social and political group based in Victoria, B.C. for anyone interested in fighting all forms of oppression, especially gender oppression).

**Family Pride Network.** (<http://familypride.uwo.ca/joy.html>). (A joint project of the LGBT Parenting Network [an initiative of the David Kelley Lesbian/Gay & HIV/AIDs Services – a program of the Family Service Association of Toronto] and the Pride Library housed at the University of Western Ontario (UWO) in London, Ontario).

**GLBTHealth.** ([www.onelist.com](http://www.onelist.com)). (A list serve made available as part of the Ottawa GLBT Wellness Project). (Contact: Peter Lockwood: [peter@plockwood](mailto:peter@plockwood)).

**International Journal of Transgenderism.** ([www.symposion.com/ijt](http://www.symposion.com/ijt)). (Online, professional, quarterly journal dealing with a variety of clinical issues focusing on transpeople).

**LGBT Parenting Network** (an initiative of the David Kelley Lesbian/Gay & HIV/AIDs Services – a program of the Family Service Association of Toronto). (Contact: Rachel Epstein: [rachelep@fsatoronto.com](mailto:rachelep@fsatoronto.com); <http://familypride.uwo.ca/talk.html>).

**Maggie's: Toronto Prostitutes' Community Service Project** (A transpositive, peer-resource and drop-in centre in downtown East Toronto for sex workers and their allies; also includes the **Prostitutes Safe Sex Project**). (Contact: Collective: 416-964-0150).

**Meal-Trans Programme** (for low income & street-active transsexual & transgendered people) Weekly drop-in: free vegan meal & programming (Mondays, 6:30-9:30 pm); 519 Church Street Community Centre (at Wellesley); [www.icomm.ca/the519/programs/homeless/mealtrans.html](http://www.icomm.ca/the519/programs/homeless/mealtrans.html)  
Coordinator: Kyle Scanlon: (416) 392-6878, x104; [mealtran@the519.org](mailto:mealtran@the519.org)

**Metropolitan Community Church of Toronto (MCCT).** (A non-denominational Christian church based in Toronto which serves the spiritual needs of the queer and trans communities). (Contact: Rev. Brent Hawkes: 416-406-6228; [www.mcctoronto.com](http://www.mcctoronto.com)).

**Older Gay, Lesbian, Bisexual & TS/TG Program** (for queer & transpeople 50 and over) (Currently no trans-specific programs but will help launch if independent facilitators initiate & maintain); 519 Church Street Community Centre (at Wellesley); [www.icomm.ca/the519/programs](http://www.icomm.ca/the519/programs) Coordinator: Dick Moore: (416) 392-6878, x118; [seniors@the519.org](mailto:seniors@the519.org)

**PFLAG-T Net (Parents, Friends and Families of Lesbians and Gays – Transgender Network).** ([www.youth-guard.org/pflag-t-net](http://www.youth-guard.org/pflag-t-net). Listserv: Send the message: subscribe tgs-pflag YOUR NAME to: [listproc@critpath.org](mailto:listproc@critpath.org) or contact the list owner at: [maggie@critpath.org](mailto:maggie@critpath.org)).

**Pride & Prejudice Program** (Central Toronto Youth Services). (Contact: Lee Andra Miller: [leeandra@ctys.org](mailto:leeandra@ctys.org); 416-924-2100, x256).

**Prisoners' HIV/AIDS Support Action Network (PASAN)**, Toronto, Ontario. (Contact: [info@pasan.org](mailto:info@pasan.org); [www.pasan.org](http://www.pasan.org)). (A community-based network of prisoners, ex-prisoners, organizations, activists and individuals working together to provide advocacy, education, and support to prisoners on HIV/AIDS and related issues).

**Rainbow Services**, Addiction Research Foundation Site, Centre for Addiction and Mental Health, Toronto, Ontario. (formerly the LesBiGay Service). (A transpositive and transinclusive service for lesbians, bisexuals, gay men, transsexual and transgendered people who are concerned about their alcohol and/or drug use). (Contact Farzana Doctor, Service Manager: [farzana\\_doctor@camh.net](mailto:farzana_doctor@camh.net)).

**Rainbow Services Depression Group Project**, Addiction Research Foundation Site, Centre for Addiction and Mental Health, Toronto, Ontario. (A 15-week therapy group starting September 2003 for queer and trans people who feel depressed; open to all individuals, including those who do not have a substance use problem. (Contact: Anne: 416-535-8501, x6093).

**Supporting Our Youth (SOY)** (Central Toronto Youth Services). (Contact: Elisa Hatton: 416-924-2100, x264, [soy@soytoronto.org](mailto:soy@soytoronto.org); [www.soytoronto.org](http://www.soytoronto.org)). **Mentoring & Housing Program.** (Contact: Leslie Chudnovskly: 416-924-2100, x247).

**Trans Access Project.** (A five-month, community-based, research study, in partnership with the Fred Victor Centre, to identify ways to create accessible, safe, welcoming and transpositive shelters and hostels for transpeople in Toronto). (Contact: Christina Strang: 416-536-9783; [transphobia@ziplip.com](mailto:transphobia@ziplip.com)).

**Trans Brazilian Project (Associacao Brasileira Interdisciplinar de AIDS [ABIA]).** (A twin project between the AIDS Committee of Toronto and an AIDS service organization in Brazil funded by the Canadian International Development Agency. ABIA is producing a documentary with travestis (Brazilian term for transgenders/transsexuals) in Rio de Janeiro about their diverse life experiences, as well as Brazilian travestis who have migrated to Toronto). (Contact: Humberto Carlo: 416-340-8484, x254; [hcarolo@actoronto.org](mailto:hcarolo@actoronto.org)).

**Trans Health Program** (Vancouver Coastal Health). ([www.groups.yahoo.com/group/trans-health](http://www.groups.yahoo.com/group/trans-health); [trans-health-subscribe@yahoogroups.com](mailto:trans-health-subscribe@yahoogroups.com)). (A newly-initiated list serve to support transpeople, their loved ones, service providers and researchers, which includes news, discussion, and

information on the BC planning process related to the new program). (Contact: Joshua Goldberg: [joshua\\_goldberg@vrhb.bc.ca](mailto:joshua_goldberg@vrhb.bc.ca)).

**Trans Youth Toronto.** (a Canadian, community-based, peer-support service for trans-identified youth). (Contact Program Coordinator at: [mealtran@the519.org](mailto:mealtran@the519.org); [www.icomm.ca/the519/programs/transyouthtoronto/e-group.html](http://www.icomm.ca/the519/programs/transyouthtoronto/e-group.html)).

**Trans-Canada.** ([www.trans-canada.org](http://www.trans-canada.org)). (An evolving list serve for Canadian transpeople).

**TransFormations.** (a Canadian psychoeducational group for trans-identified youth – a joint initiative of Pride & Prejudice [a program operating out of Central Toronto Youth Services] and Sherbourne Health Centre’s LGBTT Program). (Contacts: Group Facilitators: LeeAndra Miller: [leeandra@ctys.org](mailto:leeandra@ctys.org) and Rupert Raj: [rroj@sherbourne.on.ca](mailto:rroj@sherbourne.on.ca)).

**Trans\_Fusion Crew.** (a Canadian support group for trans-identified youth – an initiative of Supporting Our Youth, a program operating out of Central Toronto Youth Services). (Contact Program Coordinator at: [soy@soytoronto.org](mailto:soy@soytoronto.org); [www.soytoronto.org/frame.html](http://www.soytoronto.org/frame.html)).

**Transgender Aging Network (TAN).** (<http://forge-forward.org/TAN>). (An international network of people who serve, do research, training, or advocacy about, and/or are otherwise interested in transgender aging issues).

**Transgender Prisoner Study** (long-term). (Contact: Gianna Israel, Forensics Specialist & Gender Specialist: [gianna@counselsuite.com](mailto:gianna@counselsuite.com); [www.counselsuite.com](http://www.counselsuite.com) ).

**Transgendered People of Color (TGPOC).** (Listserv: [tgpoc@yahoogroups.com](mailto:tgpoc@yahoogroups.com) ).

## **Resolution**

**WHEREAS** individual and systemic oppression and transphobia seriously impact the health of Trans people in our communities; and

**WHEREAS** Health and Social Service professionals often lack the sensitivity and knowledge of the diverse needs of the Trans communities, which is necessary to enhance community capacity and provide a best practice model; and

**WHEREAS** the Community Based Participatory Action Research (CBPAR) model has the capacity to empower disadvantaged communities to assist individuals to actualize their everyday lives; and

**WHEREAS** there is a paucity of current, holistic, provincial and national research that reflects all diversities in our Trans communities; and

**WHEREAS** inadequate and inequitable funding of medical treatments and counselling services further marginalize trans people and prevent the attainment of optimal health and satisfying lives; and

**WHEREAS** the Trans Health Project highlighted the voices of the Trans communities and the need for community involvement and partnerships to increase capacity;

**THEREFORE IT BE RESOLVED THAT** the Ontario Public Health Association adopts the Trans Health Project position paper and disseminates it to all stakeholders (e.g. trans communities, professional associations, policy makers, Ontario Ministries, Public Health Units and Community Health Centres);

**BE IT FURTHER RESOLVED THAT** the OPHA advocate for the inclusion of trans health issues into the Ontario Mandatory Health Programs and Services Guidelines and all relevant publicly funded health programs;

**BE IT FURTHER RESOLVED THAT** the OPHA advocate for transpositive training for all Public Health Units and professionals, to be delivered by the trans communities wherever possible;

**BE IT FURTHER RESOLVED THAT** the OPHA takes the lead to advocate for funding of a national research strategy for the trans communities using the PAR approach;

**BE IT FURTHER RESOLVED THAT** the OPHA advocate to the Ministry of Health for the relisting OHIP coverage for sex reassignment surgery and electrolysis, in addition to advocating for the equitable, accessible and enhanced funding for medical and counselling services for trans people, including hormone therapy and other transition supports;

**BE IT FURTHER RESOLVED THAT** the OPHA advocate for trans inclusive and wherever possible, trans specific programs and services that, in partnership with trans communities, provide the continuum of comprehensive services (e.g. housing, employment, Aids Service Organizations, medical and counselling) needed by trans people. These programs and services would partner transpositive providers, peer counsellors and community volunteers;

**BE IT FURTHER RESOLVED THAT** the OPHA encourages the development, through community consultation and ownership, of new educational programs, information and supports for trans people, their partners, and families;

**BE IT FURTHER RESOLVED THAT** the OPHA supports public education through the media etc. to increase visible inclusion of the trans community.

### **Implementation**

1. Present the paper to the general membership of the OPHA at the Annual general Meeting, Nov.,2003.(PHA)
2. Disseminate the paper to all stakeholders (PHA, researchers, OPHA staff)
3. Distribute the paper to the Ontario Mandatory Health Programs and Services Guidelines review committee (OPHA staff)
4. Advocate for the inclusion of Trans health issues into the Guidelines (PHA, OPHA Board)
5. Develop a training template on transphobia and trans health issues (trans community and PHA)
6. Advocate for the training of all levels of staff in Public Health Units and CHCs (PHA, trans community ,OPHA Board and staff)
7. Advocate to the Board of the CPHA and Health Canada, the need for a national research strategy, using a CBPAR approach ( OPHA president, PHA, trans community)
8. Advocate for the relisting for sex reassignment surgery and electrolysis (PHA, trans community, OPHA Board)
9. Advocate for accessible and enhanced funding for medical and counselling services (PHA, trans community, OPHA board)
10. In partnership with the trans community, advocate for trans inclusive and trans specific programs and services (trans community, PHA, OPHA Board)
11. Encourage the development of new educational programs, information and supports (trans community, their partners and families, PHA, OPHA Board)
12. Research appropriate media for public education (PHA, trans community)
13. Seek out funding sources (trans community, PHA)
14. Develop appropriate campaigns (trans community, PHA)

**Regarding resolutions, position papers and motions:**

**Status.** Policy statements (resolutions, position papers and motions) are categorized as:

**ACTIVE**, if:

- 1.The activities outlined in the policy statement’s implementation plan have not yet been completed; or
- 2.The policy statement addresses an issue that is currently relevant to public health in Ontario.

**ARCHIVED**, if:

- 1.The activities outlined in the policy statement’s implementation plan have been completed; or
- 2.The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supersedes the latter

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