

**A MIXED METHODS INVESTIGATION OF THE NEEDS,  
EXPERIENCES, AND FULFILLMENTS OF TRANS PERSONS  
ACCESSING ONTARIO HEALTH CARE SERVICES**

by

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A thesis submitted to the Department of Gender Studies

In conformity with the requirements for  
the degree of Master's of Arts

Queen's University

Kingston, Ontario, Canada

(September, 2011)

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## **Abstract**

This study examined the societal factors and subjective beliefs that are hypothesized to be affecting the lives of trans persons accessing Ontario health care services. The purpose of this study was to uncover information pertaining to trans persons' needs and fulfillments within Ontario's health care system in order to discover what the specific health care needs of trans persons accessing health care services are as well as if they are alienated and/or systemically discriminated against when seeking medical attention. The research questions were addressed through a secure, anonymous, online questionnaire taking approximately 30 to 45 minutes to complete. A small sample of 18 to 26 individuals who identified as trans, living in Ontario and have accessed, or are currently accessing, Ontario health care services were recruited through relevant list-servs and website postings. Participants accessed a variety of open-ended and closed questions concerning sociodemographics, sexuality, health care access experiences, and health care needs. Qualitative results showed that access to Ontario health care is complicated by race, class and language for participants in this study. Experiences for trans persons with Ontario health care services varied from individual to individual; some reported no negative experiences at all, some have been refused services by the Center for Addiction and Mental Health's Gender Identity Clinic, and some avoided health care services entirely due to discrimination from medical professionals.

## Acknowledgements

First and foremost I would like to thank all of the participants who took the time to complete my research survey. Without you this project would not have been possible. Next, I would like to thank the Department of Gender Studies for giving me the opportunity to learn from the extremely intelligent professors that make up this faculty. Also, to the administrative staff, Terrie Easter Sheen and Autumn Rymal, thank you for your great efficiency and constant support.

Thank you to the Ontario Graduate Scholarship funding program for supporting my research in 2010-11. To the Canadians for Choice Foundation and Dr. Norman Barwin for recognizing the importance of gender diversity in health care research and gifting me a scholarship to aid me in the completion of this project.

My sincere gratitude and respect to Dr. Margaret Little, my supervisor, for keeping me on track. To Dr. Katherine McKittrick, thank you for helping me realize my potential and for making me stick with this project. To Dr. Scott Morgensen, my appreciation goes to you for taking the time to create a specialized trans theory reading course with me. Our biweekly discussions were invaluable to this project and I sincerely thank you for your amazing insight and dedication. To Dr. Caroline Pukall, your devotion and support have been most cherished over the last three years that we have worked together.

Finally, to my friends, family, and partner who have supported me throughout the course of my life and academic career. My love and appreciation goes to all of you, thank you.

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# Chapter 1

## Introduction

It's easy to assume that because we are all humans, gender, race, or other characteristics of study participants shouldn't matter in health research, but they certainly do. ... It was only when researchers made deliberate efforts to engage women and racial and ethnic minorities in studies that we discovered differences in how some diseases occur in and affect specific populations. Routine collection of information on race and ethnicity has expanded our understanding of conditions that are more prevalent among various groups or that affect them differently. We should strive for the same attention to and engagement of sexual and gender minorities in health research.

Dr. Robert Graham, 2011<sup>1</sup>

Trans persons represent one of the most marginalized groups in western society in terms of the numerous barriers faced when accessing and obtaining health care services. Apprehension and fear of discrimination, financial reasons, and hostility of providers, all may prevent trans persons from accessing health care (Kaiser, 2000; Lombardi, 2001). Trans persons' health issues can also be further complicated by other axes of identity including: sexuality, race, class, ability, language, and age. For this project I attempted to incorporate issues of race and class and the way these categories of identity intersect with gender with respect to accessing health care services in Ontario.

The majority of population-based surveys do not ask specific questions about gender and sexuality (Harcourt, 2006). As it stands currently with existing research on trans persons, there is little information that marks trans bodies in large scale population health surveys because most

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<sup>1</sup> Robert Graham is a professor of family medicine and public health sciences at the University Of Cincinnati College of Medicine, Cincinnati. National Academy of Sciences (2011, March 31). Researchers need to engage lesbian, gay, bisexual, and transgender populations in health studies.

surveys assume people are cisgender<sup>2</sup>; only allowing people to select “male” or “female” as their gender/sex. Also, most Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) research generally consists of self-reports of experienced discrimination with health care services, versus quantitative and qualitative questionnaires about what trans persons specifically need in terms of standardized health care (i.e annual check-ups, emergency care, injury, etc) (Blankenship, 2006; Human Rights Campaign, 2011). Even though existing research has consistently pointed out the numerous and interlocking challenges faced by trans persons in their day to day lives, much of this research ignores their health care needs and experiences with accessing health services (Mulé, et. al., 2009; Lambda, 2009, 2010; Human Rights Campaign, 2011). As well, a common fault with the existing canon of research on trans persons is that it tends to lump people into one homogenous group, failing to recognize individual differences within trans populations like race, class, and personal history for example.

Canadian scholars and health care professionals have only begun to address the health concerns of trans persons. There is a need to expand knowledge on trans persons’ health care needs so that accurate and informed decisions can be made, not only for their basic health needs (like getting an annual check-up), but also for trans specific health care needs (like safe and informed access to hormones and reassignment and/or cosmetic surgeries). Knowledge about trans health and health care needs should be extended to all medical professionals, regardless of geographical location, so that all trans persons in both urban and rural cities can benefit from accessing proficient health care services.

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<sup>2</sup> Cisgender is a word used in lieu of ‘non-trans person’. The book *Whipping Girl* by Julia Serano was my first introduction to the terms cissexual and cissexism. Serano (2007) defines cissexism as the “belief that transsexuals’ identified genders are inferior to, or less authentic than, those of cissexuals (i.e., people who are not transsexual and who have never experienced their subconscious and physical sexes as being aligned).” (p. 12)

The purpose of my research is to examine the societal factors and subjective beliefs that are hypothesized to be affecting the lives of trans persons accessing Ontario's health care system. Due to the scarcity of research on trans related health care issues and access, my study purposefully included a diverse and varied set of questions that quantitatively and qualitatively exposed some of the challenges and barriers faced by trans persons accessing health care services in Ontario. My research questions were heavily informed by anti-oppressive, anti-racist, alliance-based, and feminist frameworks in order to set my study apart from other research that tends to homogenize trans persons by asking only quantitative questions. Through an online survey, questions were asked to discover whether or not trans persons are alienated and/or systemically discriminated against when seeking medical attention, and whether or not there exists any differences between individual experiences that may be impacted by a person's race and/or class.

I am using a mixed methods approach to uncover information through qualitative and quantitative approaches in order to investigate trans persons' experiences accessing health care. Through this approach I hope to show that a new model or framework should be applied in research methodologies when considering health care access for trans persons because the current medical system in Ontario resists current understandings and diverse representations of gender, social status and race. In particular, the influence of imposed gender norms through medical models in Canadian society needs to be questioned and challenged in terms of fluidity, performance, and gender entitlement. Revealing the lived experiences of trans persons will help to challenge the social expectations of masculinity and femininity that are predominantly defined by a two-sexed system. Disclosure of how gender binaries affect the ways in which medical professionals view and treat trans persons will provide a path towards situating gender outside of

the two-sexed system and create “in-between” or “un-fixed”<sup>3</sup> identities that are recognized and treated with respect in institutions such as health care.

### **Survey and Methodology**

I addressed the research objectives through an online survey<sup>4</sup> in order to maintain the anonymity of the participants in case they might not wish to disclose who they are or in case they may have experienced negative interactions with researchers in the past and therefore are suspicious of research investigators’ intentions. There is a benefit to conducting online surveys; people are free to complete a questionnaire at their own convenience, and they may disclose more information anonymously through a web-based interface versus a human interface (Schmidt, 1997; Wyatt, 2000; Whelan, 2008). Another factor that informed my chosen method was due to the fact that I am cisgender. I did not want people to be reluctant to participate because I am not trans identified. In fact, there can even be a certain level of distrust among trans persons to participate in research, period. Trans social worker Brenda Viola (2004) states that trans persons may be reluctant to participate in research due to “their perceived powerlessness to out themselves to family, friends, employers, and co-workers—and, in some, cases, even to themselves” (p. 40). Regardless of the reasons trans persons may or may not participate in research, my cisgender identity could in fact be discovered because ethically, as part of the informed letter of information and consent, my name is disclosed to participants and they are free to e-mail me to ask questions. In fact, I had 6 people e-mail me upon reading the call out on list-servs for participants asking me questions about my politics, purpose and intentions. For example,

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<sup>3</sup> “in-between” or “unfixed” places gender on a spectrum versus specific categories, similar to literature regarding sexuality such as the “Kinsey scale” and Lisa Diamond’s notion of “sexual fluidity”.

<sup>4</sup> <https://surveys.psyq.queensu.ca/Checkbox/transhealth.aspx>

one person googled my name<sup>5</sup> looking for more information and proceeded to ask me the following in an e-mail: “I saw on google that the survey is part of your master's thesis, so I guess mostly I was curious to know a bit about your philosophy toward the survey and how do you see the survey fitting into your larger project? Also, what led you to be interested in trans issues in the first place, if you don't mind me asking?” (Personal communication, January 4, 2011).

Participants were recruited through online sources in the form of emails to the only two major trans and health related list-servs in Ontario; Trans-Advocacy-Ontario and Rainbow Health Ontario. A link to the study was also posted on two websites; Rainbow Health Ontario<sup>6</sup> under their “Current Research” page and the Sexual Health Research Laboratory’s “Current Studies”<sup>7</sup> page at Queen’s University. Snowballing methods were also employed with trans persons I have contact with. I also asked people to please pass along the survey link to others who might be interested in responding.

The survey included 131 questions regarding socio-demographics, sexuality, health history, health care access experiences in Ontario, and health care needs. Participants had the opportunity to describe, in detail, the quality of their health care and trans specific health care experiences in Ontario. In addition to this, I chose to include questions around class and race that enabled the participant to speak freely about any systemic barriers that may have influenced their experiences of being trans identified. The survey was organized in 5 major sections:

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<sup>5</sup> I asked the person in an e-mail how they found the information about me that they were questioning. It was with regards to an article that the Queen’s journal published using my name without my consent. The student e-mailed me with questions; I did not give many answers via e-mail and asked if she wanted to meet. I never heard from the student again and it was only when this participant e-mailed me that I found out about this article. The Journal has ignored me and still has not taken this article down. See, <http://queensjournal.ca/story/2010-02-12/supplement/transition-new-identity/>

<sup>6</sup> See, <http://www.rainbowhealthontario.ca/research/currentProjects.cfm>

<sup>7</sup> See, [http://www.psyc-research.com/SHRL/Ongoing\\_Studies/Ongoing\\_Studies.html](http://www.psyc-research.com/SHRL/Ongoing_Studies/Ongoing_Studies.html)

- **Part A:** Demographics,
- **Part B:** Trans-specific questions,
- **Part C:** Experiences with Ontario Health Care,
- **Part D:** General health questions, and
- **Part E:** General open-ended questions and comments.

I felt that it was important in every section of the survey, wherever appropriate, to have open-ended questions so that the participant could elaborate on any given answer if they wanted to as opposed to simply being forced to check a box and answer yes/no to a question without being able to give context or any subjective thoughts. At any point in the survey participants could discontinue by simply exiting their web browser. There was always an option to “decline response” if the participant wanted and they would still be able to continue to the next question.

I attempted to acquire results that combine both quantitative and qualitative data, but unfortunately the sample is too small to make quantitatively significant claims. The survey link was clicked on 234 times, however only 33 people viewed the letter of information and consent form and agreed to continue with the survey. Three people were not eligible at this stage because they have not accessed health care in Ontario. There were 30 people who started at least the first few questions of the survey and by the end 18 people had completed it from start to finish. Information about the specific results of this data will be discussed in chapter 2. Due to the low sample size, the data of interest in my results shifted from quantitative interpretations that focus on making correlations and generalization of results, to qualitative interpretations of the data through discourse analysis and interpretive phenomenological analysis. Descriptions of experience and understandings of the meanings of a subjective and lived occurrence is my primary focus in the survey results presented. Quantitative data will still be reported; however

these findings do not imply any causality but rather indicate the frequencies of a specific item or phenomena (i.e. discrimination from a medical professional) that occurred for trans persons accessing health care services in Ontario. While my study fell short in recruiting a large number of participants to adequately investigate health care access differences between small town and large town cities, there was a rich amount of qualitative data gather which will help to contribute to the lack of research that exists regarding trans persons' access to health care services.

I investigated phenomena, such as the experience of quality health care for gender non-normative bodies, and the meaning of what quality health care for non-normative bodies mean. This approach to analysis is informed by Interpretative Phenomenological Analysis (IPA); a methodology that was created to analyze qualitative data in the field of psychology (Fadde, 2004). Fadde (2004) captures the purpose of IPA in stating that:

... the purpose of IPA is to attempt as far as possible to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary analytical instrument. The researcher's beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals. Reflexivity is viewed as an optional tool, enabling the researcher to formally acknowledge his or her interpretative role, rather than as an essential technique for removing bias. (p. 648).

I will draw on IPA as a methodology alongside discourse analysis to draw out information, themes, and theoretical perspectives about the experiences trans persons disclosed throughout my study.

## **Literature Review: An Examination of Methods and Methodologies Used in Trans Health Related Research**

Despite the modest amount of research on trans health issues, it has consistently shown that there is a lack of knowledge within the health care profession regarding trans health needs.

This lack of knowledge not only leads to discriminatory medical practices, but also to an ongoing solidification of gender/sexual biases. Trans PULSE is a community-based research project investigating the ways in which social exclusion and transphobia shape the health care services for Ontario trans people, and how these in turn, impact their health. This project was spearheaded in 2004 by trans community members and the Sherbourne Health Centre (SHC) in Toronto, ON. Trans PULSE had a unique methodology in creating community control and involvement. Currently, it is the largest survey to date conducted in Ontario on trans health care; obtaining 433 trans identified participants (Bauer, et. al., 2010). The study gathered information pertaining to income stability, violence, housing discrimination, relationships and family, sexual health, HIV vulnerability, mental health, community connectedness, and access to health and social services for trans persons; however no data has been released to the public aside from 3 short e-Bulletins<sup>8</sup>. TransPULSE used high quality research methods in order to ensure maximum impact on policy. However, it lacked questions sensitive to race which produced a relatively biased sample due to its respondent driven sampling methods<sup>9</sup>; 86% identify as “White/Can/Amer/Euro” (Bauer et. al., 2010). In fact, in an e-mail correspondence from an individual who questioned my research study, they pointedly said that Trans PULSE’s “respondent-driven analysis had the unfortunate effect of isolating people of colour. [Also], the Eurocentric language (academese) used in the survey marginalized an already marginalized segment of the trans population.” (Personal correspondence, December 29, 2010). Also, the Trans PULSE survey had a biased sample with

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<sup>8</sup> See, [http://transpulse.ca/public\\_downloads.html](http://transpulse.ca/public_downloads.html)

<sup>9</sup> “Respondent driven sampling is a chain-referral sampling method designed to limit bias in studies of hidden populations, those from which a random sample cannot be obtained. Each participant could recruit up to 3 additional participants. Recruitment patterns and individual network sizes were tracked, and these data were used to weight all statistics based on each participant’s probability of recruitment. Statistics presented are thus population estimates for networked trans people in Ontario (i.e. those who know at least one other trans person).” (Bauer, 2010).

regards to social status; 50% make less than \$15,000/year and 21% between \$15,000 and \$29,000.

In addition to Trans PULSE in 2003, *The Trans Health Project*, sponsored by the Ontario Public Health Association's (OPHA) workgroup: The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spirit, Queer and Questioning Equity, conducted a study through community based participatory action research on "understanding transpeople as they access, or are denied, health care in Ontario" (Gapka, & Raj, 2003, p. 5). Through focus groups, self-administered questionnaires and semi-structured interviews data was gathered from a total of 63 trans persons revealing that, "Access and equity around overall (transpositive) health care and social services for transpeople poses numerous challenges/barriers" (Gapka & Raj, 2003, p. 3). For example, one participant stated that:

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. (Gapka, & Raj, 2003, p. 45).

The only other study which has been conducted in Ontario, Canada regarding the experiences of trans persons with health care and social services was in 1995 by Viviane K. Namaste. She examined the experiences of 33 transsexual people accessing health care and social services in Ontario. She found that transsexuals face a multitude of systemic barriers when attempting to access health care and social services such as mistreatment by hospital workers, harassment and abuse from police, rejection from drug and alcohol rehabilitation programs and entry into shelters (Namaste, 1995). Namaste's study, albeit an excellent point of departure, was

conducted only in one city (Toronto, ON), all but two participants identified as MTF, and it was purely qualitative in nature using one on one interview methods to collect data. My research differs from Namaste's in that it is a mixed methods approach using an online survey which allows for anonymity and a space for participants to write freely about their experiences accessing Ontario health care services, and my participant base included more than persons who identified solely as transsexuals.

Part of the challenge that researchers face in LGBT health studies is the issue of generalizability due to the relatively small size of, and diversity within, LGBT populations (Harcourt, 2006). Methods employed typically in LGBT research are targeted advertising and snowball sampling (Harcourt, 2006). In addition to this, methods to assess sexual orientation and gender identity are absent from most large scale, population-based surveys, which makes it difficult to measure LGBT health issues with statistical power (Dean et. al., 2000 as cited in Harcourt, 2006). Harcourt (2006) also addresses the fact that research involving trans persons is nascent and that small scale studies are only beginning to be conducted and published. In addition to this much of the research available is based on case study reports of the experiences of trans persons, most of which are focused on HIV with regards to health issues. The literature in general has focused mainly on gay and lesbian populations' experiences with discrimination in health care settings and not gender identity discrimination specifically. To a large extent the published literature has found that gay men and women experience culturally insensitive or hostile health care environments (Saunders, 1999; Ungvarski & Grossman, 1999 as cited in Harcourt, 2006).

In a study with 47 HIV positive participants, three minority groups were compared: gay men, bisexual men and trans persons identifying as female and/or living as women. The study asked each group questions about: (1) general experiences with health care, (2) experiences with

HIV antiretroviral therapies and issues surrounding access, and (3) adherence to these therapies and identity in relation to health care. The data collected revealed three themes: (1) the importance of sexual identity and its social and cultural context, (2) the differences in the health concerns between the sexual minorities and (3) a wide spectrum of experiences with the health care system that provide information surrounding the access to and adequacy of health care (Schilder et. al., 2001). From these themes the researchers found that trans persons are even more of a minority group than the lesbian, gay and bisexual population, and are discriminated against more than other queer identified individuals (Schilder et. al., 2001). The design of this study complicates sexuality with gender identity and confounds trans identities with queerness. The lack of individuality trans persons have in research on health care access is demonstrated though the flaws in Schilder et. al.'s study because trans persons should not be grouped in with other sexual minority groups. Research should focus only on trans persons in order to fully uncover what trans persons' experiences and needs are with health care services; which is what my study focused on.

Literature has consistently pointed towards discriminatory treatment by health care professionals. For example, trans activist Leslie Feinberg (2001) stated that:

Five years ago, while battling an undiagnosed case of bacterial endocarditis, I was refused care at a Jersey City emergency room. After the physician who examined me discovered that I am female-bodied, he ordered me out of the emergency room despite the fact that my temperature was above 104° F (40° C). He said I had a fever "because you are a very troubled person. (p. 897)

Trans writer, Patrick Califia (1997) echoes Feinberg's statement and affirms that, "The violence, discrimination and hatred heaped upon differently-gendered people is an enormous wrong. This

bigotry will stop only when the rest of "us" are able to accept our own gender conflicts and pinpoint our own prejudices about biological sex and social sex-roles" (Califia, 1997, p.10).

A lot of research that has been conducted regarding trans persons in general has focused on "Gender Identity Disorder" (GID), which is a "mental disorder" entry in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. Despite the amount of research focusing on GID, there has been little empirical research on GID in relation to the general health of trans persons. According to Factor & Rothblum (2008) since the 1950s there have been over 1,000 research articles on GID or transsexualism, all of which focused mainly on trans persons in clinical settings. For example, studies looking at GID typically investigate treatment effectiveness, psychological comorbidities (i.e. the presence of one or more disorders such as bipolar, depression, anxiety, etc.), and physical (i.e., biological or genetic) markers among individuals who have undergone treatment for, and have been labeled with, GID. Many trans persons have received a "diagnosis" of GID, and yet most of the research on GID does not investigate the basic needs, wants and experiences of trans persons. Sadly, medical professionals have pathologized trans persons for over fifty years and yet few studies have focused on key aspects of trans persons lives, such as access to health care (Factor & Rothblum, 2008).

Claiming GID for trans persons has long been criticized as a prerequisite to access to trans health care services (Califia, 1997; Meyerowitz, 2002). Additionally, the diagnosis of GID is often associated with a lengthy assessment process that can create additional barriers to access health care (i.e. money, time, location). Medical professionals are essentially "gatekeepers" in terms of granting trans persons a referral to hormonal therapy and surgery. In some cases providers may arbitrarily decide that their clients are not qualified for care after a significant

period of time and expense to the clients (Meyerowitz, 2002). Referral to medical professionals for many trans persons tend to be granted only if they fit a very narrow definition of “transsexualism”, thus denying access to those bodies that do not fit within a very medicalized interpretation of being trans-identified (Califa, 1997).

While there have been few studies that focus on trans persons’ access to health care, those that have been conducted all consistently indicate that trans persons experience some form of discrimination when accessing health services. One research project conducted by Wendy Hussey, MPH, examined 5 female to male transsexuals’ (FTMs) experiences of accessing health care in the United States, who still had at least one biological female sexual organ. The researcher gave the participants a camera to record their experiences of accessing health care in order to re-tell the experience they had through a picture story, a method Hussey calls “photovoice” (Hussey, 2006). One section of the results of particular interest to me was called “provider competence” – the ability to provide adequate health care to trans persons (Hussey, 2006, pp 139). A participant recaptures their experience by saying that:

When a transsexual person comes into a doctor’s office and is requiring care, that medical professional needs to be *professional*. They absolutely need to be medical, but they also need to be professional. They need to not ask questions that are irrelevant. They need to not ask questions that if asked of them, would put them on edge. They need to remember that they have got someone’s life in their hands. (Hussey, 2006, p. 140-141).

Other data in this study showed that there is a general lack of understanding from medical professionals of trans persons’ health care needs, and that participant’s feel “invisible” and completely “vulnerable” when accessing health services (Hussey, 2006, p. 153). The results of Hussey’s (2006) research also showed that the participants were wary to seek regular health care services because of discrimination and fear/anxiety surrounding a gynecological exam due to

insensitivity or hostility from uneducated or bigoted medical practitioners. The results of Hussey's study point towards the fact that medical professionals focus on sex-specific physical attributes from birth, like an FTM person who has a vagina, creates confusion and discomfort for medical professionals who do not quite grasp that a person's body parts do not necessarily physically change when their gender identity does. FTMs still require basic health care in terms of gynecological exams regardless of whether they have undergone certain surgical procedures. However, Hussey's (2006) study shows that FTMs are reluctant to seek regular health care that includes a gynecological exam because of the vulnerability and invisibility they feel when accessing health care services due to discriminatory practices they face from some health care professionals within "the system" (Hussey, 2006).

Another emerging theme from the existing literature on trans persons and health care access is that medical professionals are not trained thoroughly enough to provide adequate trans-specific care in many instances. Themes of vulnerability, hopelessness, hostility and invisibility seem quite common in the research on trans access to health care (Schilder, 2001; Bauer, et. al.; Harcourt, 2006; Hussey, 2006). For example, one participant in Hussey's (2006) study stated the following: "The emergency thing is so traumatic for so many of us...I want to talk about how important and how frightening the emergency room is. It's important for everyone. It's absolutely terrifying for transsexuals." (Hussey, 2006, p. 142). It is not a surprising remark that the anxiety and feelings of helplessness/vulnerability are so great for some trans persons that they do not seek regular and necessary health care.

A chapter in *Transgender Rights* by Willy Wilkinson entitled "Public Health Gains on the Transgender Community in San Francisco: Grassroots Organizing and Community-Based Research", discusses how multiple factors heighten trans persons' risks for serious health

concerns and the incredible difficulties faced when attempting to access health care services. Most trans persons experience difficulty in accessing stable employment, housing, and health care, which directly affects one's ability to maintain health and wellbeing (Wilkinson, 2006; Bauer et.al., 2010). Alongside these factors, trans persons also typically experience societal stigma, ridicule, family rejection, violence, harassment...etc. Wilkinson (2006) states that, "All races and socioeconomic statuses are affected [in trans populations], though health risks increase considerably when compounded by other layers of marginalization. For example, transgender immigrants to the United States [...] and transgender people of color have experienced tremendous difficulty securing gainful employment" (pp. 192-193). Wilkinson's statement illuminates the fact that trans persons of colour tend to be discriminated against more than white trans persons which is a discussion I will further investigate in the section entitled *Race/Culture* in chapter 2. Additionally, with regards to social status, the "Trans Health Project" conducted in Ontario in 2003 found that, "44.4% ( $n=63$ ) 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" (Gapka & Raj, 2003, p. 17). This data helps to validate the fact that class and gender are intimately intertwined with regards to trans persons and their ability to access health care services.

Results from a health access survey conducted by the FTM Alliance of Los Angeles (2004) found that 42% (52 respondents) claimed to have difficulty accessing care, 53% reported being denied services because they are trans, 68% reported having previous negative experiences with the medical community, 34% reported that in the last year there was a time where they needed to see a doctor, but couldn't because of perceived or real discrimination, and overall, 70% said they were dissatisfied with their regular health provider's knowledge of trans issues.

However, another US based study of 122 FTM trans persons was that 70% of the respondents gave a “good” or “excellent” rating with respect to the medical care they were receiving (Rachlin, Green & Lombardi, 2008). The contrasting results between these two studies confirm that more research needs to be conducted on trans persons’ needs and experiences with health care. What is interesting about Rachlin et. al.’s findings is that ¾ of FTM trans persons rated the health care they were receiving as good or excellent, however, it did not specify whether the participants were experiencing discrimination while receiving good to excellent health care. This study is important to note because some participants in my study also stated that they were receiving excellent care, however what is unique about my study is that I also asked if the participants are being discriminated against, and what types of discrimination they were encountering. To be able to compare and contrast the quality of care alongside access and experiences of discrimination for trans persons, all were important factors to consider when I conducted my research. What is also unique about my study in comparison to other research is that I did not focus only on the results and narratives that point out only the negative experiences of trans persons exclusively when accessing health care. It is equally important to allow for narratives that comment on positive experiences trans persons have had when accessing health care. In fact, a trans woman on a blog I read pointed out that, “I have a problem with those employment, housing, and discrimination [research] statistics, because they totally ignore trans women who have been successful at assimilating into society. There is no way to capture that data; and hence no way to quantify the extent it distorts your results.” (Kenna, 2007). Her point is important to consider and created a different level of analysis for the data I collected because I did not showcase only the negative experiences trans persons have discussed in my results. By incorporating both positive and negative experiences my project, unlike much of the narrowly focused research available, will

bring a full spectrum of narratives that does not erase the diverse experiences of trans persons accessing health care services in Ontario.

With respect to the specific studies outlined above by the FTM Alliance of Los Angeles (2004), and Rachlin et. al's (2008) research on FTM persons, it is not reasonable to assume that this data is generalizable from FTMs to MTFs; these are primarily two distinct populations in terms of gender identity and expression. However, in a study conducted on HIV risk factors of MTF persons, health care access and encounters with health care providers was investigated by De Santis (2009) and he found that MTFs accessing health care experience, verbal abuse, discrimination, insensitivity, they do not trust health care providers due to the perceived lack of knowledge or education on trans health issues, and there tends to be an excessive emphasis on HIV infection in the context of MTF health care. There have been no recent studies I found that intentionally compare the experiences of FTM vs. MTF trans persons' experiences with accessing health care services. However, one study involving 24 FTM and 31 MTF trans youth between the ages of 15 and 21 found that MTF trans persons are victimized at a younger age than FTM trans persons and MTF experience more physical victimization than FTM trans youth (Grossman, D'Augelli, Salter, & Hubbard, 2005). Again, it is difficult to find information of trans persons' experiences accessing health care services because no national survey includes measures of gender non-conforming categories. I will outline narratives of both FTM and MTF trans persons in the results section to allow for a qualitative comparison of experiences; this is an analysis that is lacking in almost all trans related health care research.

According to a survey conducted in the U.S., only 30 to 40% of trans persons utilize regular medical care (Feldman & Bockting, 2003). In another survey, 32% of respondents (n=101) said the largest barrier to health care was access to a provider with trans-specific

knowledge with other barriers being: access to a trans-friendly provider (30%), cost (29%), access to a specialist (28%), location (18%), and language (13%) (Sanchez, Sanchez & Danoff, 2009). Findings from two needs assessments also conducted in the U.S. found that out of 154 trans persons 26% percent of respondents said they have been denied medical services due to their trans identity (Kenagy, 2005).

One study recently conducted in Washington, DC investigated the potential impact of aging adult LGBT persons' fear of discrimination and how that might influence their access to long-term health care. Jackson, Johnson, & Roberts (2008) found that 73.2% of LGBT respondents believed that LGBT residents in health care facilities are victims of discrimination. However, these findings are leading because when research is conducted it seems as though there is a large disparity between the "LG" and "B" and the "T". For example, in Jackson et al.'s (2006) study there were 58 gay males, 61 lesbians, 9 bisexual persons, 2 trans persons. The percentage of trans persons included in this study entitled, "The Potential Impact of Discrimination Fears of Older Gays, Lesbians, Bisexuals and Transgender Individuals Living in Small- to Moderate-Sized Cities on Long-Term Health Care" was only 2 out of 132, or 1.5 % (Jackson et. al., 2008). Similarly, a health services needs assessment of Lesbian, Gay, Bisexual, Transgendered, Transsexual, Two-Spirited, Intersex Queer and Questioning (LGBTTTTIQQ) youth in the Peel Region of Ontario was conducted in 2009 and out of 44 respondents, only 4 identified as a trans person (Access Alliance, 2009). Generalizing about trans persons' fears and needs in health care is next to impossible when performing LGBT research because the "T" tends to get lumped in with the "LGB" individuals, and trans persons typically represent a very small number of the overall sample size. The majority of research in the last 20 years on LGB people has focused on

reducing barriers to health care services, but unfortunately there has been a significantly lesser amount of research on trans persons (Factor & Rothblum, 2008).

Trans persons should not be the only population of study with respect to their experiences in accessing health care services. Medical professionals should also be surveyed to see just how competent they are when it comes to knowledge about trans health care needs. In fact, in one study conducted between 1999 and 2000, 212 surveys were filled out by Program Directors of all US Internal Medicine Residencies aimed at determining how much training resident physicians received in order to deliver culturally competent health care (McGarry, Clarke, Landau & Cyr, 2008). The six vulnerable populations included: racial and ethnic minorities, non-English, speaking patients, lesbians, gay men, victims of domestic violence and patients with substance abuse problems. While it is interesting to see that specific training on lesbian health concerns rated the least important (McGarry et al., 2008), sadly, trans persons were not included in the list of “vulnerable” populations.

In an interview Dr. Tarn, a practitioner at the Sherbourne Health Centre in Toronto, he stated that, “There's a distinct lack of exposure, knowledge and training in the health-care system regarding issues for transgender and transsexual folks. A very typical story is, ‘I've had the same family doctor for years, and when I asked about gender treatment, I was asked to leave immediately.’” (Johne, 2006). A collaborative project launched in 2005 by The Council of Ontario Faculties of Medicine Supported by the Ontario Women’s Health Council has been working to integrate gender and sexuality into medical education. This project is a partnership of 6 medical schools in Ontario, the Council of Ontario Faculties of Medicine, and the Government of Ontario (Ontario Women’s Health Council) and they have created a website<sup>10</sup> which consists

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<sup>10</sup>See, [www.genderandhealth.ca](http://www.genderandhealth.ca)

of various online modules to educate medical professionals and students in Ontario on sexuality and gender diversity (Phillips, 2005). In the module called “A LBTTQI Health Primer”<sup>11</sup> there is only one small page called “Transgender Health Issues” that is not even updated<sup>12</sup>.

There is very little empirically based information about trans persons, especially with regards to basic health needs of trans youth. For example, Grossman and D’augelli (2006) performed a focus group study with 24 trans identified youth ranging in age from 15 to 20. Their focus was to explore factors (discrimination, marginalization) that affect the experiences of trans youth in the areas of physical and mental health. They found that trans youth noted problems such as helplessness and vulnerability in obtaining health care services due to reduced access to physical health services and insufficient resources to address mental health concerns (Grossman & D’augelli 2006). While this information is extremely valuable, it too was conducted in the United States and is entirely qualitative in nature.

It is clear that there are consistent findings about trans persons experiences of discrimination when accessing or attempting to access health care services in some select States in the USA, but what about in Ontario, Canada? Aside from Namaste’s (1995) qualitative study, Gapka, & Raj’s (2003) qualitative study, and TransPULSE’s (2010) province wide quantitative survey, there have not been any other studies that focus solely on trans persons’ health care needs and experiences through taking a mixed-methods approach like my research project.

TransPULSE has done a fine job at retrieving a large sample size (n=433), but they have yet to release all of their findings. Therefore, it is impossible to critique TransPULSE beyond the 2 e-

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<sup>11</sup> See, <http://www.genderandhealth.ca/en/modules/sexandsexuality/gss-intersex-issues-01.jsp>

<sup>12</sup> The page stated that Ontario doesn’t cover SRS, when in fact it has since 2008.

Bulletins they have posted summarizing a small amount of data on demographics (Bauer, et. al., 2010) and workplace discrimination (Bauer, et. al., 2011).<sup>13</sup>

Researchers state that there are stigmatizing conditions that trans persons face which contribute to a number of health disparities (Johnson, Mimiaga, & Bradford, 2008). In particular, social stigma has been linked with profound mental health consequences, such as feelings of shame and self-hatred that may lead to to suicide, depression, anxiety, substance abuse, and feelings of hopelessness that limit health-seeking behaviours (Meyer & Northridge, 2007). But what is missing from this canon of research is *how* and *why* trans persons accessing health care services are being discriminated against. Conducting studies that help to illuminate trans persons' experiences, needs and desires with health care is important because all citizens have the right to non-discriminatory<sup>14</sup> and knowledgeable access to health care services. Small, local and qualitative surveys are important, but national, quantitatively driven research on trans persons' health care needs is extremely important so that clear, accurate, and policy changing data can be gathered to help alter the discriminatory practices within the 2-sexed system in which health care services are currently operating.

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<sup>13</sup> Interestingly, as of August 1, 2011 [www.transpulse.ca](http://www.transpulse.ca) is no longer a working website.

<sup>14</sup> See Ontario Human Rights Commission Policy on preventing gender based harassment: <http://www.ohrc.on.ca/en/resources/Policies/sexgenhar/view>

## Chapter 2

### Results

Results from trans health studies typically quantify data in a very matter-of-fact way that tends to eliminate personal histories and individual narratives. The aim in this chapter is to analyze the data collected, both qualitative and quantitative, through discourse analysis and Interpretive Phenomenological Analysis (IPA) in order to draw attention to both the similarities and differences that trans persons experience when accessing health care in Ontario. Discourse analysis will be used to help analyze components of results specifically relating to language and the ways in which words like ‘transgender’ or ‘health’ are constructed through language (Willig, 2000). Discourse analysis has gained popularity in health related research because it “offers the potential to challenge our thinking about aspects of the reality of health and health care practice” (Cheek, 2004, p.1140). IPA will be used to compliment the social constructionist perspectives of discourse analysis by offering a clearer description of specific phenomena; for instance access to health care services for trans persons. IPA will ‘give voice’ to trans persons by allowing them to describe their experiences with health care access in an open-ended fashion online, which in turn allows me to interpret the participants’ experiences by ‘making sense’ of their claims through offering a critical analysis of their responses (Larkin, Watts & Clifton, 2006).<sup>15</sup>

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<sup>15</sup> My choice to use both IPA and discourse analysis (DA) stems from the mixed methods approach that enabled my survey to produce a rich amount of qualitative data alongside quantitative data. Analysis of language (DA) cannot *interpret* a person’s experiences; it can only analyze possible meanings and power relations, for example. Therefore IPA is used to deconstruct the answers to open-ended questions that allowed participants to write freely about specific feelings, needs and experiences as a trans person accessing health care services in Ontario.

The results of my study will be presented with a strong focus on key narratives that demonstrate the most diversity amongst the survey respondents. Additionally, I will engage in critical reflection of specific phenomena that were reported by participants such as, describing one's gender, legal name change, discriminatory behaviours of health care professionals, OHIP coverage for trans-specific needs and general health status of the participants. It is important to note that I, like many researchers (Mayer, Bradford & Makadon, 2008; Maher, et. al., 2008; Mulé et. al., 2009), acknowledge that more work needs to be done with trans populations to improve data collection that will aid in public health policy changes. My research is an additional, much needed study that adds to the paucity of trans health related research. As more research becomes available on sexual and gender minority populations, it becomes increasingly important as well to understand more specifically the health care concerns for LGBT of different race, class, age, and ability backgrounds (Mulé et. al., 2009). With this in mind, this chapter will pay close attention to the diverse experiences expressed by trans persons who answered the various sections of this survey concerning health care access.

## **PART A**

### **Participants**

There were differences in the number of eligible participants that fully completed the survey, versus those who discontinued the survey at various points. Since this bulk of the results will be analyzed qualitatively, I am including results for each major section only if the same number of participants completely answered from start to end of section.

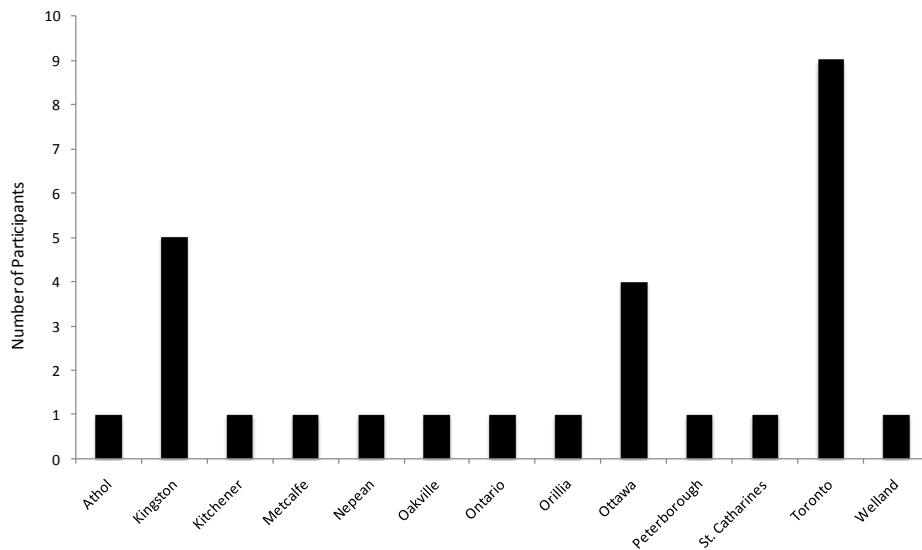
- Part A: Socio-Demographics, *N=26*
- Part B: Trans-Specific Questions, *N=21*
- Part C: Experiences with Ontario Health Care Services, *N=18*
- Part D: General Health Questions, *N=18*

## Socio-Demographics

Twenty-six participants fully completed the socio-demographics portion of my survey.

The mean age was 37, with a range of 19 to 77 years old. Nearly all of the participants selected English as their mother tongue; only three selected French and one chose Portuguese. Nine people identified with a religious community: two Protestant, one Jewish, one Christian-unspecified, one Buddhist, one Catholic, one Agnostic, one Spiritual, no label, and one Santeria/Lukumi Priestess.

The majority of the participants currently reside in Toronto and surrounding cities of Toronto. At the time of the survey completion one participant lived in a rural location (Metcalf, ON) and 5 in Kingston, ON (see Figure 1). Almost all of the participants were born in Canada (22), and very few were born outside of Canada: one in the United States, two in Western Europe and one from Latin/South America<sup>16</sup>.



**Figure 1. Current city of residence in the province of Ontario. (N=26)**

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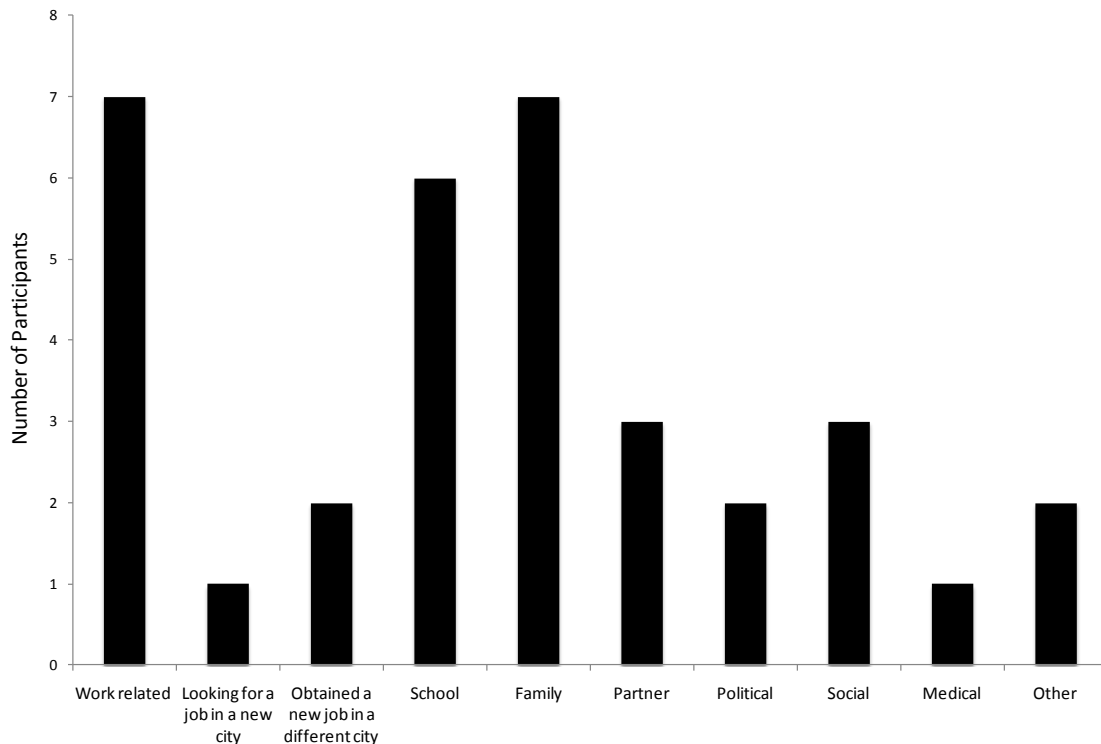
<sup>16</sup> Note: the participants born outside of Canada finished the survey completely

## **Geography**

To determine whether or not participants may have migrated from smaller cities to larger urban ones for easier and more knowledgeable access to trans health care, I asked participants to indicate which past three cities/countries they have lived in and for how long. I assumed that this question would help to determine whether or not trans persons have, (a) moved around a lot, (b) moved from smaller cities to larger ones, and/or (c) if they have moved, then what were their motivations for doing so.

I discovered that four of the 26 respondents previously lived outside of Canada prior to their present permanent residence (London, England; Rochester, USA; Copenhagen, Denmark; Lanciano, Italy). Six participants said they never have moved: one from Ottawa, one from Kingston and four from Toronto. The remaining 16 participants reported having lived in Canada their entire life thus far, with almost all having only ever resided in Ontario except for two participants. From this data I found that there were no major patterns of trans persons moving around a lot, or moving from smaller/rural cities to larger/urban ones.

For participants who stated that they have moved at least once, there was a follow up question asking about their motivations for moving. The majority of participants selected work, family, school and partner, respectively, as reasons they have moved. There was a list of several reasons participants could choose from, and they could select more than one option in the list (see Figure 2).



**Figure 2. Reasons participants endorsed for moving cities. (N=26)**

The most interesting result for me was that only one of the 26 respondents endorsed medical as a reason for relocating cities. From this sample of 26 respondents, medical/health was not a significant reason for trans persons to move. In fact, the majority of respondents currently reside in large urban cities that have access to trans specific health care services, such as Toronto, and Ottawa, therefore I would conclude that there is likely no motivation for these participants to move cities when looking specifically at health care access.

Part of my hypothesis was that trans persons might wish to move closer to a city that would have trans-accessible health care; however that assumes that participants are not currently living in such a city. I also expected that there would be data showing that participants lived in at

least a few different cities in the past, and as a result would demonstrate that participants have moved from smaller cities to larger ones if medical was a primary motivation for moving. This assumption was made because I anticipated recruiting participants from smaller cities in Ontario, and I knew that health care services for trans persons tend to be more accessible in urban cities (Oswald & Culton, 2003). However, as my results point out, my hypothesis was unable to be proven because almost all of the participants have only ever lived in a large city such as Toronto which has trans-accessible health care services like the Centre for Addiction and Mental Health (CAMH)<sup>17</sup> and the Sherbourne Health Centre<sup>18</sup>. Only one participant openly admitted that their motivation for moving cities from a smaller, suburban one to a large, urban one was due to “rejection and homelessness” (Respondent #25). Unfortunately, no other participants gave any specific details about their reasons for moving cities. Consequently, I cannot make any claims about health care being a motivation for moving cities given that many of the 26 respondents have not moved and almost all of them are currently residing in a large city that has trans-accessible services.

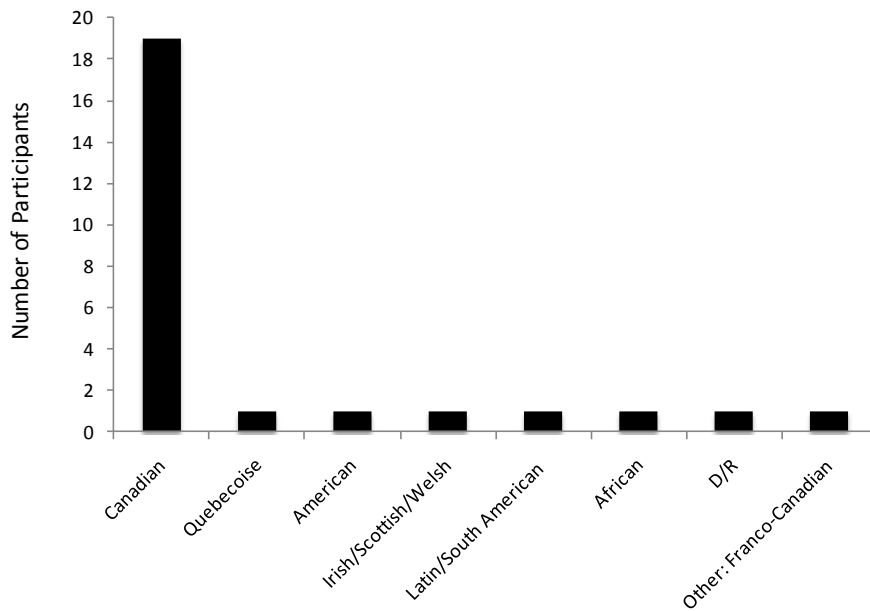
### **Race/Culture**

Over three-quarters of the participants identified their ethno-cultural heritage as “Canadian”. One person each identified as Quebecoise, Franco-Canadian, American, Irish/Scottish/Welsh, African, and Latin/South American (see Figure 3).

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<sup>17</sup> CAMH is the location of the Gender Identity Clinic where trans persons must enrol if they wish for OHIP to cover SRS. OHIP re-listed SRS in 2008 and CAMH was founded in 1998. See, [http://www.camh.net/About\\_CAMH/Guide\\_to\\_CAMH/Mental\\_Health\\_Programs/General\\_Psychiatry\\_Program/gid\\_guide\\_to\\_camh.html](http://www.camh.net/About_CAMH/Guide_to_CAMH/Mental_Health_Programs/General_Psychiatry_Program/gid_guide_to_camh.html)

<sup>18</sup> The Sherbourne Health Centre was established in 2003 to help serve the LGBT communities as well as under housed/homeless and newcomers to Canada in the southeast region of Toronto. See, <http://www.sherbourne.on.ca/about/about.html>.



**Figure 3. Participants’ ethno-cultural heritage. (N=26)**

In an attempt to challenge and re-define the white, western<sup>19</sup> narrative of trans persons, I decided to extend the question asking participants about their race/culture by allowing them to expand on whether or not their race/culture has influenced their experience of being trans, or experiences in general. Typically, most surveys include questions about participants’ demographic information; however they only allow participants to select from one pre-defined category rather than asking them to expand on how their ethno-cultural heritage may impact the researcher’s topic of investigation. Almost half (11/26) said that “yes”, their self-defined

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<sup>19</sup> I have seen in feminist, queer, trans, and anti-racist theory readings the use of both “western” and “Western”. I have intentionally chosen to use “western” with a lowercase “w” because my purpose is to not give the “western narrative” surrounding trans persons any more power than it already has. I analyze the results throughout this chapter by drawing attention to how the “west” has heavily influenced the meaning of words like trans, transsexual and transgender wherever appropriate and necessary in order to disrupt and challenge the existing canon of research and literature on trans persons in North America, and specifically in Ontario, Canada in this case.

race/culture has influenced their experience of being trans and experiences in general. One participant explained how their Jewish identity impacted their experiences of being a trans man.

The combination of Jewish/Trans is not unusual, and within both culturally and religiously Jewish (radical, lefty) community it has been relatively easy to find a welcome and people sharing those traits.

Growing up Jewish in Europe right after the War (with most of my extended family dead) WAS an experience of being part of a target group, and a pretty scared and scarred one! In Canada, on the other hand, as an adult, Jews are not a target group but a pretty highly privileged group. These two contrasting experiences have been influential especially in reinforcing the concept that discrimination is always dependent on the particular historical moment (Respondent #2).

Another participant acknowledged their white privilege as an American identified trans woman:

Being a white American, I would say that my racial/cultural identification has benefitted me in the sense that it is nothing unusual for Canadian/"Western" society to grant privilege based on skin color. While indeed my trans status has resulting on more than one occasion in persons questioning my legitimacy (as a woman, as a scientist, etc.), I recognize that I have a significant degree of privilege within the trans community, in part based on my racial/cultural identification. I have seen plenty of evidence that in Canada, a person of color deals with the legitimacy question on a significantly more regular basis. My comments above about experiencing white privilege would also stand in this more general case. Certainly I experienced that same privilege before I transitioned (Respondent #10).

Another participant discussed how their Latin/ South American cultural identity has impacted their “coming out” as trans and how white, western narratives provide a specific script or language in which to do so that does not translate in other cultures.

I'm a 'newcomer' (almost 10 yrs in Canada), so I didn't grow up with the concept of a trans man, or positive examples of trans

people. Obviously, a lot of North American trans people haven't either. Somewhat (more) rigid gender expectations also played a part. Language- lack of terms (how do you start thinking about stuff, if you don't have the language to do it?), language barriers (i.e. how do you 'come out' to your parents, knowing that there is very little support for people who don't speak English?) and assumptions around newcomers from service providers/LGBTQ community. [There is] quite a bit of racism/assumptions from the LGBTQ community, not to mention the 'whiteness' of [within the LGBTQ community] (Respondent #12).

A Canadian identified trans man gave an interesting comment about what it might have been like transitioning outside of Canada.

I have Romani background, and I wonder how I would have been seen in that culture. Being white affects how I see myself, if I'm 'allowed' to be transgender in Canada - i.e. whether it is stigmatized or not. Being Canadian, and how easy or not it is to change gender legally, socially, medically, etc. [has impacted my experiences as a trans person]. It is freakish/stigmatized in Canada generally. No supports for me (Respondent # 8).

Another participant acknowledged the language barriers trans persons face as a francophone identified Canadian trans man.

I cannot access trans+ health care services in French. The most significant of which was my inability, despite 4 years of advocacy and research, to access trans+ AND Francophone affirming mental health services. I did not know the French words to come out to my grand-parents, every June I have to decide between going to Pride ("in English") or St-Jean ("in French"). I often feel like I have to decide between being a francophone and being trans but seldom both at once even though that is who and what I am.

I found one bilingual psych that had some experience with trans clients. After doing an in-take explaining the importance of French to my life starting in childhood and of being able to discuss all aspects of my transition in my mother tongue, he asked me to respond to two questions in English. After which he

told me that given not only my fluency in English, but "lack" of accent (by which he showed his racism, as what he meant is that I swapped to an English Canadian accent) he told me that since I can pass as an English Canadian, that should be my desire and he would not see me again. The online trans forums I find are either based in France or Quebec, neither of which address the situation of being in a linguistic minority situation (Respondent #13).

Yet another participant commented on the language barrier that exists for French-speaking trans persons in Ontario by saying that:

It has been difficult to access services in French. Additionally, most of my friends were francophone, so finding people to relate to on a cultural level has been very difficult. I also have different notions of masculinity from my white anglophone friends (e.g. francophone men kiss on the cheek when saying hi). Being a linguistic minority is difficult: access to services, culture, representation, etc. (Respondent #21).

Lastly, one participant also acknowledged the privileges associated with being a white trans person who speaks English:

As a white, Welsh-Canadian, I'd argue that I had a much easier time than my trans friends of colour. Because I speak English, I was thorough indoctrinated in a very white/Anglophone trans discourse that, unlike other trans discourses around the world, strictly divides gender from sexuality. This allows me to see myself as both a queer woman and a trans woman (which is not to say that I couldn't do that in other cultures, but that the language and meanings of these things are fairly specific to white/Anglophone/North American trans discourse). Being white and Anglophone provided me with greater access to employment, among other things. I feel that this greatly shaped my trans experience. These narratives suggest that the participants are very aware of the racialization of trans bodies (Respondent #16).

The narratives from participants in my study help draw attention to the fact that trans persons of colour are underrepresented in research. It is refreshing to see that some of my

participants are aware of the privileges they experience based on their racial/cultural background, as well as the privileges they receive based on the language they speak. However, the acknowledgement of privilege based on race and language does not imply that white, English speaking trans persons don't experience discrimination for being trans. Later in this chapter I will discuss results that support the fact that trans persons experience discrimination based exclusively on their trans identity, but presently I will focus on results from my study about trans persons' ethno-cultural heritage to emphasize that trans persons of colour tend to be discriminated against *more*.

Trans researcher, Lombardi (2009), conducted research that supports my claim regarding trans persons of colour facing more discrimination than white trans persons. In her survey of 90 trans persons in California, Lombardi (2009) found that participants who identify as African-American reported the highest level of transphobic events in the past year, while white trans persons reported the lowest. According to the Boston Public Health Commission on LGBT Health (2002), "Black and Latino LGBT people are more likely to have poor health than other LGBT populations. Within Black and Latino communities, LGBT people are more likely to have poor health than straight/heterosexual (and non-transgender) Blacks and Latinos" (p. 1). Gapka & Raj (2003) similarly stated that trans persons of colour face unique and challenging barriers when accessing health care services because of the racism they may experience on top of transphobia. The combination of continual racism and transphobia can leave trans persons of colour more vulnerable to negative health outcomes than white trans persons (National Coalition for LGBT Health, n.d.). Future nation-wide health surveys, that already include questions about people's race/culture, need to incorporate demographic questions about gender identity so that disparities in access to health care can be uncovered concerning all trans persons, regardless of race.

In a documentary entitled *Still Black: A Portrait of Black Transmen*, one interviewee discussed the power/privilege shift that happens for a trans person transitioning when complicated by race. The interviewee, a self-identified FTM of colour, said that when a white biological male transitions to female, there is a decrease in power/privilege they experience in (western) society. The interviewee claims that for a white biological female transitioning to male there is an increase in power/privilege, but for a black biological woman transitioning to male, there is a decrease in power/privilege. He said that black men face more discrimination than black women because black men are “feared” whereas black women are not (Lora, 2008). The interviewee’s claim leaves out how the power/privilege would shift for a black biological man transitioning to female. Black feminist scholar bell hooks (1981) has asserted that:

No other group in America has so had their identity socialized out of existence as have black women. We are rarely recognized as a group separate and distinct from black men, or as part of the larger group “women” in this culture. When black people are talked about, sexism militates against the acknowledgement of the interests of black women; when women are talked about racism militates against a recognition of black female interests. When black people are talked about a focus tends to be on black *men*; and when women are talked about the focus tends to be on *white* women (p. 7).

So while the interviewee in *Still Black* feels that he has less power/privilege than white trans men, if a perspective like hooks’ is considered, then a black trans woman would be further marginalized and oppressed in comparison to a black trans man.

Interestingly, in a recent article entitled “Becoming a Black Man”, Louise Mitchell, a black trans man, explained that within a month of starting male hormones he said that he, “got pulled over 300 percent more than I had in the previous 23 years of driving, almost immediately. It was

astounding.” (Hernández, 2008, p. 39). Mitchell, like the interviewee in *Still Black* and the other black trans men in Hernández’s article are experiencing a very different transition than white trans men. London Dexter Ward summed up the major difference between white trans men and black trans men by stating that, “a white person who transitions to a male body “just becomes a man.” I became a Black man. I became the enemy.” (Hernández, 2008, p. 40). Hernández (2008) also explored transitioning for black trans women in her article and found that “the experience with racism is flipped in some ways for Black trans women” (p. 42). Monica Roberts, a Black trans woman, said that, “she is happy to no longer be considered a “suspect”, and has not been pulled over for “driving while Black”” (Hernández, 2008, p. 42). Roberts does attest though that, “people don’t see me as a trans woman. They see me as Black...and that’s the thing that people notice. The bottom line is, we’re black first.” (Hernández, 2008, p. 43). In contrast to the statement by Roberts in Hernández’s article, comedian, actor and activist, Wanda Sykes stated in an interview that she feels it is harder for her to be gay than black.

Yes, I believe that. I’m not talking about the history of African Americans. I’m talking about at this point right now...I don’t know of organizations and groups like Focus on the Family<sup>20</sup> and such anti-gay organizations who are putting so much money, millions and millions of dollars, into stopping me from being black or telling me I can’t exercise my blackness. There’s no equality for LGBT people. (She Said, 2011, p. 21).

So while there are different opinions and statements among racialized<sup>21</sup> groups of people, there is one common reality; race complicates gender.

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<sup>20</sup> Focus on the Family is a Christian based foundation that strongly opposes LGBT rights. See, [http://www.focusonthefamily.com/about\\_us.aspx](http://www.focusonthefamily.com/about_us.aspx)

<sup>21</sup> I use the term racialized as per The Ontario Human Rights Commission definition: “The Ontario Human Rights Commission describes communities facing racism as “racialized.” This is because society artificially constructs the idea of “race” based on geographic, historical, political, economic, social and cultural factors, as well as physical traits, that have no justification for notions of racial superiority or racial prejudice.” (OHRC, 2008)

Results from research studies on trans persons like Lombardi's (2009) and narratives such as the ones conveyed in *Still Black* and in "Becoming a Black Man", signal to me that trans theory and research needs to be critically complicated by stories outside of (white) North American discourse so that trans persons of colour are not underrepresented and consequently discriminated against more. This research is especially important in Ontario given that the province is experiencing huge demographic shifts. According to a recently published resource guide funded by the Government of Ontario and published by Health Nexus<sup>22</sup> and Health Equity Council<sup>23</sup> entitled: "Addressing Health Inequities for Racialized Communities", "it is estimated that by 2017, one in five people in Canada will belong to a community of colour. By 2017, more than half of Toronto's population will be people of colour." (Sankaran, 2011, p. 2). Combining this future demographic shift in Toronto with the fact that Toronto is the location of CAMH's Gender Identity Clinic for trans persons seeking trans related health care services, it seems imperative to me that research on health care access for trans persons of colour is conducted in order to better understand the needs and experiences of this specific population.

Trans theorist Bobby Nobel (2006) says that there needs to be a "disembodiment of whiteness and nation as universal signifiers" in trans discourse, and often intersectional frameworks are not engaged with in research methodologies involving trans populations (p.3). I attempted to do exactly what Nobel has critiqued in trans research but unfortunately the results did not manifest in terms of acquiring trans narratives from a racially diverse group of participants. However, upon reflection, the fact that I worded a question, "What race/culture do

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<sup>22</sup> Health Nexus is a health promotion specialist organization in funded by the Ontario government and Canadian government to promote community well-being and advocate for health promotion policy changes. See, [www.healthnexus.ca](http://www.healthnexus.ca).

<sup>23</sup> Health Equity Council is a Toronto, community-based organization focused on eliminating disparities and promoting health equity and diversity. See, [www.healthequitycouncil.ca](http://www.healthequitycouncil.ca)

you see yourself as most associated with?”, and included “Canadian” as a race/culture category, may have reduced my ability to discern racial difference if the participant most identified as being Canadian. I did follow-up with an open-ended question about how one’s race/culture identification may have impacted their experiences of being trans, but this made me reliant on two factors for drawing conclusions about the intersection of race and gender: (1) I assumed that participants would elaborate on their race/culture identification in subsequent questions, and (2) that the category “Canadian” signaled whiteness unless otherwise specified. I realize now through analyzing my results that the wording and the assumptions I made led to only 7 participants elaborating on how their race/culture has influenced their experience of being trans. It is possible that a trans person of colour may have identified as Canadian over another race/culture identity and I would therefore be unable to identify this respondent’s experiences of health care as being affected by their racial minority status; unless of course they elaborated specifically about this in their answer to the following question regarding the impact their race/culture identity has had on being trans identified.

One interesting point I would like to make with regard to my results is that the one participant who identified as African<sup>24</sup> said that “yes” their race/culture has impacted their experiences as a trans person, however they declined to elaborate on their personal experiences in the following open ended question. Perhaps this rejection of elaboration is due to the extreme racism and transphobia they have experienced, or perhaps it is simply due to the fact that they did not want to spend the time typing out their own personal experiences. Either way, it leaves a hole in my results that does not allow for a truly critical analysis of race and gender in my research.

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<sup>24</sup> I do not assume that because the participant has identified as African that they would be a trans person of colour. The entire continent of Africa has many races/cultures that make up its population, which is why I cannot make any analysis about how this individual’s race/culture has influenced their experiences as a trans person since they did not elaborate qualitatively on this question.

All of this speaks to the great need for further research and exploration of how race intersects with trans identities in order to better appreciate the discrimination trans persons of colour experience.

An interesting point I would like to make about the white, western discourse that informs much of trans persons narratives, is that the term “transgender/sexual” was created from a very medicalized, Euro-centric perspective. Later I will discuss in more detail some aspects of the medicalization and pathologization of trans persons, but currently I want to acknowledge the history of settler colonialism’s influence on gender-non conforming folks outside of white North America. Gender theorist Eve Shapiro (2010) clearly argues that settler colonialism is guilty of imposing names and labels on gender non-conforming Indigenous peoples. Shapiro calls on gender scholar, Vic Muñoz, to assert that “the pathology of Western gender and transgender paradigms have been mapped onto diverse gender and sexualities” (Shapiro, 2010, p. 67). In other words, the naming of non-conforming genders in North American Indigenous populations specifically reflects the ideology of white settlers who ‘discovered’ them (Shapiro, 2010). Shapiro (2006) continues to say that, “Almost everything that we know about gender non-conformity within Native American and Canadian tribes, for example, comes from the notes of White explorers as viewed through a lens that justified colonial racism” (p. 67).

In keeping up with the white, western narratives of trans persons in North America typically produced in western discourse, I want to briefly draw attention to Joanne Meyerowitz’s book *How Sex Changed: A History of Transsexuality in the United States*. Meyerowitz focused mainly on the time period between the 1950s through to the 1970s, drawing attention to

prominent figures in the medical field such as Harry Benjamin<sup>25</sup>, as well as “famous” (white) transsexuals, Christine Jorgenson and Lili Elbe<sup>26</sup>. Christine Jorgenson is almost certainly the most famous transsexual in American history. In 1952 Jorgenson made world news headlines that read: “Ex-GI becomes blonde beauty” (Meyerowitz, 2002). It was the first public press coverage of a person undergoing a sex change operation. Christine Jorgenson is an example of how transsexualism (MTF specifically) has been racialized in a very white, heteronormative, and feminine way. Jorgenson likely made history because she generated so much popularity in the press due to her conventional [white] beauty (Meyerowitz, 2002); she was a “blonde bombshell” to be precise (Stryker, 2008, p. 48). The history of transsexuality in North America has a specifically white narrative that influences the ways in which research and theory in western discourse have come to understand and be exposed to trans persons. Child and adolescent psychiatrist, Vernon A. Rosario (2009), discussed his experiences working with African-American trans youth and stated that these patients do not have a strong historical role model that they can relate to. Rosario (2009) recaps the historical development of transsexualism and the story of Christine Jorgenson as “a strong role model for an emerging transsexual community” in the 1950s, however Jorgenson portrayed the image of a transsexual woman as “feminine and classy” and this model “not only reinforced gender conventions but also heterosexuality and white ethnicity” (p. 298). Whether the history of trans persons is told through stories about Christine Jorgenson, through white settlers’ diaries, or through documentaries and articles about

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<sup>25</sup> Dr. Harry Benjamin (1885-1986) was one of the first doctors to work with trans persons and he created the Standards of Care for trans persons. The World Professional Association for Transgender Health (WPATH) was originally named after him. See, [www.wpath.org](http://www.wpath.org) and <http://www2.hu-berlin.de/sexology/GESUND/ARCHIV/COLLBEN.HTM>

<sup>26</sup> Lili Elbe (1882-1931) is a lesser known story of a MTF person who underwent one of the first known sex reassignment surgeries performed by Dr. Magnus Hirschfeld. Elbe apparently died of complications after her fifth surgery (Meyerowitz, 2002).

black trans men, there is still a need to further recognize the culturally specific way in which trans persons have been portrayed through western discourse so that it can be challenged and disrupted.

### **Immigration**

In addition to race I attempted to explore the experiences of trans immigrants. Only four out of 26 participants identified as an immigrant to Canada, and only one person, who was from Latin/South America, expanded on their experience:

It took me around 6 years to get mildly comfortable [in Canada], and deciding to stay in Canada is an ongoing process though. I was probably quite depressed at one point (never got a proper diagnosis [for being trans]), and accessing affordable mental health and positive medical services is/was a HUGE hassle (I do have OHIP), not to mention culturally appropriate and LGBTQ friendly [health services]. I moved here after High School, and I can still feel the impact of moving to a foreign country as a 'young adult'/youth. It took me a few years to re-think my life, take in new things, and go after my goals. For example, I wanted a career in communications (journalism, radio/tv), but I knew it would be really hard to compete with people who had English as their 1st language. So, I ended up in social services. And so on and so forth. It also took me a while to figure out how things work, feel less lost/helpless and trust my knowledge more (Respondent #12).

Respondent #12's remarks are similar to earlier comments from other respondents regarding their ethno/cultural heritage in that language is a large barrier to accessing health care in Ontario for some participants in my study. I am not going to critically engage in discourse around English versus non-English speaking trans persons because there are enough data in my research to fully investigate and compare the impact a participant's mother tongue has on their access to health care. I will recall here however that 2 French speaking participants made some succinct

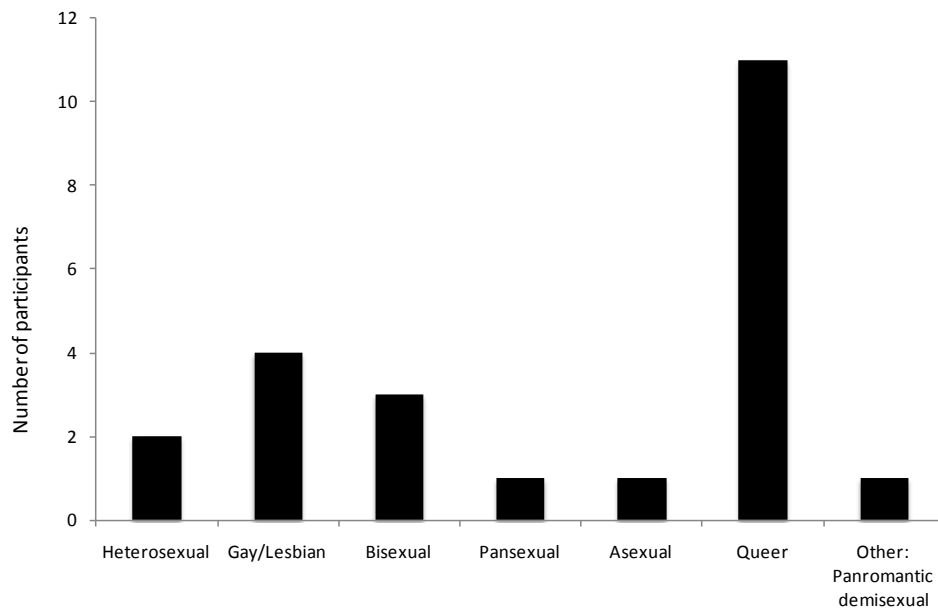
comments earlier in the Race/Culture section of this chapter about the ways in which Ontario's health care system is predominantly biased to English speaking folks.

It is also important to note that not all immigrants' experiences are alike. Those trans immigrants who are white and speak English as their first language would likely experience less discrimination than those trans immigrants whose first language is other than English. Again, my research has only scratched the surface of ways in which race, immigrant status, and language complicate understandings of trans persons' experiences accessing health care services, and their experiences overall in Ontario, Canada. In fact, trans researcher, Lombardi (2009), stated that, "the relationship between race, class, and transgender/transsexual status interrelate in regards to people's experience with discrimination" (Lombardi, 2009, p. 989). In other words, experiences of discrimination for trans persons is heavily impacted by race and class. I will discuss the ways in which class causes difficulties for trans persons accessing Ontario health care later on in this chapter in the section entitled: *Socio-economic Status*.

I want to briefly comment as well that I am aware of the fact that ability is another barrier, among many, to accessing health care services. I specifically chose not to investigate ability, or other categories of identity. Given the number of questions in my survey I chose to narrow my focus to questions on gender, race and class.

### **Sexual Orientation**

In a continued effort to disrupt how surveys with a quantitative focus ask questions that assume people must identify with a category such as, sex, gender, sexual orientation, etc., I chose to ask about participants' sexual orientation in a rather unique way; I asked: "Do you have a sexual orientation?". Out of 26 respondents all but one participant said, "yes". Out of those who responded yes, two selected "decline response" and the majority selected "queer" (see Figure 4).



**Figure 4. Sexual orientation. (n=23)**

I thought it was important to ask participants about their sexual orientation in a differential way in order to ensure that they understood that I see sexual orientation and gender identity as very distinct categories. Often trans persons’ sexuality is conflated with gender. For instance, the term transsexuality, said to have been coined by Magnus Hirschfeld in the early 1900s (Stryker, 2010), is sometimes conceptualized in research studies as a form of homosexuality (Lombardi, 2009). More specifically, the diagnosis of Gender Identity Disorder (GID) in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* that is used to “diagnose” trans persons specifically states in a section called *Specifiers* that:

For sexually mature individuals, the following specifiers may be noted based on the individual’s sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both, and Sexually Attracted to Neither**. Males with Gender Identity Disorder include substantial proportions with all four specifiers. Virtually all females with Gender Identity Disorder will receive the same specifier, Sexually

Attracted to Female, although there are exceptional cases involving females who are sexually Attracted to Males. (DSM-IV, 1994, p. 534)

This specifier is a major site of contention for many trans persons with regards to how sexuality is part of the “diagnosis” of GID. Removing the specifier of sexual orientation is proposed for the revised *DSM-V* due out May 2013<sup>27</sup>. The World Professional Association for Transgender Health’s (WPATH) Board of Directors commented on the proposed changes in the *DMS-V* by stating that:

The removal of the specifier of sexual orientation is a welcome change, acknowledging that gender identity and sexual orientation are two separate components of identity that are often conflated (e.g., Bockting, Benner, & Coleman, 2009); transgender individuals may be attracted to men, women, or other transgender persons, and their sexual orientation is of little or no consequence for making treatment decisions. (DeCuypere, G., Knudson G., & Bockting, W., 2010)

While I believe that it is important to view gender and sexuality as distinct, it is also equally important to be aware that there are persistent constraints on how individuals negotiate their sexual and gender identity because of culturally specific discourses surrounding sexual and gender diversity. I have already argued that the discourse around gender in terms of trans persons is distinctively western; this is also true of the discourse that dictates why and how people “come out” or “transition”. The narratives that perpetuate through much of North American research, literature, and cinema, portrays to a seemingly linear pattern or trajectory of (re)creating one’s sexual and gender identity; moving from one end of the sexual or gender spectrum to the opposite through stories about “coming out” or “transitioning”. The western narrative of “coming out” and “transitioning” is very scripted, regulated, white, and English. I wanted to disrupt this western

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<sup>27</sup> <http://www.dsm5.org/PROPOSEDREVISIONS/Pages/SexualandGenderIdentityDisorders.aspx>

discourse in my research by asking questions in a way that did not assume people ascribed to any specific category of sexuality or gender. By asking if participants *have* a sexual orientation, and to *describe* their gender enabled participants to speak freely about their gender and sexual orientation without imposing any predefined assumptions through western discourse about identity categories.

### **Gender**

The first question I asked regarding gender identity was open-ended so that participants did not have to pick a specific and pre-defined category of gender. The question plainly asked: “How would you describe your gender?”. Table 1 summarizes how 21 of the 26 participants responded when give the option to define their gender in an open-ended fashion.

Table 1  
*Subjective Definition of Gender by Respondents (n=21)*

Respondent	Gender Description
# 1	As female, born in the wrong body.
# 2	Complicated
# 3	Post op transsexual
# 4	I describe my gender as trans/female MTF
# 5	Female (mtf)
# 6	I consider myself to be a transwoman.
# 7	I live as a woman and see myself as a woman.
# 8	Messed up. Not cohesive. Difficult to know my gender because of social stigma, internalized transphobia. My gender is fluid. I don't like the term gender, because then it feels I have to choose something, when there isn't the language for it in English. Multi-gender might come close.
# 9	FTM transman

- # 10 I am a transgender woman. I was born male and I have taken female hormones for a few years now. I have also had hair removal, but I have had no other surgeries. I have no desire for SRS or "bottom" surgery. I am happy with my body as it is.
  - # 11 Masculine identified.
  - # 12 I'm 'trans'/transgender because I was born female, but I'm more comfortable living my life as a male. For the "outside'/larger world, I want to be seen as male. Boy/Man is a bit more tricky, male is what I'm aiming for right now. Even though I don't identify as "transsexual", I guess it also applies to me since I do plan on going on hormones/surgeries. Now, I also identify strongly as genderqueer. I don't come out as 'genderqueer' that often, because genderqueer is how I see/relate to myself. GQ is a bit of a private thing that I share with few people (and for educational/activism purposes). GQ is accepting/acknowledging my history, past and a few female characteristics (or spirit/side) that I have.
  - # 13 Whereas gender is not the same as sex, nor dependent on a identity of physiology, but rather the collection of habits, dress code, behaviour and interactions or performativity (to use Butler's preferred terminology), I identify my gender as geeky skater.
  - # 14 Fag-identified genderqueer transboy
  - # 15 Male.
  - # 16 To cis people, I identify as a woman, full-stop. To trans people, I identify as a trans woman, somewhat genderqueer-ish. I'm relatively feminine, but that changes with the seasons. Summer brings out my inner butch.
  - # 17 I would describe my gender as feminine, I feel a stronger connection with the women in my life than I do with males on a social and emotional level.
  - # 18 Neutrois. Not male or female or any amount of either of them.
  - # 19 Masculine, male.
  - # 20 Fluid. male and female.
  - # 21 I would describe it as a balanced slightly feminine, male-ish thing that is influenced by tons of things. Faggy, femmy, laid-back, male, and compassionate.
-

Following the open-ended question describing one’s gender, participants were then asked to identify with a predefined category by checking off any of the words they identified with. Table 2 illustrates that nearly all the 23/26 participants who responded to this question checked off more than one box.

Table 2  
*Frequency of Respondents Endorsing Any Gender Identity Category (N=23)*

Gender Identity Category	<i>n</i>	%
Woman/girl	12	52
Man/boy	10	43
Trans Woman/girl	8	35
Trans Man/boy	9	39
FTM	8	35
MTF	7	31
Trans	13	55
Transgender	16	67
Transsexual	10	43
Intersex	1	7
Crossdresser	1	7
Drag queen	0	0
Drag king	1	7
Bi-gender	2	11
Pan-gender	2	11
Two-spirit	0	0
Not exclusively male or female	4	19
Human Being	16	67
Other	3	15

As demonstrated by the results in Table 2, trans persons’ gender identities are not easily categorized into one neat little box. I am aware that the terms I included are mostly part of the

western discourse I critique with regards to trans persons, however, these words were chosen specifically because the research I conducted was situated in Ontario, Canada where white, English speaking residents predominate (Statistics Canada, 2006). Also, Ontario was selected specifically to conduct my research for two reasons: (1) Ontario is one of 2 provinces in Canada that covers sex reassignment surgeries for trans persons, and (2) my location as a student and full time resident in Ontario makes me familiar with Ontario's health care system.

Next, participants were presented with one last question regarding their gender. They were given the same set of words shown in Table 2 to choose from to describe their gender, except in this question they were asked to pick the one word they identify with \*most\* (see Table 3).

Table 3

*Frequency of Respondents Endorsing the One Gender Identity Category They \*Most\* Identify With (N=23)*

Gender Identity Category	<i>n</i>	%
Woman/girl	2	9
Man/boy	2	9
Trans Woman/girl	5	22
Trans Man/boy	4	17
FTM	2	9
MTF	1	4
Trans	2	9
Transgender	1	4
Transsexual	1	4
Intersex	0	0
Crossdresser	0	0
Drag queen	0	0
Drag king	0	0
Bi-gender	0	0
Pan-gender	0	0
Two-spirit	0	0
Not exclusively male or female	1	4
Human Being	1	4
Other: Neutrois	1	4
Decline Response	2	8

It is interesting to see that 16 out of the 23 (70%) who responded to this question picked a word within the category trans/transgender/transsexual when forced to select only *one* predefined word to describe their gender. In fact, through analyzing all the gender questions and incorporating answers regarding biological sex; I could place 10 participants as trans women (MTF) and 13 as

trans men (FTM), but that would defeat the whole purpose of my study's goal to disrupt trans categories of gender. However, it is worth mentioning only for the fact that all other research tends to categorize trans persons in this way - MTF or FTM? - with no allowance for anything in between or outside of predefined categories describing their gender.

My results help support the fact that participants, who earlier in the study self-identify mainly as white, Canadian, English speaking folks, understand the category of "transgender/sexual", and identify with it *most* when it is one of many gender categories to choose from. The 3 participants whose mother tongue was not English never selected a category with the word trans in it. Human being, not exclusively male or female and other: neutrois, were selected by participants where English is their second language. Trans theorist Susan Styrker (2010) says, "What counts as "transgender" varies as much as gender itself" (p. 92), so it is important to remain cognizant of the fact that the category of transgender does not have a fixed text book definition, but rather it is heavily influenced by white, western, medical discourse, and the English language. Another important note to make is that I purposefully did not include the word/label "Gender Identity Disorder" because of the history of medical intervention that is associated with the term.

It is crucial that any trans research such as this pay close attention to the politics and history of labels and definitions. Since the late 1940s, when endocrinological and surgical interventions to change sex were first utilized, "transsexualism" has situated itself predominantly in literature within western sciences. Within the scientific cannon of literature, some medical practitioners<sup>28</sup> advocate for the use of psychological methods directed at removing the

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<sup>28</sup> I am thinking specifically of Dr. Kenneth Zucker, lead psychologist at the Gender Identify Clinic for Children at CAMH whose "reparative therapy" has been criticized by fellow medical professionals specializing in helping trans persons transition. Zucker's approach to working with children who have GID

transsexual's "pathological" wishes and desires, while other practitioners aid in facilitating physical transition (i.e. hormone therapy and/or sex reassignment surgery). Historically the main focus of medical professionals was to ensure that identity, social status and biology matched, whereas today this is not always the goal or case for all trans persons. For example, those who identify as gender queer may not wish to seek physical or psychological intervention; they are satisfied with expressing their gender non-normatively without making any changes through surgery or hormones.

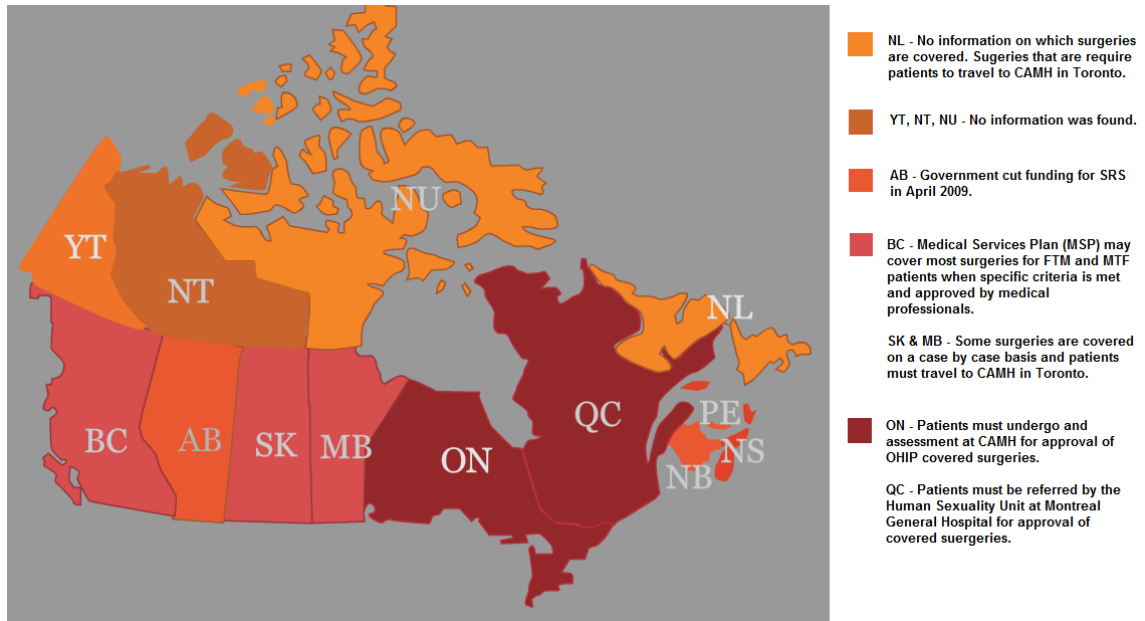
It is also important to note that it was medical experts who invented/created the diagnosis of GID and have used it to determine who can and who can't receive trans-specific medical care like sex reassignment surgery and hormone therapy. Only those persons deemed "valid cases" by medical professionals receive the diagnosis of "Gender Identity Disorder" in order to receive the medical treatments they desire in order to transition. In Ontario specifically it is Centre for Addictions and Mental Health (CAMH) located in Toronto, Ontario that decides whether or not trans persons' desired surgeries will be covered by OHIP. I will discuss this in more detail in the section entitled: *Refusal of Services in Ontario and Fulfillment of Trans Person's Health Care Needs*.

Some trans persons may not seek medical help to transition because they do not want to be pathologized with the diagnosis of GID. Conversely, some trans persons who disagree with the pathology of GID may still seek medical help in order to transition because the need and desire to transition outweighs the feeling of being pathologized (Winters, 2007). In Ontario the diagnosis of GID means that the majority of transitioning surgeries are covered by OHIP, so it can be financially motivating for many trans persons in Ontario to allow for the diagnosis of GID. In

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is to encourage children "to play and dress in a way that reflects their biological sex [which] may help them grow out of their GID" (Staley, 2011, p. 47).

fact, Ontario is one of only 2 provinces<sup>29</sup> in Canada that perform sex reassignment surgeries, and several other provinces that cover SRS require patients to travel to CAMH in Toronto, ON (see Figure 5).



**Figure 5. Map of Canada depicting the provinces and territories that cover sex reassignment surgeries through government funding. From [http://www.xtra.ca/BinaryContent/stories/77/06/7706/7706-SRS/212\\_SRS.swf](http://www.xtra.ca/BinaryContent/stories/77/06/7706/7706-SRS/212_SRS.swf). Map © 2009 Noreen Fagan, Pink Triangle Press.**

Trans persons who resist the medicalization of being trans primarily want to disassociate the pathology of being trans as having a “mental disorder”. Some trans persons, like Leslie Feinberg, oppose the label of GID all together. Feinberg (1998) articulates that, “I have always had a profound disagreement with the definition of transsexualism as a psychiatric condition and transsexuals as disordered people. My own transgendered state is a sacred calling given to me by

<sup>29</sup> *Montreal’s Centre Métropolitain De Chirurgie Plastique Inc.* in Quebec houses 2 of the 3 doctors in Canada that perform SRS (Staley, 2011).

Spirit, not a neurosis discovered by white medicine" (p. 63). Labeling people with a mental illness who do not think they are mentally ill is controlling and intrusive. If a trans person does not believe they are mentally ill and does not show any signs of impairments in daily functioning, then should GID be a medicalized condition? In many countries around the world medical interventions take place with respect to body modification such as tattoos, piercings, breast augmentation, face lifts and liposuction. How are any of these procedures different from when a trans person consciously decides to alter their body?

Despite the efforts of some trans-activists to lobby for the removal of GID from the upcoming fifth edition of the *Diagnostic Statistical Manual of Mental Disorders*, trans theorist Kate Bornstein identified some issues about removing it as a psychological category. Bornstein (1995) insists that "I am transsexual by choice, not by pathology" (p. 118). However, she points out that "the demedicalization of transsexuality would further limit surgery in this [western/USA] culture, as it would remove the label of 'illness' and so prohibit insurance companies from footing the bill." (p. 119) Therefore, some trans individuals are heavily invested in maintaining their status as 'diseased' individuals for insurance purposes. The demedicalization of transsexuality would likely terminate OHIP coverage of surgery if GID was removed from the *DSM-V*. My study did not specifically ask questions about participants' thoughts on the *DSM* and GID, but later on in the chapter I will discuss results from participants' disclosure of experiences with the Gender Identity Clinic at the Centre for Addiction and Mental Health in Toronto, Ontario.

The fact that many of my participants selected more than one gender category when given the option points out that perhaps the larger question should be: what is "pathological": the people who don't fit into a two-sexed system that insists on gender boxes of only male and female, or western society's insistence on those boxes? David Valentine's, *Imagining*

*Transgender: An Ethnography of a Category*, focuses on individuals in the late 1990s in New York City who resist the category/identity of transgender/transsexual. It is an essential part of western discourse to name things in order to understand them and talk about them. But when people resist categories like the participants in Valentine's ethnography, they tend to be questioned as to why they "choose" to do this. Resistance to categories is typically seen as a political act, but in the case of some of Valentine's participants it was simply that they did not know or ever hear the word transgender. The following interview from Valentine's ethnography depicts one way in which language can influence the category of transgender:

Anita: I identify myself as a drag queen, you know, and [laughs] and you know this is my lifestyle.

DV: You live as a woman.

Anita: I live as a woman everyday you know.

DV: Do you know what the term "transgender" means?

Anita: No

DV: You never heard it before?

Anita: No

DV: Um, boy, OK, do you know what transsexual means?

Anita: Transsexual means sex change right?

DV: Uh, yeah. You don't consider yourself to be transsexual?

Anita: No

DV: No, OK. But, and do you consider yourself to be a woman?

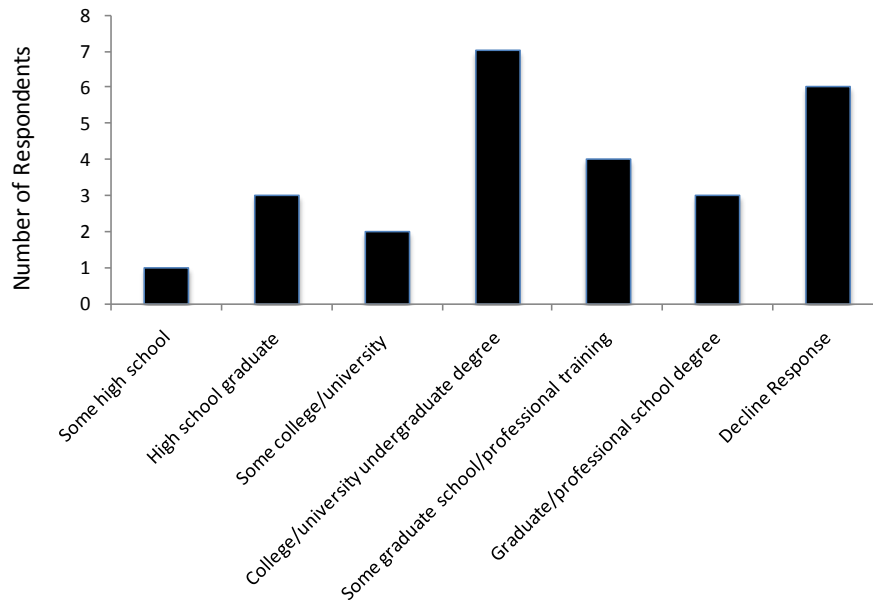
Anita: I consider... yes, yes, but I know what I – I know what I am, but I...I...you know, I treat myself like a woman, you know, I do everything like a woman. I act like a woman, I move like a woman. (p. 114-115)

Valentine's ethnography problematizes identity politics by showing that some individuals use sexuality as a signifier or description of their gender identity. As mentioned earlier, I view sexuality and gender as distinct categories; however participants in Valentine's study use "gay" to

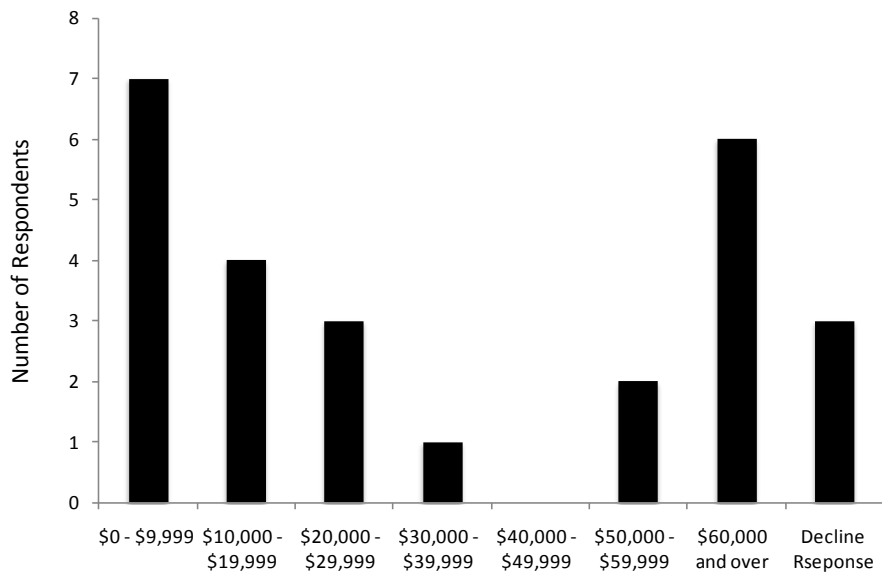
identify their gender instead of categories or words that typically fit in to the category of transgender. Valentine shows through his informants how the category of transgender has been institutionalized and the impact that this history has for the people who resist transgender as a category. He demonstrates throughout the text how the term transgender became a tool for social change while at the same time being problematic because of the ways in which the term has created a Euro-centric, white, middle-class representation that is not inclusive to all gender variant persons. Just because a word used in western discourse is read as belonging to the category of gender (i.e. transgender) and another word as belonging to the category of sexuality (i.e. gay), this does not mean that discourse around gender and sexuality cannot be disrupted and resituated in western research like mine. Categories of identity that fit comfortably within a white, western discourse should be challenged in trans research by framing questions in a way that does not assume any specific and predefined categories of identity. My research made small attempts to dislocate the western discourse surrounding gender and sexuality by asking participants to openly describe their gender and sexual orientation in their *own words*; however I did divide gender and sexuality as separate categories in order to find out how participants would define and describe themselves if presented with more than one category of identification. One participant sums up much of my analysis on gender by saying that, “I changed my name because I wanted a new name. I am taking [testosterone] because I want a more male body. These are not necessarily related to my gender, and [research] needs to avoid the whole causation/correlation thing here, and realize that people make medical/social/legal changes for many reasons. By using gender as the only explanation, it forces [trans persons] to adopt a medicalized narrative when discussing our gender.” (Respondent #21).

### Socio-economic Status

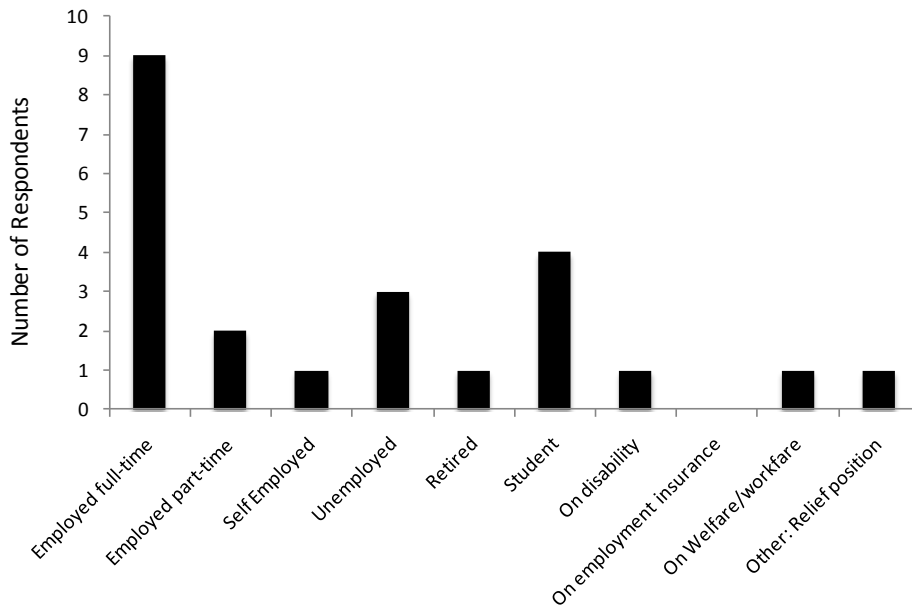
Questions regarding education (see Figure 6), income (see Figure 7), occupation (see Figure 8) and housing (see Figure 9) were asked to help situate the intersecting category of class with trans persons and their experiences in accessing Ontario health care services.



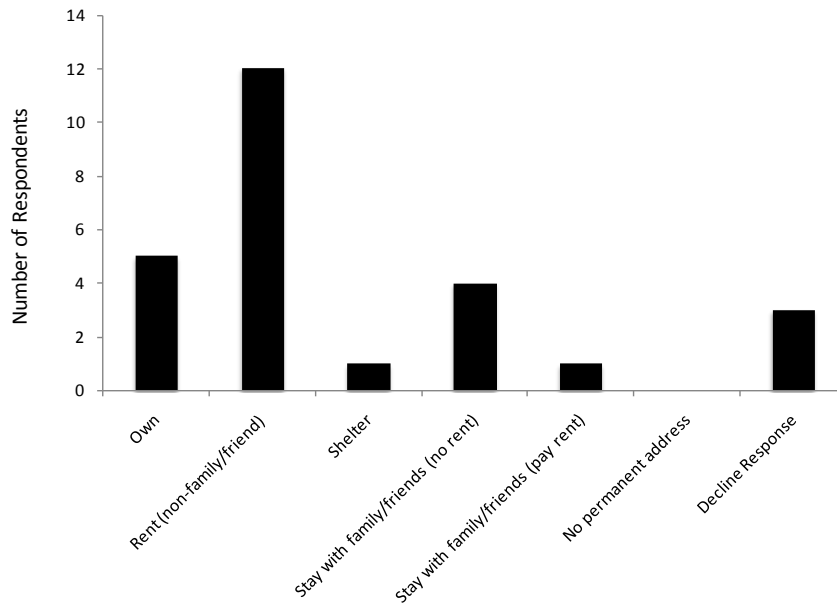
**Figure 6. Respondents' highest level of education (N=26)**



**Figure 7. Respondents' annual level of income (N=26)**



**Figure 8. Respondents' current occupational status (N=26)**



**Figure 9. Respondents' housing situation (N=26)**

More than half ( $n=23$ ) of the participants who responded have a college diploma or undergraduate university degree. Yet despite being well educated a significant number of respondents in my study live in poverty. Approximately 1/3 of participants are extremely poor with household incomes of less than \$9,999/year, while over 1/3 had healthy incomes over \$50,000/year. An interesting point to make here is that the five respondents<sup>30</sup> who make over \$60,000/year are all over 49 years old, and the two respondents<sup>31</sup> who make over \$50,000/year are in their early thirties. Two trans persons in their late forties/early fifties made less than \$9,999/year and the other six who make under \$9,999/year were between 19 and 29 years old. Additionally, 2/3 of the participants in my study make less than \$29,999/year.

Occupational statuses echoed incomes for the 23 participants who responded; over 1/3 of participants have a full-time job, three participants are unemployed, one participant is on

<sup>30</sup> Two FTM and three MTF.

<sup>31</sup> One FTM and one MTF.

welfare/workfare, one participant is on disability, and one participant works in a relief position<sup>32</sup> and makes less than \$9,999/year. Four participants are students, one identified as self-employed, and one said that they are comfortably retired with an income of over \$60,000/year. All the participants have some form of housing; over half rent, less than a quarter own, and one person lives in a shelter.

Similar to my results, the TransPULSE survey found that 50% of trans persons in Ontario make less than \$15,000/year even though more than half of the respondents had post-secondary education (Bauer, et. al., 2010, p. 1). The National Center for Transgender Equality and the National Gay and Lesbian Task Force launched a study in 2009 across all 50 states that had 6,450 trans persons respond to an extensive questionnaire. The results showed that 15% of their respondents had an income of \$10,000 or less/year, versus only 4% percent of the general US population (Grant, et. al., 2011, p.3).

It is clear from my study and other research that trans persons are living under the poverty line more so than the general population. An individual's income and socio-economic status can directly affect their ability to access to health care services, especially for trans persons despite health care services in Ontario being free for residences with an OHIP card. Also, the services specifically for trans persons that are covered, like some sex reassignment surgeries, are highly regulated by the Gender Identity Clinic at the Centre of Addiction and Mental Health in Toronto, Ontario. Therefore trans persons who do not wish to follow the rules instilled by the

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<sup>32</sup> The participant did not elaborate on what their relief position specifically entailed. This respondent lives in the Toronto area and typically relief work positions in this city involve working in youth and women's shelters, long term care facilities, or to cover shifts for employees on vacation or sick leave. See ad for relief position at: <http://www.workopolis.com/EN/job/13280892> for example. Interestingly, this participant is in their late 20s, identifies as an immigrant to Canada from Latin/South America and English is not their first language.

Gender Identity Clinic at CAMH would have to find alternative facilities for trans-specific care, and services at alternative facilities would likely be paid for out of pocket.

No provincial health insurance plan in Canada covers *all* the costs and procedures for transitioning<sup>33</sup> (see Figure 5). The full cost of transitioning, including elective surgeries, travel costs and hormones, is never entirely covered by private insurance or provincial health care. A research study analyzing the costs of sex reassignment surgeries and health care benefits with select companies in the USA in 2001 found that MTF surgeries averaged \$10,700 and \$17,900 for FTM (Horton & Chase, 2004, p. 11)<sup>34</sup>. Beyond SRS there can also be psychologist/counselor fees for some, hormone therapy, speech therapy, other surgical interventions like facial feminization and laser hair removal for MTF persons, chest contouring for FTM persons, and not to mention potential travel costs and even possibly a new wardrobe for many trans persons. There are also costs involved in changing legal documents to match one's new gender identity.

According to a recent publication, *Social Determinants of Health: The Canadian Facts*:

Income is perhaps the most important social determinant of health. Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use. In Canada, income

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<sup>33</sup> Ontario reinstated SRS coverage in 2008 (after 10 years of being delisted) See, [http://www.camh.net/Care\\_Treatment/Program\\_Descriptions/Mental\\_Health\\_Programs/Gender\\_Identity\\_Clinic/gender\\_identity\\_criteria\\_surgery.html](http://www.camh.net/Care_Treatment/Program_Descriptions/Mental_Health_Programs/Gender_Identity_Clinic/gender_identity_criteria_surgery.html). OHIP will cover for FTMs: Mastectomy, hysterectomy and chest contouring, and for MTFs: Penectomy, vaginoplasty and orchiectomy. *NOT* covered: hormones, oophorectomy (removal of ovaries), phalloplasty or metoidioplasty (creation of penis), scrotoplasty for FTMs, and Labiaplasty for MTFs. See interactive map of Canada and what is covered where: [http://www.xtra.ca/BinaryContent/stories/77/06/7706/7706-SRS/212\\_SRS.swf](http://www.xtra.ca/BinaryContent/stories/77/06/7706/7706-SRS/212_SRS.swf)

<sup>34</sup> There are not many research papers outlining the costs associated with transitioning. Upon search the Internet, I found one discussion on yahoo where a poster from Canada claimed that it cost \$80,000 and 4.5 years to transition from MTF. See, <http://ca.answers.yahoo.com/question/index?qid=20100609165633AADck2z> Additionally, a Bangkok plastic surgery clinic specializing in SRS outlined all the prices associated with specific surgeries for MTF and the costs if all were performed add up to well over \$100,000, not to mention the travel costs! See, <http://www.bangkokplasticsurgery.com/sex-change-surgery.html>

determines the quality of other social determinants of health such as food security, housing, and other basic prerequisites of health. (Mikkonen, & Raphael, 2010, p. 12).

My research alongside others mentioned previously supports the fact that trans persons suffer from lower incomes in comparison to the general public. Socio-economic status intersects with gender for trans persons in a pervasive way that can limit their ability to access health care services in Ontario. Examples to support this claim will be explored in Part C which is dedicated to examining the experiences of trans persons with Ontario health care services.

## **Part B**

### **Trans Specific Questions**

Twenty-one participants completed Part B of the survey on questions dedicated to trans specific information. Because my focus is on the experiences of trans persons accessing health care services in Ontario, only important questions were asked relating to legal gender/name change and experiences with trans specific services and resources they have accessed. There was no need to perpetuate a form of discrimination trans persons experience; being asked questions that are irrelevant to the research focus. For example, similar to the “Heterosexual Questionnaire”<sup>35</sup> (Rochlin , 2008), Skolnik & Anonymous’ (2008) “Privileges Held by Non-Trans People”<sup>36</sup> show how some questions trans persons are asked can be intrusive and unnecessary. For example, asking a trans person what their genitals look like is extremely unnecessary and invasive, especially when the research focus does not gain any practical and helpful information by asking

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<sup>35</sup> In 1972 Martin Rochlin created the “Heterosexual Questionnaire” to show how ridiculous and intrusive it is to ask homosexual people certain questions by swapping “homosexual” with heterosexual” in commonly asked questions to LGBT persons. For example, one question reads, “What do you think caused your heterosexuality” (Rochlin, 2008, p. 299).

<sup>36</sup>For example, some points in this article are: “My validity of a man/woman/human is not based upon how much surgery I’ve had or how well I “pass” as a non-transperson.”, “I am not expected to constantly defend my medical decisions.”, and “Strangers do not ask me what my “real name” [birth name] is and then assume they have a right to call me by that name” (Skolnik & Anonymous, 2008, p. 300-301).

this. My study remained focused on the research question at hand and did not ask questions that were needless and did not contribute to obtaining useful results.

When asked, “At what age did you first become aware you were trans”, the range was from as young as 3 years old to mid 50s. The average (16/21 people) response was in the age range of 5 to 16 years old. Similar to the participants in my study, Grossman and D’augelli (2006) reported that trans youth reported that they knew they were trans at puberty. This question is important to ask because if results from studies such as mine show that trans persons are aware of their desired gender at such a young age, then education on trans related topics such as health needs for medical professionals and gender diversity training for *all* health care service providers is imperative. Incorporating gender diversity issues in medical and social work curriculum would help inform youth and educators about trans persons’ experiences and perspectives.

### **Legal Gender/Name Change**

Access to health care in Ontario requires a person to have and present a health card when accessing services (Ontario Health Insurance Plan, n.d), but a health card that reflects a different gender than the patient presents can cause significant challenges. As a result this survey asked questions about whether or not respondents had legally changed their gender/name on government identification documents, including OHIP. It surprised me that when asked if participants had legally changed their name, only 8 said yes and 12 said no. When asked about other legal documents<sup>37</sup> only 4/21 participants said yes. Out of the 4 respondents who said yes, 2 people have changed OHIP, one just their birth certificate, and one participant has changed all of their legal documents (license, OHIP, birth certificate and passport).

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<sup>37</sup> driver’s license, birth certificate, OHIP, and passport

I was intrigued to find out why so few participants have changed identity documents legally. As it turns out there are costs involved in requesting a legal name change in Ontario for identification cards, as well as a lengthy amount of paperwork. In order to change your name legally in Ontario it costs \$137 and takes about 6 weeks to process the 17 page document (Ministry of Ontario Government Services, 2009). This document only allows individuals to select from “male or female” for the category of “sex” and you must have been living in Ontario for a minimum of 12 months with no criminal record in order to be eligible to change your name.

Changing one’s birth certificate information in Canada varies from province to province. A website created by a trans medical doctor, *Becky Allison, M.D.*, has a fairly complete set of details for legal gender and name change in various Canadian province and American states<sup>38</sup>. Ontario requires the following to change one’s name: the "Application to change an adult’s name", an original copy of your birth certificate, a signature of a guarantor, and a signature of a commissioner (Allison, n.d.). To change one’s sex designation in Ontario one must take the following steps: (1) contact the Registrar General’s office and request an "Application for Change of Sex Designation on Birth Registry" package which consists of three forms to be filled in, (2) obtain "Medical Certificate of Transsexual Surgery" from the doctor who performed the surgery, and (3) have another physician complete the "Medical Certificate to Substantiate Transsexual Surgery was Performed" form. The cost to have all these forms completed adds up to \$74 (Allison, n.d.).

Based on the research I conducted, it appears that there is no simple way to search for answers regarding legal gender/name change. For example, when searching for information on “name change” on the Ministry of Ontario’s website, the results returned were not informative to

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<sup>38</sup> See, <http://www.drbecky.com/birthcert.html> Also see, <http://www.tsroadmap.com/reality/name-change.html> for more information on the steps it takes to change your name legally.

trans persons; all the results link to name change applications in relation to marriage<sup>39</sup>. This investigation has not been included in any of the research I have found to date, making my survey a unique contribution to field of research on trans persons' experiences with Ontario health care services. The results from this section of my survey compounded with investigations on how to legally change one's gender/name demonstrates that poverty would significantly affect a trans person's ability to legally change their gender/name on government documentation. If gender is not a marker that can easily be changed on legal documents for trans persons, then their identification cards, like OHIP, would state a gender opposite to the one they are presenting. This could lead to discriminatory behaviours, whether intentional or not, if medical professionals see a different gender/name on a card versus what is presented in person. In fact, several respondents in my study stated that one common form of discrimination they have experienced with medical professionals is having someone use the wrong name/pronoun. Also, I feel it is safe to assume that if 66% of the participants in my study make less than \$29,999/year, budgeting for legal gender/name change on documents would be difficult. Another barrier to completing legal "sex designation" change for participants in my study would be that they need a medical doctor to substantiate through a signature on a medical form that "Transsexual Surgery was Performed" (Allison, n.d.), which means trans persons need to have undergone surgery altering their body in order to legally change their gender on their birth certificate, and subsequently their OHIP card. The majority of participants in my study have not sought or completed full gender reassignment surgery, which lends to why there were few respondents who have successfully and legally changed their gender/name on identification documents.

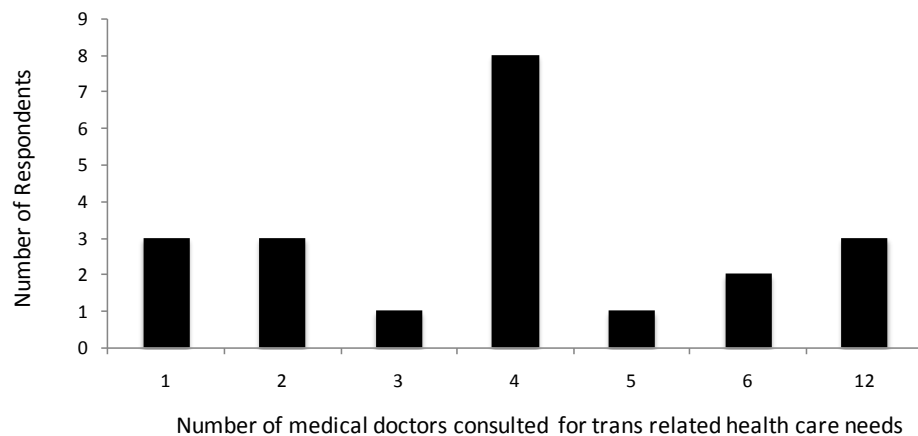
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<sup>39</sup> See, "Correcting the sex indicated on the birth certificate" on the website: [http://www.ontario.ca/en/information\\_bundle/individuals/119600.html](http://www.ontario.ca/en/information_bundle/individuals/119600.html)

One shortcoming in this section of my survey is that I did not ask why participants had not changed their legal name. For example, a more critical analysis could have been engaged if I knew whether their name/gender has not been changed due to cost, time, not having had surgery to obtain an official letter from a doctor, or if it was a conscious decision to not change any of their identity documents legally. In future trans health research I would recommend that scholars take note of the importance of gender/name change on identification documents for trans persons.

### **Interactions with Medical Professionals and Trans Related Services**

I was interested in asking participants how many medical doctors they have consulted in order to see if trans persons seek out care from several doctors before finding one who can actually help them fulfill their trans specific health needs. More than three-quarters of participants said that they have seen 4 or more medical doctors for trans-specific health needs, with a range from 1 to 12 (see Figure 10).



**Figure 10.** Number of medical doctors consulted for trans related health care needs (N=21)

I interpret these results as an indication that trans persons need to seek care from more doctors than cissexual persons because typically general practitioners are not as educated on trans-related health care needs. Therefore trans persons might seek help from many doctors until they have found one who understands their specific needs. In fact, there is a specialized document called *Standards of Care*<sup>40</sup> published by the World Professional Association for Transgender Health that is dedicated to assisting medical professionals in aiding trans persons with psychiatric, psychological, medical, and surgical health needs. There is no equivalent document for cissexual people, likely because there is an assumption in medical training that people who access health care are cissexual.

In an attempt to find out more about trans persons' interactions with medical services and professionals in Ontario, I asked participants about the types of sources of support for trans information they have accessed. I found that more than half of my respondents (12/21) used the Internet as their first resource and source support. Participants were given the opportunity to elaborate on the types of sources of support they have accessed for their trans specific needs.

#### ***Interactions with their own general practitioners (GP)***

Four respondents elaborated on their experiences with their own personal medical doctor. Overall, these participants were happy with their GP. One respondent who identified as Quebécoise said that they have experienced "excellent physiological health care, but I have to leave my cultural background (and by extension my mental health) in the waiting room." (Respondent # 13). Another respondent said that their "first GP was supportive but ignorant, the second also supportive but ignorant, and the third is a terrific experienced generalist with a strong interest in and knowledge of trans issues" (Respondent, #2). Finally, one respondent said that

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<sup>40</sup>See, [http://www.wpath.org/publications\\_standards.cfm](http://www.wpath.org/publications_standards.cfm)

their GP referred them to the Sherbourne Health Centre in Toronto and that it was the “best referral ever.” (Respondent #16). One respondent said that they have had “bad experiences” with all trans related services (Respondent #8) and unfortunately they did not elaborate any further on this.

The positive narratives are important to point out because research results typically focus on only the negative comments participants have in relation to health care access and services. Perhaps the positive experiences outlined by participants in my study are due to the length of time they have been seeing their GP, along with their age and class status. Of the four respondents, two are over 50 years old and all of them make an income over \$50,000/year. More research on specific experiences with trans persons’ personal medical doctors would be useful to help inform policy changes at the educational level for medical students. My study was generally focused on overall experiences that allowed participants to elaborate on specific instances that were important to them to discuss rather than having multiple questions on specific instances of experiences that may not have applied to all respondents.

### ***Interactions with other medical doctors***

The general consensus for respondents on this question was that medical doctors other than their own personal GP do not have much of an investment in knowing the participant and their trans specific needs. One respondent said that their experiences have been a “mixed bag” and that “surgeons mostly care for the money, so aftercare is usually mediocre.” (Respondent #13). Another explained that they “Saw two different doctors at the Sherbourne [Health Centre] and [they were] wonderful. Except [for the fact that] my current doctor tries to show me off to medical students because she says I'm so "well-adjusted. [A] bit weird.” (Respondent #16). These comments are not surprising given that much research shows that medical doctors to be

insensitive to trans persons (Mayer, et. al., 2008; Mulé, et. al., 2008; Lombardi, 2009; grant et. al., 2011).

### ***Interactions with social workers, counselors/therapists***

Only one respondent had feedback about their experience with a social worker. The participant stated that it was, “Horrible. She was the LGBT programs and resource officer, the 1st person I came out to as trans, and she told me never again to tell anyone or I would lose all of my LGBTQ friends, as well as my family.” (Respondent #13). Three respondents commented on accessing services from counselors/therapists and said that it was “Useful as an alternative and a less medicalized format than [sic] psychiatrists, but not covered by OHIP.” (Respondent #13). One respondent stated that counselors/therapists do not provide “quality service” (Respondent #8), and another said that they are “not knowledgeable regarding trans issues but well aware of how discrimination works.” (Respondent #4). These comments reiterate just how uninformed and uneducated health care professionals are when it comes to trans specific needs and concerns.

### ***Interactions with psychologists/psychiatrists***

Psychologists and psychiatrists play a very important role for trans persons, especially if they want to transition with surgery and hormones. In fact, one respondent (#17) stated that seeing a psychologist/psychiatrist is “required for an endocrinologist”. As mentioned earlier on in this chapter, CAMH is the “gatekeeper” for trans persons wishing to transition and have the expenses covered by OHIP. Part of the standards of care for trans persons to be “eligible” for surgery is they need to have an assessment by a psychiatrist and psychotherapy in order to be eligible for referral to an endocrinologist for surgery (WPATH, 2001). Additionally, for the “implementation

of the real-life experience<sup>41</sup> or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months.” (WPATH, 2001, p. 10). One participant elaborated on their frustrations with such policies and procedures through explaining that they had to see a psychologist because they “needed a letter to get hormones. [I am] very angry about this, but [the doctor] was fine. I saw him twice for 20 minutes each time and he wrote me the relevant letter of assessment, with which I could also access surgery if I should ever wish to.” (Respondent #2). Another participant similarly explains that they were “referred to CAMH for OHIP to cover surgery” (Respondent #7). Another participant said that they have “had tremendously positive and negative experiences [with psychologists/psychiatrists]. All of my interactions with CAMH were alternatively traumatic or useless. But there are some good [doctors] out there.” (Respondent # 13).

The participants in my study have no positive comments with regards to the Gender Identity Clinic at CAMH in Toronto. The reliance trans persons have on psychologists/psychiatrists to grant them permission to transition illustrates how a trans person’s desired gender becomes a pathological disorder. Again, the importance for health care professionals to be educated on trans specific health needs is extremely important, especially when some such as psychologist or psychiatrist is the only “valid” medical professional who has the power to “allow” trans persons the ability to undergo provincially funded surgery in Ontario.

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<sup>41</sup> “a person must live full time in the preferred gender for twelve months prior to genital surgery” (WPAH, 2001, p. 7)

### *Experiences with using the Internet as a resource*

I included the Internet as a resource because of its uncomplicated accessibility to trans specific information. Understanding that the Internet is a privilege and not everyone has access to it, I still included this question because my respondents were already accessing the Internet to take my survey in the first place. One participant explained that, “The Internet really contributed a lot into who I am as a person, and especially as a queer trans person” (Respondent #16). Another respondent simply stated that, “It’s my life line” (Respondent # 8). The Internet, while an excellent learning resource, cannot physically help a person transition. As one participant put it, “[there are] many great [resources] for those questioning their identity and whether or not to start [hormones] or get top surgery ... [but] as with anything else that is online, people feel they can be downright cruel from the safety of behind a screen.” (Respondent #13). So while the Internet is a popular first choice to seek help/find resources according to the participants in my study, it can also be a hostile place where discrimination and transphobia are still present. Asking about the Internet as a health resource is unique to my study because no other survey has investigated the impact of the Internet on trans health care and access. Even though I did not ask questions that elaborated on the use of the Internet as a trans specific resource, it is clear that if 12 out of 21 participants in my study used the Internet *first* as a source of information, then it is possible that trans persons’ needs and fulfillments about trans specific information and support are more easily and quickly satisfied through online sources over interactions with medical professionals.

### **Who is Covering Trans Related Services?**

More than half of the respondents who have accessed or are accessing trans-related services had to travel more than 50 KM to use some of the resources mentioned above (10/16). One person indicated going to Thailand for surgery, another traveled to three other countries for

health related services: Austin, TX, Paris, France and Copenhagen, Denmark. The rest indicated mainly traveling within Ontario for trans related health. Clearly class affects the types of services available to a trans person in Ontario. For example, one participant living in Ottawa specifically said that: “OHIP won't fund HRT if you don't go through CAMH, and I can't wait on them [OHIP] to get testosterone AND I can't afford to travel to Toronto.” Trans specific services accessed by respondents and how each service was paid for, OHIP, private insurer, or self, was quite varied (see Table 4).

Table 4

*Services/Treatments Participants Accessed/Accessing and How Services/Treatments Were/Are Paid For (n=19)*

Services/Treatment	<i>n</i> using service/treatment		Paid for by					
	<i>n</i>	%	<i>n</i> OHIP	%	<i>n</i> Private Insurer	%	<i>n</i> Self	%
Counseling/Therapy	14	77.78	2	14.29	4	28.57	8	57.14
Psychiatric/ Psychological Assessment	9	50.00	9	100.00	1	11.11	1	11.11
Hormonal Treatments	14	77.78	4	28.57	8	57.14	10	71.43
Electrolysis/ Speech Therapy	8	44.44	0	0.00	0	0.00	8	100.00
Surgical Interventions	3	16.67	2	66.67	0	0.00	2	66.67
Cosmetic Surgical interventions	1	5.56	0	0.00	0	0.00	1	100.00
Genital Reassignment Surgery	4	22.22	1	25.00	0	0.00	3	75.00

Results from my study show that genital reassignment surgery, despite being provincially covered by OHIP, was primarily funded by respondents themselves. Several reasons could account for this, such as coverage being delisted in 1998 and re-listed in 2008 (Ontario Ministry of Health, 2008). Since I did not ask the date of people's surgery, I cannot conclude whether or not OHIP is reliably accessible to trans persons based on my results. Instead I can only analyze the comments

made by participants in the next section. My results in this section can and should be used as a point of departure for future research that investigates trans persons' use and accessibility to OHIP funded services.

### **Refusal of Services in Ontario and the Fulfillment of Trans Persons' Health Care Needs**

The Gender Identity Clinic at the Centre for Addiction and Mental Health located in Toronto Ontario is the only medical institution that OHIP recognizes as a care facility for trans persons who wish to undergo surgical procedures to transition.

Sex-reassignment surgical procedures, including reconstruction of genitalia and mastectomy, are an insured benefit effective June 3, 2008 only if they are performed on patients who have completed the Gender Identity Clinic program operated by the Centre for Addiction and Mental Health and for whom the Clinic has recommended that surgery take place. (Ministry of Health and Long Term Care, 2008, p.1).

I have read a lot of comments on list-servs<sup>42</sup> and e-mails that correspond to participants' responses in my study; trans persons in Ontario are very critical of the role CAMH plays as the "gatekeeper" for trans persons wishing to transition and have the costs covered by OHIP. Many participants in my study have commented on their negative experiences with CAMH. Wanting to investigate more thoroughly the types of experiences trans persons have had in Ontario accessing health care, I asked about the types of health care services participants have accessed, and if they have been denied access to any of those services.

The key reasons participants outlined for being denied access to trans specific services, like hormones and surgery, almost all related to negative experiences with CAMH. Out of the 13 respondents in this section, six participants said they have not been refused any trans related

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<sup>42</sup> I have been a member of the trans advocacy Ontario group (trans-advocacy-ontario@googlegroups.com) for over 3 years. Much of the dialogue I have encountered criticizes and dislikes the guidelines and procedures that CAMH follows.

services and two of these respondents elaborated as to why that is. One participant explained that, “I have not been refused any treatments most likely due to the fact that I have not started my life as a woman and act as most males would when in public” (Respondent # 17). The other participant, who is an American immigrant to Canada, said that, “I have not been refused for any services as such, however I have been put on waitlists at multiple clinics to get a family doctor for my time in Canada and I have never gotten through (after living in Ontario for about 14 months) (Respondent #10). It is important to point out that those persons who have not been denied trans related health services vary broadly in age and income, so there is no correlation that I can draw between age, income, and access to trans related health services based on the results in this section. Future investigations would benefit from narratives about trans persons positive experiences with accessing health care services in order to unlock possible ways in which to alter the many ways in which health care services for trans persons in Ontario is discriminatory and inaccessible.

The participants who elaborated on their experiences of being denied trans specific services, the service that was universal throughout their comments was access to hormones and surgery. This line of questioning in my survey is slightly different than questions in other health related research in that I split up the questions pertaining to trans specific health care access and questions regarding general primary health care access. For example, the 2009 National Transgender Discrimination Survey across the USA found that 19% of their sample ( $n=6,450$ ) reported being refused medical care because they are trans (Grant, et. al., 2011, p. 6), however it did not specify if the service was trans specific or for general health care. I wanted to see if there was a difference in the frequency of discrimination and denial of access if the need was trans specific versus general. In other words, I assumed that if a trans person was seeing a medical

professional for hormones or surgery, there would be fewer instances of refusal of services because the service they are seeking is trans specific, and more importantly the doctor obviously specializes in trans related needs. Below I outline the participants' experiences of being denied trans specific services in Ontario and in Part C I discuss participants' experiences with general health care services.

Two respondents explained that their refusal of services related to their current health conditions. One participant said that, "I was delayed in starting hormone therapy due to situational depression diagnosed by my GP." (Respondent #6). Another participant who does not live close to Toronto said that, "At first [OHIP] wouldn't fund my hysterectomy, but because of bad health issues, they are now. OHIP won't fund HRT if you don't go through CAMH, and I can't wait on them to get testosterone AND I can't afford to travel to Toronto." (Respondent #5). It is important that trans persons' general health is up to par for them to be eligible for hormones and surgery. CAMH states as part of their guideline that, "we do not make determinations of medical eligibility, only psychiatric eligibility and readiness. Medical eligibility determination is made by the endocrinologist and/or surgeon. It is possible that you are eligible from a psychiatric perspective, but not a medical perspective." (CAMH, 2009).

Even though CAMH takes necessary precautions in terms of physical and mental health readiness for trans persons to transition, they are still the only ones in control of which trans persons get "certified" for transition in order to be eligible for OHIP to fund the surgeries. Having a monopoly such as CAMH does, makes it impossible to have different approaches, doctors or locations to helping trans persons in Ontario transition. As you will see in the comments below, participants in my study are fed up and angry with the hostile environment at CAMH's Gender Identity Clinic. One respondent elaborated in detail about their experience with CAMH.

My GP refused to prescribe my hormones. I found a Release of Liability form on the internet (I think from a gender clinic in Australia), initialed it everywhere, and only then would she prescribe them for me. She was, I suppose, afraid of being held liable in a medical area where there is no knowledge, no research, and so no idea what long term effects are. OHIP doesn't pay for double mastectomy, nor hysterectomy for trans people. The gynecologist (in Toronto) told me I had to get my hysterectomy done fast, because the province of Ontario was getting strict in not paying for trans men to get hysterectomies. So, this service was paid for by OHIP, because I was 'female' legally, and she wrote on the form the reason was a "polyp" - a benign tiny growth that would require an entire hysterectomy. So, I got this major surgery done way before I was ready, for fear that I would have to pay thousands of dollars for it later. I still mourn this fact. The only place I could have gone for OHIP coverage was CAMH in Toronto, and I would have to jump through their hoops in order to be dignified by them as 'truly trans' in order to get my double mastectomy paid for. CAMH treats trans people with contempt - they are extremely disrespectful, and treat us like we are pathologies to 'cure'. Friends of mine who have tried to go to CAMH have come out traumatized. I was not willing to put myself through this."  
(Respondent #8)

One participant bluntly said that. "I have not sought a double mastectomy because that would require me to go through the GID clinic at CAMH." (Respondent #9) and another stated that, "CAMH in Toronto has refused me hormone therapy on various counts." (Respondent #19). As the participants have noted, CAMH has only been discussed in an extremely negative and detestable light. Further investigation into CAMH's policies and procedures is imperative for trans persons in Ontario because it is the *only* institute that OHIP recognizes to have provincially funded surgeries. I think it is appalling that there is only one location for trans persons' to have access to for funded surgeries when OHIP is insurance that covers such surgeries in the entire province. Toronto is not the epicenter of Ontario and the government needs to recognize that trans persons should be entitled to services specific to their needs in *all* cities across Ontario.

Lastly, one participant sums up their multiple experiences of denial of trans related services beyond CAMH in Toronto.

[As a trans man I have been denied services for]: (1) Revision for the depression in my chest as a result of chest reconstruction. The original surgeon cited lack of experience, another said "you're very hairy, I know many trans men who would do anything to have as hairy of a chest, you can't have everything in life. You should consider seeing a psychiatrist." (2) Refills of testosterone by multiple pharmacists because it's a controlled substance. (3) A lab technician refused to do a vaginal ultrasound because I'm trans, doing instead a regular ultrasound, which is not nearly as good at detecting signs of uterine cancer. (Respondent #13)

So while CAMH is the most vilified health agency in my study for being the most inaccessible with respect to trans related services, there are also other services where denial of access occurs. These narratives from my participants help to strengthen the fact that there is a great need for competent trans education for all health care and medical professionals.

### **Challenges to Denial of Services**

Seven out of 21 participants have been refused trans specific services in my study and five have challenged their denial of care. One participant who was denied coverage for counseling therapy by a private insurer explained that, "The challenge will be through my therapist/psychologist. It will be initiated shortly. Outcome is unknown at this time." (Respondent #3). The participant whose GP denied them access to hormones because of their situational depression said that, "I persisted on the grounds that the refusal made my depression worse. My GP consulted with others that had more experience with [hormone therapy] and she consented as long as my depression did not get worse." (Respondent #6). One participant explained that they took matters into their own

hands after their GP denied them access to hormones. They said that, “I gave my GP a signed release of liability. She prescribes me hormones, but [she said she would] take no responsibility for my health. She is not friendly, which makes going to her for other needs difficult, and so I don't go when I should.” (Respondent #8). This comment shows how uninformed, unwilling and hostile some medical doctors can be with regards to helping trans patients fulfill their health needs.

Yet another example of the difficulty trans persons face accessing trans specific services was outlined by this participant's comment regarding their refusal to have revisions done to their chest in order to fix a depression caused from their initial chest reconstructive surgery.

I [finally] found a third surgeon willing to do a revision to my chest. I had my GP call the pharmacies, confirm my prescriptions and turned the computer screen to prove I was not requesting a refill too early according to the pharmacy's own records. I did not dispute the regular ultrasound, because I had already been humiliated in the waiting room and I was extremely dysphoric about my uterus.” (Respondent #13).

Finally, one participant who has been refused services from CAMH asked their GP to help review the policies at CAMH and is investigating their “rights to health care.” (Respondent #19).

Expecting a mixed bag of results regarding trans persons' experiences with access to trans specific services, I asked participants if they have received all the trans related health care they need. Only six out of 21 said yes. Certainly if over two-thirds of trans persons in my study said that they have not received all the trans-health care they need, then there are clearly systemic barriers at work in Ontario's health care system. Participants were able to openly explain why they felt that they have not received all the health care they need. This is unique to my study in comparison to other research because it is a question that is often asked in a closed fashion way. By giving participants the opportunity to subjectively explain anonymously why they feel they

are not getting the care they deserve allows for very candid responses that are not typically part of published health care research. For example, this unique response from one participant would likely never show up in a results section of health care research because they would be considered an outlier based on their age. This respondent is a 77 year old MTF and has been married for over 50 years and explained that she has not received all the trans related care she needs because:

Partially not asked for [referring to SRS specifically] because of marriage situation. Were I to transition completely, something I feel I need to live a complete life, I would end up divorced. I could not bear to lose my wife of over 50 years. I love her more deeply than I can possibly explain. (Respondent #1).

Other responses included: “Because trans people are never taken seriously” (Respondent #4), and “because I’m young.” (Respondent #19). Three participants explained that the waiting lists are too long to receive a diagnosis from CAMH and that, “Even in Toronto it seems there are not enough doctors who are able to assist with trans healthcare.” (Respondent #10). Another participant said that, “OHIP should not require one to ONLY go through CAMH and follow their outdated procedures to get Sexual Reassignment Surgery” (Respondent #7).

Another major reason my participants feel that they have not received all the trans related care they need is due to transphobia. One participant stated that:

Systemic transphobia, lack of training by medical professionals, lack of support by hospitals for doctors to learn/try new things (thinking of urologists here but other specialists as well). I'm told things have greatly improved at CAMH, Dr. [name removed] has mostly retired (will still be called upon for long distance appointments) and [name removed] has retired as well. But there needs to be more than 1 assessment centre for SRS, **more trans+ family physicians throughout the province so many of us can leave Toronto and many more can avoid moving here just for health care.** (Respondent #13).

Another participant discussed transphobia, moving cities, and CAMH as barriers to getting health care through describing that, “I am finding it difficult to find trans friendly primary care in a new city, and I am afraid of facing transphobia from medical professionals. I have not sought SRS because I cannot afford it, and will likely be turned down by CAMH for being gay” (Respondent #15). The most compelling, well argued, and impactful answer I received was:

Gatekeeping folk who know nothing about trans health would rather I bind 12 hours a day, break some ribs, than pay for my top surgery. The state is incompetent and people are going to keep dying and put even more of a strain on the health care system if they keep this up. Universal health care? [only] if you are a cisgender, hetero, white, able-bodied, anglophone, [then] maybe.” (Respondent #21).

Respondent #21’s comment completely envelopes all the important points I am making about the ways in which access to health care for trans persons is entirely dependent on the ways in which their gender intersects with race, class, ability, sexuality and language. The comments in this section are new and vital to the field of research on trans persons’ access to health care services in Ontario.

Despite the fact that my study had a small sample size, it is still powerful in drawing attention to trans persons’ experiences with accessing Ontario health care services. Descriptions given by participants indicate that not all trans persons are able to access health services easily. In my study, trans persons face several barriers such as: institutional barriers from places like CAMH due to their strict policies and procedures, socio-economic barriers because not all of the participants have the disposable income to afford trans-specific services, and language barriers that make it difficult for some participants to communicate their trans-specific needs in a predominately English based health care system in Ontario. The overwhelming majority of

participants in my study that have not received all the trans-related health care they need clearly supports my hypothesis that trans persons are faced with multiple barriers when attempting to access Ontario health care services. The next section of my research is dedicated to exploring the types of discrimination trans persons have faced when accessing Ontario health care services.

## **Part C**

### **Experiences with Ontario Health Care Services**

Twenty-one participants started to answer questions in this section about experiences with accessing Ontario health-care services and 18 completed to the end of the section.

Out of the 18 participants, only one person has not accessed Ontario health care services within the last year. The most popular medical professional participants have accessed is a family physician (10 out of 18 participants), followed by a general health center (3), the Sherbourne Health Centre in Toronto (2), emergency hospital (1), psychologist (1), and counselor (1). Almost all the participants have a regular family doctor (16/18); one person claims to seek regular health care from “whoever is available” and one person says that they go to a walk-in clinic in their neighbourhood if they are sick.

I asked if participants are “out as trans” to health care professionals and found that 16 out of 18 say they are, one participant is not, and one participant declined response. I also asked participants whether or not the medical professional they seek care from most often is knowledgeable about their trans specific health care needs; 11 out of 18 said yes and 7 out of 18 said that *they*, the respondents, had to educate the medical professional on their trans specific health needs. Participants also rated their first experience of accessing general health care services as a trans person; 9/18 rated it as a positive experience, 6/18 as a neutral experience, and 4/18 as a

negative experience. These results indicate a slight difference in the participants' experiences with trans related service and general health care services. Again, it is important to mention that the participants who have had positive experiences enjoy a mid-class yearly salary, which likely contributes to their positive experiences. Based on the results from the previous section, trans persons in my study have had more negative experiences accessing trans specific services than they have with general health services. In order to investigate this further, I asked participants about the medical professionals they are experiencing discrimination from.

### **Discrimination from Medical Professionals in Primary Health Care Services**

In order to uncover why trans persons have had negative experiences accessing primary health care, I asked participants if they have ever been discriminated against because of their trans identity by a medical professional; 8 out of 18 participants said “yes”. Nurses were the largest group in the medical profession who acted in a discriminatory fashion towards trans persons in my study, followed by general practitioners and medical doctors at walk-in clinics and hospitals (see Table 5).

Table 5

*Discrimination Faced by Trans Persons from Medical Professionals (n=8)*

Medical Professional	<i>n</i>	%
GP/Family Doctor	4	50.00%
MD at Hospital	3	37.50%
MD at walk-in clinic	3	37.50%
Psychiatrist	2	25.00%
Psychologist	1	12.50%
Nurse	6	75.00%

Next, I asked if participants have ever been denied access from a specific professional in health care and 3 out of 18 said yes; by a cardiologist, a lab technician and a nurse. One respondent

actually remarked that they had to travel from Toronto all the way to Phoenix, AZ to obtain the service they were seeking. Again, these results differ slightly from the results on trans specific services being denied to participants. Seven participants have been denied trans specific services versus three for general health services. I understand that my sample is small, but these results are interesting because I expected that more discrimination and refusal of care would take place in general health care access settings because the majority of general practitioners are not trained in trans related issues in the same way a medical professionals working specifically with trans persons would be. These results again point out that more research needs to be conducted on the needs and fulfillments of trans persons accessing Ontario health care services, especially with respect to the policies and procedures at the Gender Identity Clinic at CAMH.

Unfortunately the survey did not ask about specific details of access denial by medical professionals. It would have been useful to find out what the participants account of their experience was with the medical professional. For example, asking more about what the health care professional said and what the participant's reaction was would have given a more detailed explanation of what a trans person's encounters are like with medical professionals from a subjective point of view. I did, however, ask about some typical types of discriminatory behaviours that respondents may have encountered, and in this section of the survey participants were able to elaborate on instances of discrimination in more detail (see Table 6).

Table 6

*Types of Discriminatory Behaviours Experienced (n=8)*

Discriminatory Behaviours Experienced	<i>n</i>	%
Laughed at	3	37.50
Pointed at	2	25.00
Stared at	5	62.50
Ignored	5	62.50
Denied care	3	37.50
Wrong name used	5	62.50
Incorrect pronoun used	6	75.00
Unnecessary questions asked	6	75.00
Derogatory name	1	12.50
Didn't answer health care concerns	5	62.50
Referred elsewhere for health care despite the fact that the medical professional and place could have addressed your concern	5	62.50

Some participants gave subjective accounts of their experiences of discrimination. One participant said that,

Oh you're the first transsexual I've ever seen (excitedly). We hope you understand that this (hormones) is an extremely controversial treatment. We advise you to stop it (a few hours after a heart attack). They wouldn't advise a cisgender man to undergo castration in a similar circumstance, eh? [Also, having a] stream of medical students coming in to check me out. (Respondent #2).

Two participants elaborated on people using the wrong pronoun. One said that, “On occasion, I get referred to as Sir even though it is clear I present as female.” (Respondent #3) and another stated, “Having a Dr. at CAMH ask for "her" chart when asking for my chart. It was done quietly,

but still in front of me.” (Respondent #11). The sheer ignorance of medical professionals is shown through these comments and is reinforced by the following participants’ experiences.

The worst is the waiting area at Emergency and them calling out your male name or using Mr. or male pronouns. If you were not the centre of attention before this, you certainly were after as everyone stares and you hear them say "I told you so" as they speak to each other. Also I was told by staff that my prescription from their hospital was a fake in their hospital. My doctor addressed the issue. (Respondent #6)

Doctor at sleep lab asked why I was taking testosterone, I explained I was a transsexual, he got flustered and starting asking me questions about my genitals and when I wanted to get surgery, I told him that wasn't relevant to my sleeping problems and he told me to stop wasting his time, and answer his questions. (Respondent #15)

My old GP sent me to CAMH without even researching anything; she didn't want to deal with my issues. Because she was ignorant and neglected my concerns I got a new GP. People have called me she and my old female name even though I've expressed that I'm male and prefer my male name. Prior to my legal name change medical persons would give me really odd looks when they saw my birth name, because I appear male. (Respondent # 19)

These narratives are important to point out instead of just throwing out statistics on the percentage of trans persons who experience discrimination by medical professionals when accessing health care services. Through presenting the subjective experiences of trans persons, the statistics become humanized and carry more clout in terms of making real changes to education for medical professionals and health care institutional policies.

Two standardized questionnaires were incorporated in my survey: The “Patients’ Reactions Assessment” which is composed of questions designed to measure the affective quality of doctor-patient interactions (Galassi, Schanberg & Ware, 1992), and the “Medical Avoidance Survey” which is composed of questions to assess the extent to which patients’ avoid medical

treatment due to fear of various procedures or anticipated (negative) outcomes (Kleinknecht, Thorndike, & Wells, 1996). However, because the sample size is too low to make significant claims, I will only comment on some key findings from the “Medical Avoidance Survey” (MAS) purely for interest sake. Participants were given 21 items to rate on a zero to four scale with zero being: “I have never, and would not avoid medical treatment for this reason”, and four being: “I have avoided for this reason in the past and at this time I do not think I can go because of it.” (MAS; Kleinknecht, Thorndike, & Wells, 1996).

The MAS item “Embarrassment over having to expose your body” is of interest to mention because trans persons may feel anxious about the physical appearance of their body if it is not congruent with what they want and desire. Embarrassment over having to expose one’s body can be read as fear of discrimination, or alienation from medical professionals, especially if medical professional are uneducated in terms of trans persons specific needs. Eleven out of 17 participants have at least thought about avoiding seeking care, to having fully avoided seeking health care due to embarrassment over having to expose their body. As well, over half (9/17) have thought about avoiding to having fully avoided seeking care due to the “cost of medicine”. My results, while only descriptive in nature, support the fact that trans persons avoid seeking health care due to barriers such as socio-economic status and fear of discrimination from medical professionals. Based on the data I have gathered, it is clear that there needs to be more research and education for trans persons’ health care needs and requirements in Ontario’s health care system. In fact one participant articulated that, “Trans people avoid medical care because so many medical persons are uneducated about our condition, if medical professionals were trained then perhaps trans persons would feel more comfortable getting their medical needs met.” (Respondent # 8).

My results here are similar to many other studies. The National Transgender Discrimination Survey (2009) found 28% of respondents postponed care when they were sick or injured due to anticipated discrimination, and 48% postponed care because they could not afford it (Grant, et. al., 2011, p. 6).

## Part D

### General Health Questions

I asked participants about the status of their overall health in order to find out about any physical and mental health conditions from a more general perspective. Over half (11/18) of the participants said they have a medical or psychological condition (see Table 7).

Table 7

#### *Current Self-described and Diagnosed Medical or Psychological Condition and Treatment*

Condition			
Self-reported	Diagnosed	Diagnosed by	Treatment
Gender dysphoria, recent heart bypass surgery.	Gender dysphoria, heart disease	Psychiatrist, cardiologist	ASA, Ratio-Omeprazole, Teva-Metropolol
Heart disease	Heart disease	Medical doctors	Statin, beta blocker, ace-inhibitor
Ongoing hormonal treatment	Gender dysphoria and ongoing treatment following gender reassignment surgery	Therapist and endocrinologist	Estrogen and progesterone
Pain in genital area. Still dealing with depression, although not as severely.	Gender Identity disorder, situational depression, heart condition since depression.	N/A	Estrace, Spiroton, Mirtazapine, Ratio-Lenoltec
Post-traumatic stress disorder	PTSD	Psychologist	Effexor
Transposition of the great arteries (TGA), bipolar, asthma, dishyrotic eczema	TGA, bipolar disorder, dishyrotic eczema	Cardiologist, psychologist, dermatologist	Digoxin, vasotec, cardizem, sotalol, symbicort, warfarin, corticosteroids
Occasional light-headedness.	Low blood pressure	Medical doctor	N/A
I am mid-process of phalloplasty and scrotoplasty.	Gender Identity Disorder	GID: Therapist & endocrinologist	Deladestryl testosterone usually but I had to stop it for surgery
Seasonal affective disorder, back pain, sleep apnea	Sleep apnea	Medical doctor	N/A
Borderline personality disorder	Borderline P.D.	Psychologist	Seroquil, clonazapam
Reproductive health issues. Anxiety (GAD).	Cysts on ovaries, endometriosis. GAD.	Medical doctor	N/A

Table 7 showed that trans persons in my study have a wide range of physical and mental health care needs that are far beyond their identity as a trans person. This information is important because it helps to validate the vast need for education and policies in Ontario's health care system to enforce treatment of human beings first. Discriminatory practices towards trans persons have shown to be pervasive in Ontario's health care system in my study and this needs to be dismantled. Only through more research and informed education for health care professionals will trans persons' needs and desires be met when accessing health care services in Ontario. In fact, one participant elaborated on how education is needed and would be useful based on their personal experience with needing primary medical attention.

I had a hemorrhoid, and went to see a nurse practitioner at my GP's office. She told me to pull my pants down, I did, she looked and quickly jumped back 3 feet because she saw my genitalia did not match my appearance. She quickly prescribed me extremely expensive cream, and ran away. This is only one example of many funny (not so at the time) experiences I have had with doctors, nurses, ward clerks/receptionists, etc. (Respondent #8).

Respondent #8 continued to say that education would be important because of situations like this, however, "It depends if [education] is in a trans-hating (i.e. pathology) or helping [way]. The research first has to be done on trans medical needs. It hasn't been done. It would help if [medical doctors] were taught that we are humans." Another participant echoes this comment by stating that, "the paucity of trans health information that's available to GPs [is absurd]. The fact there is only one clinic in the entire province who can diagnose GID for the purposes of obtaining SRS." (Respondent #9). I feel that it is high time for Ontario to initiate policies that discourage discriminatory behaviours towards trans persons accessing health care, and encourage trans-specific health care training for medical professionals.

One participant's comment about being mid-process of a phalloplasty<sup>43</sup> and scrotoplasty<sup>44</sup> was particularly interesting. The participant said that they were taking testosterone but they had to stop it for surgery and articulated that, "It's okay to chemically castrate a trans man, even if they would not do an orchiectomy<sup>45</sup> on a cis man." (Respondent #13). This participant was insinuating that forcing a trans man to stop testosterone for surgery is unfair and ridiculous if you consider that a biological man would not have his naturally occurring testosterone removed via an orchiectomy for surgery that might reconstruct/repair the penis and scrotum. Similarly, another participant explains that:

Because trans people are seen as freaks. Women who have breast cancer get double mastectomies to remove the growths. Then, they are offered breast enhancement by OHIP. Wouldn't want a woman to not have boobs. There are other surgeries like this that are paid for by OHIP. Yet, I had to fight tooth and nail, and suffer being despised, by most health care practitioners I came into contact with. The other doctors did not know anything about trans issues - it is not covered in medical school at all. Because of a perceived conflict of interest, I believe CAMH is unfit to provide the sole GID clinic in Ontario and as such, I've actively avoided accessing that clinic. In doing so, I have not been able to obtain a double mastectomy (top surgery) in a manner I can afford (Respondent #8)

These participants raise a great point that I have often thought about; at what point does medicine/health care cease to be medical and become pathological? Should cissexual persons who want to alter their body through surgical interventions be considered "pathological"? Trans persons are considered pathological only because they may want to alter their physical body to match their mental and emotional one. If a biological woman who had breast cancer in only one breast wants to have the healthy breast removed; does that make her mentally ill? Western society

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<sup>43</sup> Phalloplasty: construction of a penis

<sup>44</sup> Scrotoplasty: construction of a scrotum

<sup>45</sup> Orchiectomy is the removal of the testicles, and is performed to stop most of the body's production of testosterone. The penis and the scrotum remain intact.

controls which people get to alter their body through medicalized discourses. A biological woman wanting to enhance her breasts is fine, but a biological man needs to seek psychological counseling if he knows he is a woman and wants to change his body to have breasts. I would also argue that if GID is recognized by medical professionals, and thus constructs trans persons in a “mentally pathological” way, then trans persons should be a prioritized population for health care. Just because other mental “disorders” like anxiety, depression and bipolar are more readily recognized and acknowledged to be affecting a larger population of individuals, that does not mean trans persons are not “valid” cases. In fact, the DSM still has GID as a mental disorder with specific criteria for diagnosis. Also, if Ontario remains a province that supports OHIP coverage for trans persons transitioning, then it is especially prudent to have informed and safe access to health services for trans persons. Overall, the results of my study indicate that trans persons are not getting all their health care needs met, they are faced with barriers when accessing health care services, and are experiencing discrimination from medical professionals in Ontario.

## **Part E**

### **General Comments**

The last section of my survey was designed with a few open-ended questions to enable participants to speak freely about anything I might have missed asking them what they wanted to comment on. I feel this is an important and rich section of the survey because it allows participants the space to write down anything that comes to mind, and they know someone will be reading it. Every respondent (18) said yes to “would be useful to have a program funded by the Ontario government that trains and educates medical professionals on trans-specific health needs”. I want to highlight some of the positive comments below because surveys do not typically show these narratives.

I am exceptionally lucky to live in a city where decent trans care is available. I am also exceptionally lucky to be able to actually get it - waiting lists are shockingly long and there are nowhere near enough services to fill the needs both for primary medical care and for mental health care. I also work hard to try and make care more available to more of us! (I work in part educating doctors, nurses, mental health practitioners etc on trans issues) (Respondent #2).

As a trans person in Ontario who is fortunate enough to be able to access the Sherbourne Health Centre, I'm doing great. However, I fear leaving Toronto and losing my healthcare, so I have stayed in Toronto despite feeling that I want to live elsewhere. (Respondent #16).

My experiences haven't all been bad. But, mostly when someone treats me with the basic dignity afforded a human, I get very excited. But, I don't trust the medical profession at all. I don't go to the doctor when I am sick because of this. I have been offended and insulted by too many people who are supposed to be helping me. (Respondent #10).

Services in Ottawa have been quite excellent and available, however, the dedicated gender related professionals who can serve the transgender community are few and highly sought after, I understand there are waiting lists beginning to form for their services. Further some are aging and will be nearing retirement soon. There is an increasing need for these professionals as there are more of us are coming out. (Respondent #3)

Good luck and thanks for undertaking this important research. (Respondent #13).

Thanks for doing this. (Respondent #1)

Good survey! Thanks! (Respondent #20).

These responses demonstrate that trans persons appreciate the need for further research about their needs and experiences with health care services in Ontario as well as further education and training for medical professionals.

## Chapter 3

We have no patterns for relating across our human differences as equals. As a result, those differences have been misnamed and misused in the service of separation and confusion. Certainly there are very real differences between us, of race, age, and sex. But it is not those differences that are separating us. It is rather our refusal to recognize those differences, and to examine the distortions that result from our misnaming them and their effects upon human behaviour and expectation.

Audre Lorde, 2007.<sup>46</sup>

### Summary

My study revealed, through a mixed methods online survey, the types of systemic barriers and the prevalence of discriminatory practices by medical professionals that trans persons face when accessing Ontario Health Care services. Additionally, subjective accounts of the participants' needs, experiences, and fulfillments were used to analyze participants' socio-demographics in order to help explain how diverse racial and social classes can further complicate trans persons access to health care services. The most unique contribution of my research study was the way in which the methods and methodology were constructed and executed. I used both quantitative and qualitative questions incorporated into an online survey that were informed by anti-oppressive, anti-racist, alliance-based, and feminist theoretical frameworks. The method of an online survey allowed for the participants' anonymity in answering open-ended questions that enabled them to write freely about their experiences, needs and desires with respect to Ontario health care services. What is most distinctive about the results was the amount of rich qualitative data that was obtained. Typically health research on trans persons focuses on the numbers and statistics of

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<sup>46</sup> Audre Lorde, *Identities: Thinking Intersectionally*, 2007, p. 179.

negative experiences. My results do comply with other research in that trans persons experience discrimination when accessing health care, however, my data elaborated on those subjective accounts of negative experiences while at the same time illuminating the positive experiences trans persons may have with health care services. It is unfair to ignore the voices of trans persons who have had positive experiences because it totalizes all trans persons' experiences as negative, thus ignoring those who have had a different experiences.

Overall, participants in my study have contributed towards a better understanding of how trans persons accessing Ontario health care services are regarded and treated. By disclosing their own subjective accounts of personal experiences with health care services in Ontario, my participants have contributed to a larger body of research on trans health care services and access that is much needed. I believe that my results can help to positively influence initiation of future research on health care access for trans persons, as well as impact the creation/alteration of educational programs for medical professionals involved in the health care of trans persons. Since little research has focused on the subjective experiences of trans persons accessing health care in a mixed-methods fashion, the results of my study are different than the strictly empirical or strictly qualitative research that has been conducted thus far in Ontario, Canada. My unique contribution to the existing canon of trans related health care research can be used as a stepping stone towards facilitating and impacting policy changes at institutional and informational levels.

The results from this study can lead to two important policy changes with future research. One important change would come from future research in Ontario that focuses on the Gender Identity Clinic at the Center for Addiction and Mental Health in Toronto. Many of my participants have criticized CAMH vehemently, therefore an investigation that questions the policies and procedures of CAMH for determining trans persons' eligibility to transition in order

to have OHIP coverage would be extremely valuable. A second line of future research would be one that focuses on the intersecting identities of trans persons in terms of race, class and language. Results from my study showed that trans persons face barriers not only due to their transgender identity, but also due to the social status, race and the language they speak. Overall, my research is a valuable contribution to the paucity of trans health research in Canada because it outlined several important narratives of trans persons' needs, desires and experiences when accessing Ontario health care services. One final and important contribution would be using this data towards educating health care professionals about the complexity of experiences and intersecting identities that complicate trans persons access to health care in Ontario beyond their gender.

According to Namaste (2000) and Bauer et. al. (2009), every time trans persons seek help for their health, they are an anomaly because of institutional and informational erasure. In other words, when looking at the health care system in Ontario specifically, it is impossible to enter a *woman* in to the computer system at a hospital as having *testicular cancer*, or similarly there is no form that allows medical professionals to enter a *man* into the system to undergo a *hysterectomy*. This exemplifies how easily institutional and informational erasure occurs in the health care system; there are no policies or procedures in place to work with trans persons in a non-discriminatory way that maintains their desired identity. Institutional and informational erasure can only be resolved if gender becomes situated outside of the existing infrastructure that subscribes to a two-sexed system. Only when the categories of gender are unsituated from the male/female binary will relevant and important statistics about trans persons in Canada be obtained and subsequently substantiated. According to Rainbow Health Ontario (n.d.),

In 2003, Statistic Canada added a question about Sexual identity to the Canadian Community Health Survey (CCHS). This single

question is being added to all Statistics Canada surveys, and this is an important first step in describing the health and social needs of LGB Canadians. The next urgent step is to include questions about:

- Same-sex behaviour (sex of sex partners, past-year and lifetime)
- Same-sex attraction (for those over age 20), and
- Gender identity

As my results show, the needs, experiences and fulfillments of trans persons' accessing Ontario health care services are complicated by history, race and class. The western, imperialist category of "transsexual/transgender" homogenizes trans bodies in a limited way that erases trans persons who are further marginalized by other aspects of identity beyond gender. The hegemonic discourse surrounding trans persons in Ontario has created restrictions for trans persons who do not fit (or do not want to fit) within the white, middle-class, western category transgender. Trans research and theory needs more narratives by trans persons who disrupt the hegemonic understandings of what/how gender is desired and embodied, and how that influences access to health care services.

### **Key Findings – Privilege, Discrimination and (Dis)satisfaction**

My own personal bias and assumptions initiating this research correlate with the literature reviewed; that trans persons are discriminated against when seeking medical care. In order to avoid falling victim of researcher bias, I approached my results as openly as possible so that I could analyze the results critically without my personal beliefs obstructing my analysis.

#### **Privilege**

The majority of my participants identified as Canadian. By asking participants if their race/culture has influenced their experiences of being trans, my results offered something new to the field of research on trans health care access because no other survey I found asked participants to elaborate on how their race has intersected with their trans identity. I was dissatisfied that there

were only two trans persons who responded that were not from North America, and I am aware that the wording of this question may have influenced my interpretation of results, however, this points out that more research needs to focus on trans persons of colour and their experiences with health care access. It was excellent to have narratives from participants who recognized and acknowledged the privileges they are afforded due to being a white, English speaking, Canadian.

Unsurprisingly, based on other research, over half of the trans persons in my study had an income below \$19,999, which is below the provincial poverty line<sup>47</sup>. The social class status of my participants helped to explain why so few have legally changed their gender/name. Because Ontario funds surgeries for trans persons, I thought it was important to ask whether participants have legally changed their gender/name on government documents. Throughout my investigation I found that there are several costs associated with just filing the paperwork and one also needs to have surgery, and it needs to be validated by a medical doctor in order to legally change a person's sex marker on an Ontario birth certificate. There has been next to no research conducted on the unnecessary bureaucratic channels trans persons must navigate through in order to change their gender/name. In the U.S. trans persons also face challenges in obtaining identity documents that reflect their desired gender, and this can create barriers to employment and education for some (Spade & Arkles, 2005). Perhaps if there was a more affordable and simpler way to do so then there would be fewer instances of discrimination from medical professionals because health and identity cards would match the person's desired gender and name.

Another interesting find in my results was that mid-class trans persons have experienced positive interactions with medical professionals when accessing Ontario health care services. Social class status directly affected the experiences of trans persons accessing health care services

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<sup>47</sup> See, [http://www.ccsd.ca/factsheets/fs\\_lico05\\_bt.htm](http://www.ccsd.ca/factsheets/fs_lico05_bt.htm)

in my study in both positive and negative ways. Further investigations would be beneficial in order to help determine the ways in which Ontario's health care system discriminates and privileges trans persons with various social class statuses. Research on class privilege for trans persons is especially important at the policy making level with respect to provincially-funded health care services versus privatized health care services because sex reassignment surgery is a service that has been delisted in the past. So even though some services for trans persons are currently covered in Ontario, there is no guarantee how long they will be covered for, especially if the current governing party does not believe trans persons health care needs are important enough to fund.

Language as a barrier to health care was a surprising result and something that has not been investigated in trans health care research. Two Francophone-Canadians elaborated on how Ontario's health care system is completely prejudiced toward English-speaking persons. There are so few doctors that specialize in trans specific care that language, according to my respondents, is not a priority and they are forced to speak English when interacting with health care professionals. It is clear from my results that trans access to health care in Ontario is privileged towards white, English speaking, middle class residents – this needs to be addressed in future research studies so that racialized, non-English speaking and other social classes of trans persons are considered.

### **Discrimination and (Dis)satisfaction**

My focus was on uncovering the discriminatory behaviours medical professionals engage in with trans persons, and yet I was surprised (and happy) to find out that not all trans persons are experiencing discrimination or refusal of services in Ontario. The other surprising finding to me was that trans persons were denied access to trans specific services more than general health care

services. Granted, my sample size was quite low, but these results are important because no other research study has separated questions about access and denial of care based on whether or not the service is related to trans specific needs of just general health care needs. In fact, my study found that approximately two-thirds of participants have not received all the trans-related health care they require. Another unique line of questioning in my survey was asking participants why they feel they have not received all the trans health care they need. By enabling a space in the survey for participants to write openly about the reasons they feel they have not received all the trans care they need created valuable qualitative data about the breadth of reasons why participants' needs have not been fulfilled. Answers ranged from avoiding CAMH, to believing they are too young, to not wanting to lose their partner of 50 years.

Most surprising to me was that OHIP only covers some sex reassignment surgeries and all trans person must go through CAMH to be eligible. Only one participant had OHIP cover their genital reassignment surgery in my study. This again points out that an investigation into the policies and procedures of the Gender Identity Clinic at CAMH should be undertaken. Almost half of the participants have been discriminated against by medical professionals because of their trans identity, and surprisingly nurses were the biggest perpetrators. This indicated to me that more research needs to focus on health care professionals beyond medical doctors, and that education on trans health care is imperative in health care education and training. In fact, all of my participants believe that it would be useful to have a program funded by the Ontario government that trains and educates medical professionals on trans-specific health needs.

As some of the key findings from my results showed, all of my participants' reporting on their experiential quality of health care access focused specifically on the medical agencies, structures and professionals/individuals within the health care system of Ontario. Experiences of

discrimination and barriers to health care access due to social class status, race, language, institutional policies and procedures, and knowledge of health care providers were also influencing factors for trans-accessible health care reported by my participants. While some participants' experiences of health care access and with medical practitioners reported were positive, this still does not preclude an overall dissatisfaction with the larger medical structures they are forced to rely upon for their care.

### **Key Findings: A Theoretical Breakdown**

Regardless of the nature of the discrimination suffered, be it related to one's sexual orientation, race, age, religion, size, ability or gender identity, discrimination erodes dignity, the ability to participate in society as equals, and the ability to experience oneself as fully human.

Riki Anne Wilchins (1997) writes:

There is something peculiarly incestuous about trans-experience. It robs us of our bodies, our intimate moments, our sexuality, our childhood. It robs us of honesty, of open friendship, of the luxury of looking into a mirror without pain staring back at us. It means hiding from friends and family, from spouses and children, as surely as it means hiding from the police car during an evening stroll, or from that knot of laughing boys down at the corner when we go out for a coke. In the end, it is as tiring as a constant pain and as barren as the bottom of an empty well at high noon. (p. 21)

As I mentioned in chapter 2, trans persons should be afforded respectable and affordable health care access like the rest of Ontario's residents. I believe that part of the failure to meet the needs and desires of trans persons access to health care stems primarily from a lack of information about trans persons in general. Research is one arena that I would argue trans persons are minimally considered in comparison to other marginal populations, and when trans persons are discussed by researchers, there is a very medical focus that informs the narrative through western

discourse. As previously mentioned, my research focused on breaking this pattern by integrating a theoretical framework heavily informed by anti-oppressive, anti-racist, alliance-based, and feminist frameworks. Discussions of gender binaries do not just trouble medical and technological canons surrounding trans persons, but academic and theoretical works as well, which is why I want to breakdown my results theoretically through mentioning some work that was influential to me in this research project.

*Sex Change, Social Change* is a collection of essays, key notes at conferences, interviews, and letters by Viviane Namaste, a Canadian scholar and transsexual activist. She has two main goals: first, to expose the shortcomings of dialogue on trans persons that are typically limited to questions of identity; second, is to provide an alternative framework that will enable a more functional and informed discussion about trans persons. According to Namaste, trans theorists, activists and feminists tend to focus on identity politics when discussing trans persons. Rather than talking about the experiences of trans persons, Namaste argues that most academic approaches to trans persons focus on the “production” of trans persons by medical institutions. Namaste argues that trans persons are not produced by these institution but rather they are erased from the institutional world (Namaste, 2005).

The focus on only gender identity renders the everyday actions of that person invisible by focusing on the construction of gender through the trans-body. This erasure is a systematic form of oppression that is no different than oppression because of one’s class, race, sexuality or ability. While Namaste’s argument is cohesive I would argue that whether a trans person wants to have gender reconstruction surgery, take hormones, do both or neither, the construction of the trans-body is still heavily reliant on medical intervention and (western) societal expectations of what gender is. The ways in which questions in my survey were worded was influenced by Namaste

when specifically asking participants to openly describe their gender and their experiences in general when accessing Ontario health care services.

Dean Spade<sup>48</sup>, lawyer, scholar, trans and civil rights activist, outlines the contention he feels between his own body as a trans man and the way in which medical systems interpret and dictate the ways in which a trans person should embody their gender in the following excerpt from an article he published in 2005.

The medical model, ultimately, was what I had to contend with in order to achieve the embodiment I was seeking. I learned quickly that to achieve that embodiment, I needed to perform a desire for gender normativity, to convince the doctors that I suffered from GID and wanted to “be” a “man” in a narrow sense of both words. My quest for body alteration had to be legitimized by a medical reference to, and pretended belief in, a binary gender system that I had been working to dismantle since adolescence. Later, as I contended with my own legal gender status and that of my clients, I would learn that not only medical treatment, but also legal rights and social services for trans people are dependent upon successful navigation of that medical system. (Spade, 2003, p. 24).

Trans theorist and historian Susan Stryker (2006) also gives an account of how she grapples with the way her body is constructed within different groups. This is an excellent example of how trans persons’ identity has perceptions and definitions imposed upon them based on circumstance or situation. Stryker states:

Every circumstance of life seemed to conspire against me in one vast, composite act of invalidation and erasure. In the body I was born with, I had been invisible as the person I considered myself to be; I had been invisible as a queer while the form of my body made my desires look straight. Now, as a dyke I am invisible among women; as a transsexual, I am invisible among dykes. As the partner of a new mother, I am often invisible as a transsexual, a woman, and a lesbian. I’ve lost track of the friends and

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<sup>48</sup> Spade also founded the Sylvia Rivera Law Project in 2002 that offers free legal advice to trans, low-income and persons of colour. See, <http://srlp.org/>

acquaintances these past nine months who've asked me if I was the father. It shows so dramatically how much they simply don't get what I'm doing with my body. The high price of whatever visible, intelligible, self-representation I have achieved makes the continuing experience of invisibility maddeningly difficult to bear. (Stryker, 2006, p. 251)

Writer and trans activist Leslie Feinberg recalls the civil rights movement and states that:

I am told I must check off M or F because it is a legal necessity. But when I was a child, I was required to check off race on all legal records. It took mighty militant battles against institutionalized racist discrimination to remove that mandatory question from documents. . . . Why is the categorization of sex a legal question at all? (Feinberg, 1998, p. 62).

Spade, Stryker, and Feinberg all demonstrate through their commentary how trans persons can experience a great deal of oppression and discrimination from many different groups and circumstances, especially from the medical model's interpretation and imposition of gender norms. Discrimination against trans persons when accessing health care services is particularly damaging because if a person is denied care or given poor care, then the status of their health is compromised. In fact, trans persons have died due to refusal of care by transphobic medical professionals (Cara, 2010).

New research on trans health care would benefit from incorporating theoretical frameworks that challenge assumptions about trans persons. For example, Stephen Whittle (2006) posits that the time has come where we are seeing a new form of "transgender performativity" (p. 198). The notion of transgender performativity stems from the fact that several trans person, as writers and speakers, are theorizing about the word gender from their perspective. Whittle (2006) says that "The default assumption that underlies any notion of a transgender existence is that gender is immutable and it is fixed through biological constraints, and social construction merely affects any representation that biology may take." (p. 199-200). Trans theory helps to challenge

the basic tenets of biological determinism that informs most health related research; that there are only two sexes and genders. Trans persons can choose to transition fully, partially or not at all, and there needs to be a language in dualistic societies that confronts the gender binary in order to be inclusive of trans persons in the health care institutions.

Trans activist, biologist, writer, performer, and self-identified transsexual woman, Julia Serano (2007), maintains that people often assume that “trans individuals transition not because they want to align their physical and subconscious sexes, but because they want to express either femininity or masculinity” (p. 95). She says that gender expression is perhaps the most widely commented on, critiqued and regulated aspect of gender. From the moment we are born we are socialized into a world of pink or blue, girl or boy, feminine or masculine. Gender expression is highly regulated in western society; boys are socialized to become masculine, and girls feminine (Serano, 2007). Serano (2007) argues against both gender essentialist and social constructionist views. She claims that the fatal flaw of gender essentialists is that not all men are masculine and not all women feminine. She says there are “exceptional gender expressions” (p. 97). That is, some men are feminine, some women are masculine, and there are people who express combinations of masculinity and femininity. Serano (2007) also explains that, “By focusing on gender entitlement rather than gender performance, we may finally take the next step toward a world where all people can choose their genders and sexualities at will, rather than feeling coerced by others.” (p. 362). Serano’s arguments are important because research on trans persons’ health care access should not assume that they subscribe to gender binaries, or all have a desire to fully transition from one gender to the opposite, and these ideologies were incorporated in the framing of my research questions.

Gender, sex, and sexuality distinctions were made in my research questions even though I am aware that such distinctions do not exist for all persons or cultural groups. I would prefer to talk to a whole person, absent of western identity politics, but in the case of my research project, it is a necessary analytical distinction which is spawned by the very nature of the medical systems that my respondents are dealing with. As mentioned in Chapter 2, I felt it important to separate gender and sexuality because some research maps gender on to sexuality, especially in the case of GID and the specifier sexuality. Whittle (2006) says that “transgender people have not been allowed either objectivity or sexuality. Sexuality was lost as it was constructed for them in the form of repressed homosexuality being appeased through reassignment surgery, or heterosexuality (in their new sex-role) was imposed on them by the medical profession in order to justify what was seen as a “medical collusion with and unattainable fantasy” ” (p. 199). Whittle’s statement is exactly the reason I chose to distinguish between gender and sexuality for this study. I did not want my research investigating health care access for trans persons to look like it was reproducing any historical categories that mapped sexuality on to gender.<sup>49</sup>

Psychoanalytic psychologist, Robert Stoller, was one of the earliest medical doctors to address the differences between biological sex and psychological gender. Stoller (2006) believes that, “we must turn to psychology as an essential methodology in our understanding of sexuality.” (p. 57). I understand his position and do not negate the importance that psychology and the professionals in this field have played for trans persons, but I believe that it is equally as important to include a diversity of methodologies when researching gender and sexuality.

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<sup>49</sup> Specifically, during the era of sexology in the early 1900s there was an absence of the category “transgender”, but everything that is thought of today in western terms as transgender was already described through works by von Krafft-Ebbing and Hirschfeld, for example, and was explained as "sexual inversion," and "hermaphrodites" and "sexual inverts/homosexuals". This was the backdrop for which "transsexualism" was defined by scientists in the mid-twentieth century. (Benjamin, 2006; Hirschfeld, 2006; von Krafft-Ebbing, 2006)

Psychology, gender studies, critical anti-racist and feminist methodologies are theoretical frameworks that I have incorporated throughout my study in order to disseminate a truly mixed-methods approach to trans persons experiences accessing Ontario health care.

### **Limitations**

My research was situated in Ontario specifically because I am a resident here and have personal knowledge of the province's health care system. The intention for conducting an online survey was to reach a larger population of trans persons versus trying to conduct one on one interviews or create focus groups. Unfortunately, as I mentioned in the introduction, the sample size was smaller than I had anticipated. The reasons for obtaining a small sample size can be critiqued in three specific ways.

(1) The survey was fairly long, taking approximately 45 to 60 minute to complete (131 questions in total). The amount of time I expected from participants is a lot considering I did not compensate participants in any way.

(2) The method of an online survey assumes trans persons in Ontario have access to the internet and a computer. This assumption is class based and is likely another fact attributing to the low sample size. However it is interesting to note that the majority of respondents in my study had incomes below the poverty line.

(3) Probably the most influential factor in obtaining a small sample size is I, the researcher. I want to be clear that even before I set down this path to investigate trans health care access, my primary interest has always focused on the question: why are health care professionals discriminatory and unknowledgeable when it comes to treating people who are gender non-conforming and sexually diverse? As a former Life Science student who identifies as queer, I have been consistently frustrated with the lack of information that exists for queer sexualities and

differently gendered folks. I wanted to interrogate the “system” and find out why gender and sexuality is so underrepresented in research and education. After 4 years of study I decided to narrow my research interests and focus on gender and health; specifically trans persons accessing health care in Ontario. My intention was never to “help” trans persons, but rather scrutinize the medical professionals and facilities trans persons are accessing or attempting to access for health care.

By conducting an online survey I anticipated that any concerns participants had about being “subjects of research” would be minimal because it was completely anonymous and open to any trans person that was interested in participating. I also believed that my own positionality and identity would not need to be inserted into my research due to the fact that there was no face to face interaction in an online study. My assumptions were challenged when some participants e-mailed me questioning my politics, purpose and motivation for conducting this research.<sup>50</sup> And when I attempted to make contact with trans community listservs to post the study link I was interrogated about my intentions. As a cissexual-identified person some trans persons did not want me conducting this research because they felt I was an outsider to their community, I wouldn’t understand their needs and desires in terms of health care as a non-trans person.

Initially, I had planned to run two phases of my study: first, activate the survey online and obtain feedback from participants to help restructure the questions in a more participatory fashion, and second, make changes to the survey and launch a second phase that incorporated all the received feedback. The two phases did not happen because the people I attempted to engage with did not offer any suggestions, or they had no time, or they were uninterested, or some

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<sup>50</sup> Six people e-mailed me about my study once the link was sent out via list-servs and web postings within the first 2 weeks it went live. Also, note that people could contact me because the letter of information and consent ethically requires my e-mail as primary investigator in accordance to GREB standards.

actually thought what I was doing was great and no changes were necessary<sup>51</sup>. I felt obligated to respect the individuals who questioned me and not push the survey out in to the trans communities in Ontario. I could have advertised more, sought out more websites to link my study, and tried harder to interact with trans persons who approached me, however, I felt that it was no longer my place to “force” my study on trans persons. I left the survey link up on Rainbow Health Ontario’s website, and the Trans Advocacy Ontario listserv, allowing for open access to the link until June. I wanted to ensure I maintained my own identity politics while at the same time remain inclusive, aware, and sensitive to the identities and politics of trans persons as the study remained active online. I questioned how to ethically keep my research going when it is something that not all people want me to be doing, or frankly, care about me doing.

I did not want to fail at addressing my positionality throughout my research and analysis because if I did, it would leave me and my project open to criticism and spectacle, thereby eroding the credibility of the methodologies and the entire research process. Jacob Hale (1997) asserts that it is important for a non-trans person to “interrogate your own subject position and the ways in which you have power that we [trans persons] don't.” Cressida J. Heyes (2003) echoes Hale’s point and indicates that:

Questions about the location of a non-trans author in an article primarily concerned with trans issues are important; my personal motivations are, as always, deeply intertwined with the structure of my arguments. This is perhaps especially important to acknowledge when much of what has been written about trans people by non-trans feminists has not only been hostile but has also taken an explicit *dis* identification with transsexuals’ experiences as its critical standpoint. (p. 1096)

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<sup>51</sup> I interacted with a total of 12 people via e-mails, in person and over skype. People would take the survey and offer minor changes that had nothing to do with any critical content. Some people said that they completed the survey but they had no feedback to offer me. Lastly, I assumed people were uninterested when they did not respond to my e-mail after several weeks and therefore I did not push further in asking them for their feedback or critique.

Lastly, sampling rigor could be questioned because the survey was run online and was open to anyone who met eligibility criteria; trans identified, over 18 and can read English. Also, controlling for truthfulness of participants responses can never be accounted for 100% through online survey methods, which is true of almost all research methods and methodologies. In addition, the chosen method can be criticized for being classist in assuming that the majority of trans persons have access to, or own a computer with internet.

Methodology can be interpreted as anticipating change, and therefore one changes with it. I set out to run a mixed-methods survey with more substantial quantitative data that would yield statistical power and have results where correlations could be made. Instead I ended up obtaining a small sample with very rich qualitative data that contains quantitative information in terms of percentage and frequencies. Despite the shift in data results, this project remained focused on asking questions that produced results addressing the intended research question: what are the needs, experiences and fulfillments of trans persons accessing Ontario's health care system?

## **Conclusion**

I met a second year resident from Kingston recently who works as a doctor at Kingston General Hospital (KGH). She considers herself an ally to trans persons and desperately wants to help implement change in the health care system by training nurses and doctors about sexual and gender diversity. She went on to tell me that even though there are efforts being implemented in medical school and at KGH to educate health care service providers on the needs of trans persons and sexual minorities, these educational workshops are not enforced and very few want to voluntarily participate. This is where research that produces valid and respected results and statistics can help. It is rare that policy makers at the institutional level will listen without

empirical evidence. This is not acceptable to me. Ontario's health care system needs to recognize the social locations, ethno-cultural heritage and the impact of institutional and informational structures that marginalizes and impacts the access to health care even further for trans persons.

At the 2010 Rainbow Health Ontario conference that I attended I participated in a workshop with about 35 people. The focus was on LGBT issues in health care and policy on Ontario and when we were asked to split into groups to discuss various aspects of LGBT health care, only 3 people, myself included, split off to focus on the "T" part of Ontario health care access. We discussed the fact that more research needs to happen around trans health care issues for it to be fully recognized as part of "LGBT" health care research. Can Ontario's health care system actually make viable adjustments in order to bring about policy changes that require health care professionals to be educated on more trans-specific health care needs? Can gender categories and identities be unfixed, unsituated or undone? Is it even beneficial and productive – and if so for whom? Are the statistics high enough in Canada to validate an attempt for such policy changes? In Canada there are no demographic questions that work outside the male/female gender binary included in nationwide surveys like the census. Policy changes and basic awareness of the needs of marginalized populations seem to be influenced only by large empirical studies, but these large numbers cannot get produced if there are no demographic questions that work outside the male/female gender binary when completing nationwide survey's like the census. So who is going to listen and care about trans persons when there are so few viable discussions happening around trans health care?

Why is it that when people do not understand something or someone that does not fit neatly into a heteronormative, binaristic and white/western category; discrimination and dismissal tends to emerge and dominate. Why can't health care professionals (not all of course, but this

statement is based on my study results) just try one simple thing: respectfully acknowledge the gender identity of their patient. It is my hope that the results of my study will help to instigate new research about the needs, fulfillments and experiences of trans persons accessing health care services at a policy making level in order to help change the existing landscape of medical and health care that incorporates trans-friendly, anti-racist, anti-oppressive, and queer positive attitudes.

## References

- Access Alliance Multicultural Health & Community Services, Research Department. (2009). *Needs Assessment of LGBTTTIQQ Youth in Peel Region Mississauga: Associated Youth Services of Peel (AYSP)* Retrieved from <http://www.rainbowhealthontario.ca/admin/resources/downloadResource.cfm?resourceID=07302c01-3048-8bc6-e8c7-e1571452c746>
- Alegria, C. A. (2011), Transgender identity and health care: Implications for psychosocial and physical evaluation. *Journal of the American Academy of Nurse Practitioners*, 23(4), 175–182.
- Allison, B. (n.d.). *U. S. States and Canadian Provinces: Instructions For Changing Name And Sex On Birth Certificate*. Retrieved from <http://www.drbecky.com/birthcert.html>
- Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K.M., & Boyce, M. (2009). ‘I Don’t Think This Is Theoretical; This Is Our Lives’’: How Erasure Impacts Health Care for Transgender People. *Journal of the Assoc. of Nurses in AIDS Care*, 20 (5), 348- 361.
- Bauer, G.R., Boyce, M., Coleman, T., Kaay, M., Scanlon, K., Travers, R. (2010). Who are trans people in Ontario?. *TransPULSE e-Bulletin*, 1(1).
- Bauer, G.R., Nussbaum, N., Travers, R., Munro, L., Pyne, J., & Redman, N. (2011). We’ve Got Work to Do: Workplace Discrimination and Employment Challenges for Trans People in Ontario. *TransPULSE e-Bulletin*, 1(2).

- Bauer, G.R. (August 16, 2010). *Estimating Unmet Need for OHIP-funded Sex Reassignment Surgeries. A report prepared for the Ministry of health and Long-term Care of Ontario.*  
Retrieved [http://transpulse.ca/public\\_downloads.html](http://transpulse.ca/public_downloads.html)
- Benjamin, H. (2006). Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes. In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 194-202). New York: Routledge.
- Blankenship, M. (April 11, 2006). Affirming transgender care. (Callen-Lorde Community Health Center) (Brief article). *The Advocate (The national gay & lesbian newsmagazine)*, p.46(1).
- Bornstein, K.(1995). *Gender Outlaw: On Men, Women, and the Rest of Us*. New York: Vintage Books.
- Boston Public Health Commission on LGBT Health. (2002, June, 28). *Double Jeopardy: How Racism and Homophobia Impact the Health of Black and Latino Lesbian, Gay, Bisexual, and Transgender (LGBT) Communities*. Retrieved from [http://www.hawaii.edu/hivandaids/Double\\_Jeopardy\\_\\_How\\_Racism\\_and\\_Homophobia\\_Impact\\_the\\_Health\\_of\\_Black\\_and\\_Latino\\_LGBT\\_Communities.doc](http://www.hawaii.edu/hivandaids/Double_Jeopardy__How_Racism_and_Homophobia_Impact_the_Health_of_Black_and_Latino_LGBT_Communities.doc)
- Budd, E., Singer, B., Bobbin, M., & Xavier, J. (2005). A needs assessment of transgendered people of color living in washington, DC. *International Journal of Transgenderism*, 8(2), 31-47.
- Califia, P. (1997). *Sex changes: The politics of Transgenderism*. San Francisco: Cleis Press.
- Cara. (2010, August 3). *Emergency Room Allegedly Denied Treatment to Woman Because She is Trans*. Retrieved from <http://thecurvature.com/2010/08/03/emergency-room-allegedly-denied-treatment-to-woman-because-she-is-trans/>

- Collins, P.H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, 568(1), 41-53.
- Centre for Addiction and Mental Health (CAMH). (2009). *Gender Identity Clinic: Criteria for Those Seeking Hormones and/or Surgery*. Retrieved from [http://www.camh.net/About\\_CAMH/Guide\\_to\\_CAMH/Mental\\_Health\\_Programs/General\\_Psychiatry\\_Program/gender\\_identity\\_criteriasurgery.html](http://www.camh.net/About_CAMH/Guide_to_CAMH/Mental_Health_Programs/General_Psychiatry_Program/gender_identity_criteriasurgery.html)
- Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, 14(8), 1140-1150.
- Currah, P. Juang, R.M., & Minter, S.P. (2006). *Transgender Rights*. Minneapolis: The University of Minnesota Press.
- DeCuypere, G., Knudson G., & Bockting, W. (2010). *Response of the World Professional Association for Transgender Health to the Proposed DSM 5 Criteria for Gender Incongruence*. Retrieved from [http://www.wpath.org/publications\\_public\\_policy.cfm](http://www.wpath.org/publications_public_policy.cfm)
- De Santis, J. P. (2009). HIV infection risk factors among male-to-female transgender persons: A review of the literature. *The Journal of the Association of Nurses in AIDS Care : JANAC*, 20(5), 362-372.
- Ekins, R. (2005). Science, politics and clinical intervention: Harry Benjamin, transsexualism and the problem of heteronormativity. *Sexualities*, 8(3), 306-328.
- Factor, R., & Rothblum, E. (2008). Exploring Gender Identity and Community Among Three Groups of Transgender Individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review*, 17(3), 235-253.
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of the Nutrition Society*, 63, 647-653.

- Feinberg, Leslie. (2001) "Trans health crisis: for us it's life or death". *American Journal of Public Health*. 91(6):897-900.
- Feldman, J., & Bockting, W. (2003). Transgender health. *Minnesota Medicine*, 86(7), 25–32.
- Galassi, J. P., Schanberg, R., & Ware, W. B. (1992). The Patient Reactions Assessment: A brief measure of the quality of the patient-provider medical relationship. *Psychological Assessment*, 4, 346-351.
- FTM Alliance of Los Angeles. (2004). *Results of the 2003 Health Access Survey: The Female-to-Male Transgender Community Experiences Multiple Barriers to Healthcare in Southern California*. Los Angeles FTM Alliance of Los Angeles.
- Gapka, S. & Raj, R. (2003). *Trans Health Project*. A position paper and resolution adopted by the Ontario Public Health Association (OPHA). Retrieved from [http://www.opha.on.ca/our\\_voice/ppres/papers/2003-06\\_pp.pdf](http://www.opha.on.ca/our_voice/ppres/papers/2003-06_pp.pdf)
- Gehi, P. S., & Arkles, G. (2007). Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People. *Sexuality Research & Social Policy: Journal of NSRC*, 4(4), 7-35.
- Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Retrieved from [http://www.thetaskforce.org/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf)
- Grossman, A. H., D'Augelli, A. R., Salter, N. P., & Hubbard, S. M. (2005). Comparing gender expression, gender nonconformity, and parents' responses of female-to-male and male-to-female transgender youth: Implications for counseling. *Journal of LGBT Issues in Counseling*, 1, 41–59.

- Grossman, A. H. & D'augelli, A. R. (2006). Transgender Youth -- Invisible and Vulnerable. *Journal of Homosexuality*, 51(1), 111-128.
- Hale, J., C. (1997). "Suggested Rules for Non-Transsexuals Writing about Transsexuals, Transsexuality, Transsexualism, or Trans \_\_\_\_." January 5, 1997. Accessed on April 13, 2010. <http://sandystone.com/hale.rules.html>
- Harcourt, J. (2006) *Current issues in lesbian, gay, bisexual, and transgender health*. New York: Harrington Park Press.
- Hernández, D. (2008). A BECOMING A BLACK MAN. *Colorlines*, 11(1), 38.
- Heyes, C. J. (2003). Feminist solidarity after queer theory: The case of transgender. *Signs*, 28(4), 1093-1120.
- Hirschfeld, M. (2006). The Transvestities. The Erotic Drive to Cross-Dress. In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 194-202). New York: Routledge.
- Horton, M. (2008). Cost of Transgender Health Benefits, Out & Equal Workplace Summit, September 2008, Retrieved from <http://www.tgender.net/taw/thbcost.html#thbcost>
- hooks, b. (1981). *Ain't I A Woman*. Boston, MA: South End Press.
- Hussey, W. (2006). Slivers of the Journey: The use of Photovoice and Storytelling to Examine Female to Male Transsexuals' Experience of Health Care Access. In Harcourt, J. (Ed.), *Current issues in lesbian, gay, bisexual, and transgender health* (pp. 129-158). New York: Harrington Park Press.
- Human Rights Campaign. (2011). *Healthcare Equality Index 2011*. Retrieved from [http://www.hrc.org/documents/Healthcare\\_Equality\\_Index\\_2011.pdf](http://www.hrc.org/documents/Healthcare_Equality_Index_2011.pdf)
- Jackson, N. C., Johnson, M. J. & Roberts, R. (2008). The Potential Impact of Discrimination Fears of Older Gays, Lesbians, Bisexuals and Transgender Individuals Living in Small- to

- Moderate-Sized Cities on Long-Term Health Care. *Journal of Homosexuality*, 54(3), 325-339.
- Jackson, B., Daley, A., Moore, D., Mulé, N., Ross, L., and Travers, A. (2006). *Whose Public Health?* Retrieved from [http://www.rainbowhealthnetwork.ca/files/whose\\_public\\_health.pdf](http://www.rainbowhealthnetwork.ca/files/whose_public_health.pdf)
- Johnson, C. V., Mimiaga, M. J. & Bradford, J. (2008). Health Care Issues Among Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Populations in the United States: Introduction. *Journal of Homosexuality*, 54(3), 213-224.
- Johne, M. (2006). 'Trans' Canada. *Medical Post*, 42(29), 1.
- Kaiser Permanente National Diversity Council. (2000) *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population*. Oakland, CA. Kaiser Permanente.
- Kelley, L., Chou, C. L., Dibble, S. L., & Robertson, P. A. (2008). A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students. *Teaching & Learning in Medicine*, 20(3), 248-253.
- Kenagy, G. (2005). Transgender Health: Findings from Two Needs Assessment Studies in Philadelphia. *Health & Social Work*, 30(1), 19-26.
- Kenna. (2007, July 7). Cold Showers and Statistics. [Web log comment]. Message posted to <http://transgroupblog.blogspot.com/2007/07/cold-showers-and-statistics.html>
- Kleinknecht, R.A., Thorndike, R.M. and Walls, M.M. (1996). Factorial dimensions and correlates of blood, injury, injection and related medical fears: Cross validation of the Medical Fear Survey. *Behaviour Research and Therapy*, 34 (4), 323-331

- Lambda Legal. (2009). *When Health Care Isn't Caring: Transgender and Gender-nonconforming People*. Retrieved from [http://data.lambdalegal.org/publications/downloads/whcic-insert\\_transgender-and-gender-nonconforming-people.pdf](http://data.lambdalegal.org/publications/downloads/whcic-insert_transgender-and-gender-nonconforming-people.pdf)
- Lambda Legal. (2010). *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*. Retrieved from [http://data.lambdalegal.org/publications/downloads/whcic-report\\_when-health-care-isnt-caring.pdf](http://data.lambdalegal.org/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf)
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120.
- Lombardi E. (2001) Enhancing Transgender Health Care. *American Journal of Public Health*. 91(6):869-872.
- Lombardi, E. (2009). Varieties of Transgender/Transsexual Lives and Their Relationship with Transphobia. *Journal of Homosexuality*, 56(8), 977-992.
- Lora, A. R., (Producer), & Ziegler, K.R. (Director). (2009). *Still Black: A Portrait of Black Transmen* [DVD]. USA: Blackstarmedia.
- Lorde, A. (2007). Identities: Thinking Intersectionally. *Journal of Lesbian Studies*, 11(3/4), 179-179.
- McGarry, K. A., Clarke, J. G., Landau, C., & Cyr, M. G. (2008). Caring for vulnerable populations: Curricula in U.S. internal medicine residencies. *Journal of Homosexuality*, 54(3), 225–232.
- Maher, M. J., Landini, K., Emano, D. M., Knight, A. M., Lantz, G. D., Parrie, M., & ... Sever, L. M. (2009). Hirschfeld to Hooker to Herek to High Schools: A Study of the History and

- Development of GLBT Empirical Research, Institutional Policies, and the Relationship Between the Two. *Journal of Homosexuality*, 56(7), 921-958.
- Mayer, K., Bradford, J., & Makadon, H. (2008). Sexual and Gender Minority Health: What We Know and What Needs to Be Done. *American Journal of Public Health*, 98(6), 989-95.
- Meyer, I. H., & Northridge, M. E. (Eds.). (2007). *The Health of Sexual Minorities*. New York, NY: Springer.
- Meyerowitz, J. (2002) *How Sex Changed. A History of Transsexuality in the United States*. Cambridge, MA: Harvard University Press.
- Ministry of Ontario Government Services. (2009). *Application to change an adult's name*. Retrieved from [http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/007-11155E~3/\\$File/11155E.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/007-11155E~3/$File/11155E.pdf)
- Ministry of Health and Long Term Care. (2008). *Subject: Relisting of Sex Reassignment Surgery under OHIP*. Retrieved from <http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4480.pdf>
- Mulé, N. J., Ross, L. E., Deepröse, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health*, 8(1), 18-18.
- Namaste, Ki (1995). *Access denied: A report on the experiences of transsexuals and transgenderists with health care and social services in Ontario*. Project Affirmation, Toronto, Ontario.
- Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. Chicago: University of Chicago Press.

- Namaste, V., K. (2005) *Sex Change, Social Change Reflections on Identity, Institution, and Imperialism*. Chicago.: University of Chicago.
- National Coalition for LGBT Health. (n.d.) *All of the Above: LGBT People of Color*. Retrieved from <http://lgbthealth.webolutionary.com/sites/default/files/LGBT%20POC.pdf>
- National Academy of Sciences (2011, March 31). Researchers need to engage lesbian, gay, bisexual, and transgender populations in health studies. Retrieved from <http://www.sciencedaily.com/releases/2011/03/110331114939.htm>
- Noble, J.B. (2006). *Sons of the Movement: FtM's Risking Incoherence on a Post-Queer Cultural Landscape*. Toronto: Women's Press.
- Ontario Health Insurance Plan (OHIP). (n.d.). Retrieved from <http://www.health.gov.on.ca/en/public/programs/ohip/>
- Ontario Human Rights Commission (OHRC). (2008). *RACISM & RACIAL DISCRIMINATION: Your Rights and Responsibilities*. Retrieved from <http://www.ohrc.on.ca/en/issues/racism>
- Ontario Ministry of Health and Long-Term Care Bulletin #4480. (2008). *Subject: Relisting of Sex Reassignment Surgery under OHIP*. Retrieved from <http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4480.pdf>
- Oswald, R.F., & Culton L.S. (2003). Under the Rainbow: Rural Gay Life and Its Relevance for Family. *National Council on Family Relations*. 52(1), 72-81.
- Phillips, S.P. (2005). *Gender and health: Integrating gender into medical education*. Retrieved from [www.genderandhealth.ca](http://www.genderandhealth.ca)
- Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality*, 54(3), 243–258.

- Rainbow Health Ontario. (n.d). *LGBT Health and Public Policy*, Retrieved from  
<http://www.rainbowhealthontario.ca/research/policy.cfm>
- Rochlin, M. (2009). Heterosexism in Research: The Heterosexual Questionnaire. In Ferber, A., Holcomb, K., & Wentling, T. (Eds.) *Sex, Gender & Sexuality* (pp. 299-300). New York: Oxford University Press.
- Rosario, V. A. (2009). African-American Transgender Youth. *Journal of Gay & Lesbian Mental Health*, 13(4), 298-308.
- Sanchez, N., Sanchez, J., & Danoff, A. (2009). Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City. *American Journal of Public Health*, 99(4), 713-19.
- Sankaran, S. (2011). *Addressing Health Inequities for Racialized Communities: A Resource Guide*. Retrived from [http://www.healthnexus.ca/projects/building\\_capacity/index.htm](http://www.healthnexus.ca/projects/building_capacity/index.htm)
- Schilder, A.J., Kennedy, C., Goldstone, I.L., Ogden, R.D., Hogg, R.S., & O'Shaughnessy, M.V. (2001) "Being dealt with as a whole person." Care seeking and adherence: the benefits of culturally competent care. *Social Science & Medicine*. 52, 1643-1659.
- Schmidt, W. C. (1997). World-wide web survey research: Benefits, potential problems, and solutions. *Behavior Research Methods, Instruments, & Computers*. 29, 274–279.
- Shapiro, E. (2010). *Gender Circuits: Bodies and Identities in a Technological Age*. New York, NY: Routledge.
- She Said. (2011, September). *Curve*, 21, p. 21.

- Skolnik, A., & Anonymous. (2008). Privileges Held by Non-Trans People. In Ferber, A., Holcomb, K., & Wentling, T. (Eds.) *Sex, Gender & Sexuality* (pp. 299-300). New York: Oxford University Press.
- Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In Murray, M. & Chamberlain, W. (Eds), *Qualitative Health Psychology: Theories and Methods*. (pp. 218–240). London: Sage Publications.
- Spade, D. (2003). Resisting medicine, Re/modeling gender. *Berkeley Women's Law Journal*, 18, 15.
- Spade, D., & Arkles, Z. G. (2005). Deregulating gender: Transgender rights in the U.S. *Division 44 Newsletter*, 21(2), 18-19.
- Spade, D. (2009). *Trans Politics on a Neoliberal Landscape*. Retrieved from <http://www.deanspade.net/wp-content/uploads/2010/07/templefinal.pdf>
- Staley, R. (2011, August 22.). When boys would rather not be boys. *MacLean's*, 124 (34), p. 45-49.
- Statistics Canada. (2006). *Visible minority groups, 2006 counts, for Canada and census metropolitan areas and census agglomerations - 20% sample data*. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/hlt/97-562/pages/page.cfm?Lang=E&Geo=CMA&Code=01&Table=1&Data=Count&StartRec=51&Sort=2&Display=Page&CSDFilter=5000>.

- Stoller, R., (2006). Biological Substrates of Sexual Behaviour. In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 53-57). New York: Routledge.
- Stryker, S. (2006). My Words to Victor Frankenstein Above the Village of Chamounix: Performing Transgender Rage. In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 244-56). New York: Routledge.
- Stryker, S. (2008). *Transgender History*. Berkley, CA: Seal Press.
- Valentine, David. (2007). *Imagining Transgender: An Ethnography of a Category*. Durham: Duke University Press.
- Viola, B. (2004). Transgender: A Psycho- Social Research Dilemma. *Transgender Tapestry*, (107), 40-41.
- von Krafft-Ebing. (2006). Selections from Psychopathia Sexualis with Special Reference to Contrary Sexual Instinct. A Medio-Legal Study. In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 194-202). New York: Routledge.
- Whelan, T. J. (2008, April). *Antecedents of anonymity perceptions in Web-based surveys*. Paper presented at the 23rd annual meeting of the Society for Industrial and Organizational Psychology, San Francisco, CA.
- Whittle, S. (2006). Where Did We Go Wrong? Feminism and Trans Theory—Two Teams on the Same Side? In Stryker, S. & Whittle, S. (Eds.), *The Transgender Studies Reader* (pp. 194-202). New York: Routledge.
- Wilchins, R., A. (1997). *Read my lips: Sexual subversion and the end of gender*. Ithica, NY: Firebrand Books.
- Wilkinson, W. (2006). Public Health Gains of the Transgender Community in San Francisco: Grassroots organizing and Community-Based Research. In Currah, P. Juang, R.M., & Minter,

- S.P. (Eds.) *Transgender Rights* (pp. 192-214). Minneapolis: The University of Minnesota Press.
- Willig, C. (2000). A discourse-dynamic approach to the study of subjectivity in health psychology. *Theory & Psychology, 10*(4), 547-570.
- Winters, K. (2007). *Issues of GID Diagnosis for Transsexual Women and Men*. Retrieved from <http://www.gidreform.org/GID30285a.pdf>
- World Professional Association for Transgender Health (WPATH). (2001). *The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Edition*. Retrieved from <http://www.wpath.org/documents2/socv6.pdf>
- Wylie, S. A., Corliss, H. L., Boulanger, V., Prokop, L. A., & Austin, S. B. (2010). Socially assigned gender nonconformity: A brief measure for use in surveillance and investigation of health disparities. *Sex Roles, 63*(3), 264-276.
- Wyatt, J. C. (2000). When to use web-based surveys. *Journal of the American Medical Informatics Association, 7*, 426-429.

## **Appendix A**

### **Online Recruiting Advertisements**

#### **1. Request to Administrators and Moderators to Post Recruiting Information**

Dear \_\_\_\_\_,

My name is Shannon Coyle and I am currently a research investigator in the Department of Gender Studies at Queen's University. I am currently running a study looking for participants over 18 years of age, fluent in English, and who identify along the transgender spectrum to complete a secure online survey examining experiences in accessing Ontario's health care system.

Below is a copy of an online posting I would appreciate your organization posting on my behalf.  
*(Insert 2. Online Recruitment Posting)*

I appreciate your consideration and time in helping me with my research. If you would like more information, please do not hesitate to contact me at; [shannon.coyle@queensu.ca](mailto:shannon.coyle@queensu.ca) or 613-533-6233.

Sincerely,

Shannon Coyle

B.Sc., B.AH., MA Candidate.

Department of Gender Studies, Queen's University

#### **2. Online Recruitment Posting**

Research investigator, Shannon Coyle, in the Department of Gender Studies at Queen's University is looking for participants over 18 years of age, fluent in English, and who identify

along the transgender spectrum to complete a secure online survey examining experiences in accessing Ontario's health care system.

Your participation would entail completing an online survey, which includes questions about your access and experiences with health care services in Ontario, health care needs, and general sociodemographic questions. The survey will take approximately 45 to 60 minutes to complete and all information is kept strictly confidential.

If you are interested in participating and would like more information, please contact Shannon Coyle; [shannon.coyle@queensu.ca](mailto:shannon.coyle@queensu.ca), 613-533-6233 or Margaret Little; [mjhl@queensu.ca](mailto:mjhl@queensu.ca), 613-533-6000 ext. 75670, in the Gender Studies Department by email at

Alternatively, you can visit the following website to directly access the survey: \_\_\_\_\_.  
All calls and email contacts are treated with the strictest confidentiality.

Thank you for your time.

## Appendix B

### Online Survey Questionnaire

#### PART A: DEMOGRAPHICS

The following questions ask about your demographic information. If you are uncomfortable answering any question(s), please select the Decline Response option, or type DR in the space provided.

1. Date of birth: \_\_ month \_\_\_year
2. Are you currently a resident of Ontario?

a) Yes

**IF YES:** *(the following questions will appear below)*

2A: Are you currently accessing Ontario Health Care services?

- a. Yes (if yes – continue survey)
- b. No (if No – end survey, ineligible)

b) No

**IF NO:** *(the following questions will appear below)*

2B: Are you currently accessing Ontario Health Care services?

- a. Yes (if yes – continue survey) and the following will appear:
  1. As a non-Ontarian resident, how are you eligible to access Ontario health care services? (i.e. As a student in an Ontario University)

\_\_\_\_\_

b. No (if No – end survey, ineligible)

c) Decline Response

3. Place of birth:
  - a) Canada
  - b) United States
  - c) Eastern Europe

- d) Western Europe
- e) Africa
- f) Asia
- g) Australia
- h) Middle East
- i) Latin/South America
- j) Caribbean
- k) Other: \_\_\_\_\_
- l) Decline Response

4. Where do you currently reside? (**\*\*If you are a student living away from home or travel for work often, please indicate which city your school/work is in AND where you consider “home” to be if it is not the same as the city you are attending school in**)

- a) City: \_\_\_\_\_
- b) Province/State: \_\_\_\_\_
- c) Country: \_\_\_\_\_

5. Prior to your current city of residence, what are the last 3 cities you lived in and for how long?

- a) City, country \_\_\_\_\_ Length of residence (in month , years) \_\_\_\_\_
- b) City, country \_\_\_\_\_ Length of residence (in month , years ) \_\_\_\_\_
- c) City, country \_\_\_\_\_ Length of residence(in month , years) \_\_\_\_\_

6. What were the reasons for moving to your current city of residence? (check all that apply)

- a) Work related

If selected the following questions will appear:

- I lost my job and am moving to find new opportunities in a new city
- I do not have a job and am looking for new opportunities in a new city
- I have obtained a new job in a different city

- b) School

- c) Family
- d) Partner
- e) Political
- f) Social
- g) Medical
- h) Other: \_\_\_\_\_

7. What race/culture do you see yourself as most associated with?

- a) Canadian
- b) Québécoise
- c) American
- d) Irish/Scottish/Welsh
- e) Aboriginal / Native Canadian / Native American
- f) Greek/Italian
- g) Eastern European
- h) Western European
- i) African
- j) Asian
- k) Australian
- l) Middle Eastern
- m) Latin/South American
- n) Caribbean
- o) Other: \_\_\_\_\_
- p) Decline Response

8. Has your racial/cultural identification influenced your experience of being trans identified and/or your experiences at all?

- a. Yes
- b. No
- c. Decline Response

**IF YES:** *(the following questions will appear below)*

Please explain:

---

9. Do you identify as an immigrant to Canada?

a) Yes

**IF YES:** *(the following questions will appear below)*

Has your status as an immigrant in Canada influenced your experience of being trans identified /or your experiences at all?

a. Yes

b. No

c. Decline Response

**IF YES:** *(the following questions will appear below)*

Please explain:

---

b) No

c) Decline Response

10. What is your mother tongue?

a) English

b) French

c) Other: \_\_\_\_\_

d) Decline Response

11. Do you have a sexual orientation?

a) Yes

**IF YES:** *(the following questions will appear below)*

11A. What sexual orientation do you most identify with?

a. Heterosexual

b. Gay/Lesbian

- c. Bisexual
- d. Pansexual
- e. Asexual
- f. Queer
- g. Other: \_\_\_\_\_
- h. Decline Response

- b) No
- c) Decline response

12. What was your religious upbringing?

- a) Catholic
- b) Protestant
- c) Christian-unspecified
- d) Jewish
- e) Mormon
- f) Jehovah Witness
- g) Muslim
- h) Hindu
- i) Buddhist
- j) Native
- k) "Spiritual, no label"
- l) None
- m) Other: \_\_\_\_\_
- n) Decline Response

13. Do you currently identify with a religious community?

- a) Yes

**IF YES:** *(the following questions will appear below)*

- 13A: What is your primary religious affiliation?

- a) Catholic
- b) Protestant
- c) Christian-unspecified
- d) Jewish
- e) Mormon
- f) Jehovah Witness
- g) Muslim
- h) Hindu
- i) Buddhist
- j) Native
- k) "Spiritual, no label"
- l) Atheist
- m) Agnostic
- n) Other: \_\_\_\_\_
- o) Decline Response

7B:	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>Decline</b>	
	<b>Not at all</b>						<b>Extremely</b>						<b>Response</b>
	<b>important</b>						<b>Important</b>						
How important is religion in													

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your daily life? |

- b) No
- c) Decline Response

14. How would you describe your gender: \_\_\_\_\_(blank text field first)

15. Please check the identities that you identify with (*check all that apply*):

- a) Woman/girl
- b) Man/boy
- c) Trans Woman/girl
- d) Trans Man/boy
- e) FTM
- f) MTF
- g) Trans
- h) Transgender
- i) Transsexual
- j) Intersex
- k) Crossdresser
- l) Drag queen
- m) Drag king
- n) Bi-gender
- o) Pan-gender
- p) Two-spirit
- q) Not exclusively male or female
- r) Human Being
- s) Other: \_\_\_\_\_
- t) Decline response

16. If you checked more than one identity above, with which one do you identify the \*most\*?

- a) Woman/girl
- b) Man/boy
- c) Trans Woman/girl

- d) Trans Man/boy
- e) FTM
- f) MTF
- g) Trans
- h) Transgender
- i) Transsexual
- j) Intersex
- k) Crossdresser
- l) Drag queen
- m) Drag king
- n) Bi-gender
- o) Pan-gender
- p) Two-spirit
- q) Not exclusively male or female
- r) Human Being
- s) Other:\_\_\_\_\_
- t) Decline response

17. What was your birth sex?

- a) Male
- b) Female
- c) Intersex assigned female
- d) Intersex assigned male
- e) Intersex not assigned
- f) Decline Response

18. Do you have a diagnosed intersex condition?

- a) Yes

**IF YES:** *(the following question will appear below)*

Please describe your diagnosed intersex condition:\_\_\_\_\_

- b) No
- c) Uncertain

d) Decline Response

19. What is the highest level of formal education you have received?

- a) Some high school
- b) High school graduate
- c) Some trade school
- d) Trade school graduate
- e) Some college/university – didn't finish
- f) College/university undergraduate degree
- g) Some graduate school/professional training
- h) Graduate/professional school degree
- i) Other: \_\_\_\_\_
- j) Decline Response

20. What is your occupational status?

- a) Employed full-time
- b) Employed part-time
- c) Unemployed
- d) Retired
- e) Student
- f) On disability (*Ontario Disability Support Program*)
- g) On Employment Insurance (EI)
- h) On welfare/workfare
- i) Other: \_\_\_\_\_
- j) Decline Response

21. What is your individual approximate total annual income?

- a) \$0 - \$ 9,999
- b) \$10,000 - \$19,999
- c) \$20,000 - \$29,999
- d) \$30,000 - \$39,999
- e) \$40,000 - \$49,999
- f) \$50,000 - \$59,999
- g) \$60,000 and over
- h) Decline Response

23. What is your housing situation?

- a) Own a home
- b) Rental (non-family/friend)
- c) Shelter
- d) Stay with friends/family (no rent)
- e) Stay with friends/family (and pay rent)
- f) No permanent address
- g) Other: \_\_\_\_\_
- h) Decline Response

24. Are you currently in a relationship?

a. Yes

**IF YES:** *(the following questions will appear below)*

- 11A: How long have you been in this relationship? \_\_\_ years \_\_\_ months
- 11B: What is your partner's identity (check all that apply)?
  - a) Woman/girl
  - b) Man/boy
  - c) Trans Woman/girl
  - d) Trans Man/boy
  - e) FTM
  - f) MTF
  - g) Trans
  - h) Transgender
  - i) Transsexual
  - j) Intersex
  - k) Crossdresser
  - l) Drag queen
  - m) Drag king
  - n) Bi-gender
  - o) Pan-gender
  - p) Two-spirit
  - q) Human Being

r) Other: \_\_\_\_\_

s) Decline Response

*(Question 11 continued: Are you in a relationship?)*

b. No

c. Decline Response

25. If you checked more than one identity above, with which one would you say your partner identifies with \*most\*?

a. Woman/girl

b. Man/boy

c. Trans Woman/girl

d. Trans Man/boy

e. FTM

f. MTF

g. Trans

h. Transgender

i. Transsexual

j. Intersex

k. Crossdresser

l. Drag queen

m. Drag king

n. Bi-gender

o. Pan-gender

p. Two-spirit

q. Not exclusively male or female

r. Human Being

s. Other: \_\_\_\_\_

t. Not Applicable

u. Decline response

26. Do you live in Kingston, ON or the surrounding area? (This question is to determine how frequent trans-identified persons are accessing health care services in the Kingston community)
- a. Yes
  - b. No
  - c. Decline Response

**PART B: TRANS SPECIFIC QUESTIONS**

The following questions ask about trans specific health information. If you are uncomfortable answering any question(s), please select the Decline Response option, or type DR in the space provided.

1. At what age did you first become aware that your physical gender was not in alignment with your felt gender? \_\_\_\_\_

2. Have you legally changed your name to match your current sense of gender identity?

- a) Yes
- b) No
- c) Decline Response

3. Have you currently changed your assigned sex on legal documents (i.e. birth certificate, passport) to match your gender identity?

- a) Yes

*If YES the following will appear:*

Which documents have you successfully changed? (check all that apply)

- Driver's license
- Birth certificate
- OHIP card
- Canadian passport
- Non-Canadian passport
- Indian status card
- Canadian citizenship card
- Other: \_\_\_\_\_

- b) No
- c) Decline Response

4. How many medical doctors have you consulted for trans related health care needs? \_\_\_\_\_

5. If you have sought support, could you indicate below the sources from which you initially sought support and the order in which you sought that support? (*i.e. place a "1" in the box beside Internet if that's the first source you used.*)
- Your own general practitioner (GP)/family doctor
  - Other general practitioner (GP) /medical doctor
  - Social Worker
  - Counselor/Therapist
  - Psychologist/Psychiatrist
  - Internet trans community sources
  - LGBT community resources
  - Other (please state) \_\_\_\_\_

5a) Could you describe your experience of these initial supports? \_\_\_\_\_

6. Which of the following services **have you used in the past, or are you currently using?**(*check all that apply*)

<b>check all that apply</b>		<b>How were you referred to these services (e.g. Self, GP, Psychiatrist, consultant etc.)</b>	<b>Where (city/town) were these services located?</b>	<b>Did you have to travel more than 50 km to access this service?</b>
<input type="checkbox"/>	Counseling/Therapy			Yes/No DR
<input type="checkbox"/>	Psychiatric/Psychological Assessment			Yes/No DR
<input type="checkbox"/>	Hormonal Treatments			Yes/No DR
<input type="checkbox"/>	Electrolysis Speech Therapy			Yes/No DR
<input type="checkbox"/>	Surgical Interventions			Yes/No DR
<input type="checkbox"/>	Cosmetic Surgical interventions			Yes/No DR
<input type="checkbox"/>	Genital Reassignment Surgery			Yes/No DR

<input type="checkbox"/>	Other (as above)			Yes/No DR
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7. How have you financed your access to these services? *(Please indicate all that apply for each service.)*

[drop down of yes, no, N/A and DR]	<u>OHIP</u>	<u>Private Health Insurer</u>	<u>Own Resources</u>
		Please Specify:	
Counseling/Therapy			
Psychiatric/Psychological Assessment			
Hormonal Treatments			
Electrolysis Speech Therapy			
Surgical Interventions			
Cosmetic Surgical interventions			
Genital Reassignment Surgery			
Other (as above)			

8. Have you been refused financial assistance at any point for any of the above treatments and services? Could you outline the service(s) for which you were refused, the reasons for the refusal(s) and the body/bodies (e.g OHIP, Health insurer) which actually refused.

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9. Did you challenge any refusals?

a) Yes

*If YES the following question will appear:*

If yes, how did you challenge the decision(s) and what has been the outcome?

---

b) No

c) Decline Response

10. Are you/have you received all the trans-health care you require?

a) Yes

b) No

*If NO:* Why do you think that is? \_\_\_\_\_

c) Decline Response

**PART C: EXPERIENCES WITH ONTARIO HEALTH CARE**

The following questions concern your experiences with accessing and/or using the Ontario Health Care System. If you do not wish to answer a question, select the Decline Response option, or type DR in the space provided.

1. Are you currently accessing Ontario Health Care Services? (*i.e. have a family doctor, have gone to emergency hospital care in Ontario, seeing a medical professional regularly, etc.*)

- a) Yes
- b) No

*If No:* Have you accessed services in the past?

- a) Yes
- b) No
- c) Decline Response

How long ago did you access services? (month/year)\_\_\_\_\_

- c) Decline Response

2. Where did you first seek health care services in Ontario as a trans identified person?

City: \_\_\_\_\_

Facility: \_\_\_\_\_ (i.e. General practitioner/family Dr., drop in clinic, hospital, psychologist, etc.)

3. Was your first attempt at accessing Ontario health related services as a trans identified person:

- a) Positive
- b) Negative
- c) Decline Response
- d) Other: \_\_\_\_\_

4. Have you ever been discriminated against for your trans identity by a medical professional?

- a) Yes

*If YES,* by whom: (check all that apply)

- i. Family medical doctor (General Practitioner)
- ii. Medical doctor in a hospital (i.e. in Emergency Care)
- iii. Medical doctor in a walk-in clinic
- iv. Psychiatrist
- v. Psychologist
- vi. Nurse practitioner
- vii. Paramedic
- viii. Other: \_\_\_\_\_
- ix. Decline response

- b) No
- c) Decline Response

5. Have you ever been denied access to health care by a medical professional because of your trans identity?

- a) Yes

*If YES*, by whom: (check all that apply)

- i. Family medical doctor (General Practitioner)
- ii. Medical doctor in a hospital (i.e. in Emergency Care)
- iii. Medical doctor in a walk-in clinic
- iv. Psychiatrist
- v. Psychologist
- vi. Nurse practitioner
- vii. Paramedic
- viii. Other: \_\_\_\_\_
- ix. Decline response

- b) No
- c) Decline Response

6. Did you ever travel outside of your city to receive health care because of discrimination from a health care professional?

a) Yes

*If YES:* how far did you have to travel? (from which city to which city)\_\_\_\_\_

b) No

c) Decline Response

7. Below is a list of discriminatory behaviours. Please select and indicate the approximate number of times you have encountered this behavior as a trans identified person while accessing any health care service in Ontario. Also, please give an example if you have experienced this behaviour, or *type in N/A if you have never encountered this behaviour, or DR if you wish to decline giving an example*

<b>Behaviour</b>	<b>Yes, No, DR</b>	<b>Number of times</b>	<b>City Location</b>	<b>Give an example</b>
Laughed at			[drop down] <b>1. Single tier city (population over 1 million)</b> <b>2. Upper tier city (population less than 1 million)</b> <b>3. Both types of cities</b> <b>4. Decline Response</b>	Open text, N/A or DR
Pointed at				
Stared at				
Ignored				
Denied care				
Addressed by a name other than your chosen one, despite having told them your name				

Purposely had someone use an incorrect pronoun to address you				
Had unnecessary questions asked that were not related to your health care concern				
Called a derogatory name				
Did not answer your health care concerns				
Was referred elsewhere for health care despite the fact that the medical professional and place could have addressed your concern				
Other: (Specify)				

8. Do you have a regular general practitioner/family doctor?
- a) Yes

b) No

*If NO*, who/where do you seek health care from when you have medical/health concerns?

\_\_\_\_\_

c) Decline Response

9. Are you out as trans to the medical professionals you seek care from?

a) Yes

*If YES*, specify which medical professionals you are out to: \_\_\_\_\_

b) No

c) Decline Response

10. How educated was/were the medical professionals you saw regarding trans specific health care needs?

a) Extremely

b) Moderately

c) Mildly

d) Not at all

e) I had to educate them on my specific needs

f) Not applicable

g) Decline Response

The following questions concern your relationship with the health professional mainly responsible for your current health care needs. Think about your recent contacts with this person and answer the following questions by selecting the option that best describes how you feel about your recent contacts with this health professional. If you do not wish to answer a question, select the Decline Response option, or type DR in the space provided. (*Assume “treatment” to be whatever the reason for your encounter or visit with the health care professional*)

11. Is this health professional a medical doctor?

a) Yes

b) No

**IF NO** (*the following question will appear below*):

- What is their profession?

- a) Physiotherapist
- b) Psychologist
- c) Acupuncturist
- d) Naturopath
- e) Other: \_\_\_\_\_

c) Decline Response

**12. (PATIENT REACTIONS ASSESSMENT (PRA) MEASURE)**

	Very strongly disagree	Strongly disagree	Disagree	Unsure	Agree	Strongly agree	Very strongly agree	Decline Response
<p>I understand the possible side effects of treatment.</p> <p>If this person tells me something that is different from what I was told before, it is difficult for me to ask about it in order to get it straightened out.</p> <p>The person is warm and caring toward me.</p> <p>If I don't understand something the person says, I have difficulty asking for more information.</p> <p>The person told me what they hope the treatment will do for me.</p> <p>This person makes me feel comfortable about discussing personal or sensitive issues.</p> <p>It is hard for me to tell the person about new symptoms.</p>								

<p>It is hard for me to ask about how my treatment is going.</p> <p>This person really respects me.</p> <p>I understand pretty well the medical plan for helping me.</p> <p>After talking to this person, I have a good idea of what changes to expect in my health over the next weeks and months.</p> <p>When I talk to this person, I sometimes end up feeling insulted.</p> <p>I have difficulty asking this person questions.</p> <p>The treatment procedure was clearly explained to me.</p> <p>This individual <u>doesn't</u> seem interested in me as a person.</p>	
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13. How satisfied are you with how the medical community has dealt with your health care concerns and needs?
- a) Very satisfied
  - b) Satisfied
  - c) Undecided
  - d) Dissatisfied
  - e) Very dissatisfied
  - f) Decline Response

The following questions concern having under gone a general, annual health physical with a health care professional. Think about your experience with this person and answer the following questions by selecting the option that best describes how you feel about your contact with this

health professional. If you do not wish to answer a question, select the Decline Response option, or type DR in the space provided.

1. Have you had a regular general, annual health exam check up by a health care professional in Ontario within the last 5 years?
  - a) Yes (If Yes → **go to Q3**)
  - b) No (If No → **skip to Q2**)
  - c) Decline Response
  
2. Have you ever had a general, annual health exam check up by a health care professional in Ontario?
  - a) Yes *If YES*: When was your last check-up: \_\_\_\_\_
  - b) No *If NO*: **Skip to Q3**
  - c) Decline Response
  
3. Have you ever had a general, annual health exam check up by a health care professional NOT in Ontario?
  - a) Yes *If YES*: Where and when was your last check-up: \_\_\_\_\_
  - b) No *If NO*: **Skip to Q7**
  - c) Decline Response
  
4. Did the doctor explain what he/she was going to do before/during the health visit?
  - a) Yes, the doctor told me what he/she would be doing before/during the exam.
  - b) No, the doctor did not tell me about the procedures he/she would perform before, during, or after the exam.
  - c) The doctor explained what he/she was doing some of the time; he/she explained certain procedures.
  - d) I don't remember.
  - e) Decline Response

5. Did the doctor ask questions about your sexual history or your reason(s) for booking the appointment before starting the exam (e.g., before performing any procedures)?
- a) Yes, the doctor asked me some questions before beginning the exam.
  - b) No, the doctor did not ask me any questions before beginning the exam.
  - c) I don't remember.
  - d) Decline Response
6. The following questions are about how you felt during the exam. Please select the number between 0 and 10 for each of the questions that best describe how you felt during your health care exam.

6A:	0	1	2	3	4	5	6	7	8	9	10	Decline Response
	<b>Not at all</b>										<b>Extremely</b>	
	<b>anxious</b>										<b>anxious</b>	
How anxious were you BEFORE the exam?												
How anxious were you DURING the exam?												
6B:	0	1	2	3	4	5	6	7	8	9	10	Decline Response
	<b>Not at all</b>										<b>Extremely</b>	
	<b>embarrassed</b>										<b>embarrassed</b>	
How embarrassed												

were you during the exam?	
6C:	<p style="text-align: center;"> <b>0</b>      <b>1 2 3 4 5 6 7 8 9</b>      <b>10</b>      <b>Decline</b>  <b>Not at all</b>      <b>Extremely</b>      <b>Response</b>  <b>distressing</b>      <b>distressing</b> </p>
How distressing was the exam?	
6D:	<p style="text-align: center;"> <b>0</b>      <b>1 2 3 4</b>      <b>5</b>      <b>Decline</b>  <b>Very negative</b>      <b>Very positive</b>      <b>Response</b>  <b>experience</b>      <b>experience</b> </p>
Overall, how would you describe your health care exam?	

7. What was the doctor's gender?

- a) Male
- b) Female
- c) Other: \_\_\_\_\_
- d) Don't remember
- e) Decline Response

**(MEDICAL AVOIDANCE SURVEY)**

Below are listed some reasons that people give for not going to see doctors and for not seeking medical care. After carefully reading the scales below, please indicate if and how much you have ever avoided medical treatment due to the listed reason. If you do not wish to answer a question, select the Decline Response option, or type DR in the space provided.

- 0 = I have never, and would not avoid medical treatment for this reason. (I always seek treatment when needed)
- 1 = I have not avoided due to this reason but have seriously thought about it. (I go, but I hesitated)
- 2 = I have avoided due to this reason but I usually go when necessary.
- 3 = I have avoided several times for this reason in the past, but would probably go if it meant life or death.
- 4 = I have avoided for this reason in the past and at this time I do not think I can go because of it.

**Have you ever avoided going to the doctor to seek health care due to:**

0 1 2 3 4 D  
R

	0	1	2	3	4	D	R
7A. Embarrassment over having to expose your body							
7B. Finding time in your day to get there and then waiting?							
7C. Embarrassment that others will find out what possible diagnosis you have?							
7D. Fear that you would find that you have a serious illness or injury?							
7E. Fear that you might experience too much pain or discomfort?							
7F. The cost of doctor's appointments (i.e. services not covered by OHIP)							
7G. Fear that you might receive a hypodermic needle injection?							
7H. Fear that you would have blood drawn from you?							
7I. Not having a regular doctor who knows you and your health?							
7J. Fear that you might need surgery?							
7K. Fear that a doctor or nurse might think badly of you for not taking better care of yourself physically?							
7L. Fear that you might have to see the various types of medical equipment?							
7M. The difficulty of arranging transportation?							
7N. Fear that you might faint when having an injection or blood taken?							
7O. fear you might need stitches?							

7P. The cost of medicine							
7Q. Fear that you might have cancer?							
7R. Fear that you might be found to have HIV/AIDS?							
7S. Fear that you might have to undergo lengthy treatment?							
7T. Fear that you might have to have an X-ray?							
7U. The difficulty in getting an appointment?							
OTHER: _____ _____							

## **PART D: HEALTH QUESTIONS**

The following questions ask about specific health information. If you are uncomfortable answering any question(s), please select the Decline Response option, or type DR in the space provided.

1. Are you currently experiencing any medical or psychological condition?  
Yes → go to #11b                      No → go to #2

1a. *If yes*, what condition(s) do you experience?

1b. Have you received a diagnosis for this condition? Yes → go to #1c  
No → go to #1e

1c. What diagnosis did you receive?

1d. From whom did you receive the diagnosis? (i.e medical doctor, psychologist etc.)

1e. Are you taking any medication for this condition? YES → go to #11f  
NO → go to #11g

1f. *If yes*, what medication(s) are you currently taking?

1g. Are you receiving any other treatment for this condition? YES → go to #1h  
NO → go to #1i

1h. If you are receiving other treatment for this condition, which treatment(s) are you currently receiving?

1i. Have you previously taken any medication or received any other treatment for this condition? YES → go to #1j NO → go to #11k

1j. *If yes*, what medication(s) or treatment(s) did you previously use?

1k. On a scale from 0 to 10, where 0 is not at all and 10 is significant, please rate how much this condition interferes with your daily functioning? (0 to 10, and Decline Response)

### **PART E: GENERAL QUESTIONS AND COMMENTS**

The following questions are open ended and concern and relate to any general comments and concerns you wish to comment on, specifically in relation to your experiences with accessing and/or using the Ontario Health Care System. If you do not wish to answer a question, select the Decline Response option, or type DR in the space provided. Similarly, if the question is not applicable to you, simply type in N/A.

1. If there are any other specific challenges or barriers that you have faced as a trans identified person in accessing Ontario Health Care Services , please describe them here:  
\_\_\_\_\_
2. Do you feel it would be useful to have a program funded by the Ontario government that trains and educates medical professionals on trans-specific health needs?
  - a. Yes
  - b. No
  - c. Please explain: \_\_\_\_\_
  - d. Decline Response
3. In general, do you feel it would be useful for educated medical professionals on trans-related health care needs to engage in community outreach programs in cities across Ontario?
  - a. Yes
  - b. No
  - c. Please explain: \_\_\_\_\_
  - d. Decline Response
4. Do you feel it would be **especially** useful for educated medical professionals on trans-related health care needs to engage in community outreach programs in **smaller, rural (upper-tier) cities** across Ontario?
  - a. Yes
  - b. No
  - c. Please explain: \_\_\_\_\_
  - d. Decline Response

**Thank you for your co-operation and participation!**

**Please feel free to include any comments you have about the survey below.**

## Appendix C

### Letter of information and Consent Form

#### Letter of Information

#### **A Comparative Analysis of Transgender Experiences in Accessing Ontario Health Care Services in Single-tier vs. Upper-tier municipalities**

##### **Investigator:**

*Shannon Coyle, BSc, BAH, Department of Gender Studies, Queen's University*

##### **Introduction**

This research project is being conducted by Shannon Coyle (613-533-6233), a graduate student under the supervision of Dr. Margaret Little (613)533-6000 ext. 75670 in the Department of Gender Studies, Queen's University. This study has been granted clearance according to the recommended principles of Canadian ethics guidelines and Queen's policies.

##### **Purpose of the study**

The purpose of this study is to examine the societal factors and cognitive forces that are hypothesized to be affecting the lives of trans persons in both single tier (i.e. urban) and upper tier (i.e. rural) municipalities when accessing Ontario's health care system. Due to the paucity of research on trans related health care issues and access, this study includes a diverse and varied set of questions to attempt to expose any challenges and barriers faced by trans persons accessing health care services in Ontario.

##### **Eligibility**

**Any person who identifies on the transgender spectrum, over the age of 18, having accessed or is currently accessing Ontario health care services, and is fluent in English, is eligible to participate.**

##### **Study procedures**

Your participation involves completing a secure online survey, which will take approximately 45 to 60 minutes. The format of this survey takes into account that individuals have varied levels of experiences and comfort and therefore both open-ended questions to provide narratives of experiences are included along with questions that are closed (involving the participant to simply select from a drop down menu or rating scale).

Before beginning the survey, you will be asked a few questions to determine your eligibility. If you are not eligible, you will receive a message thanking you for volunteering. If you are eligible, you will proceed directly to the survey. It includes questions concerning sociodemographics, sexuality, health history, health care access experiences in Ontario, and health care needs. The researcher is available by phone and e-mail to answer any questions that you may have about the survey.

**Advantages of participating in this study**

By participating in this study, you will have the opportunity to describe the quality of experiences with Ontario's health care system. The results of this research will contribute to a better understanding of how trans-identified persons accessing Ontario health care services are regarded and treated. The findings of this research project may have important implications for health professionals involved in such care. Should you be interested, you are entitled to a copy of the findings.

**Disadvantages of participating in this study**

There are no known physical, psychological, economic, or social risks associated with this study. However, some of the questions concern sensitive and personal topics. It is possible that you may experience some discomfort in answering these questions. You are, however, not obligated to answer any material that you find objectionable or that makes you feel uncomfortable; each question includes a 'decline response' option and you will still be eligible to enter the draw if you choose 'decline response' for any/all questions. You may withdraw from the study at any time by either: a) closing the browser window or b) selecting 'decline response' for the remaining questions.

**Confidential nature of this study**

Your participation in this study is strictly confidential. The investigators will take all reasonable measures to protect the confidentiality of your records. When you register on the secure website, you will be assigned a login ID number that will be associated with your responses to the survey. These ID numbers are stored in an encrypted file to preserve your privacy. Any contact information provided will be stored in a separate encrypted file, and will only be used to contact you if you indicate interest in participating in future studies. You will not be identified in any publication or reports of this research; data will be aggregated in all reports of this study.

**Discontinuation of this study**

Your participation in this procedure is completely voluntary and you may withdraw from this study at any time, without any negative consequences. Furthermore, you are free to refuse to answer any question posed without need of any explanation on your part by choosing the 'decline response' option for any question(s).

**Contact Information**

Any questions about study participation may be directed to: Shannon Coyle at 613-533-6233, [shannon.coyle@queensu.ca](mailto:shannon.coyle@queensu.ca); or her supervisor, Margaret Little, at 613-533-6000 ext. 75670, [mjhl@queensu.ca](mailto:mjhl@queensu.ca). If you have additional questions or concerns, you may also contact Bev Baines, Head of the Department of Gender Studies at Queen's University 613-533-6000 ext. 75030, [bainesb@queensu.ca](mailto:bainesb@queensu.ca).

Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at [chair.GREB@queensu.ca](mailto:chair.GREB@queensu.ca) or 613-533-6081.

**Please print this letter, or copy and save it, for your own records.**

Some of the questions in this survey are sensitive and personal in nature. If you are feeling distressed, please consult the following resources for help (these resources are also included at the end of the survey):

**Telehealth Ontario: 1-866-797-0000**

**Internet Resources**

- **Trans-Health.com** [www.trans-health.com](http://www.trans-health.com)
- **TransGender Care** [www.transgendercare.com/default.asp](http://www.transgendercare.com/default.asp)
- **Canadian Rainbow Health Coalition** [www.rainbowhealth.ca](http://www.rainbowhealth.ca)
- **LGBT Health Channel** [www.gayhealthchannel.com](http://www.gayhealthchannel.com)
- **TGStation** [www.tgstation.com](http://www.tgstation.com)
- **Harry Benjamin's "Standards of Care for Gender Identity Disorders"** [http://symposion.com/ijt/soc\\_2001/index.htm](http://symposion.com/ijt/soc_2001/index.htm)
- **Intersex Society of North America** [www.isna.org](http://www.isna.org)
- **Intersexed and Transgendered People** [www.itpeople.org](http://www.itpeople.org)

**Hotline:**

- **Lesbian, Gay, Bi Youth Hotline**, 1-800-268-9688, is a provincial hotline for gay, lesbian, bisexual, transsexual, transgendered, two-spirited and unsure youth.

**Provincial Resources:**

- **Rainbow Health Ontario (RHO)** [www.rainbowhealthontario.ca](http://www.rainbowhealthontario.ca) is a province-wide program that works to improve the health and well-being of lesbian, gay, bisexual and trans people in Ontario through education, research, outreach and public policy advocacy.
- **Centre for Addictions and Mental Health** <http://www.camh.net/>  
Provides a wide range of information on substance use and mental health issues.

**Toronto Resources**

- **Sherbourne Health Centre** <http://sherbourne.on.ca/> is an urban primary health care centre serving the diverse communities of southeast Toronto since 2003.
- **Hassle Free Clinic** <http://www.hasslefreeclinic.org/> provides free medical and counselling services in many areas of sexual health. Located in downtown Toronto.

## Consent Form

Please read the following with regards to your participation in the study entitled: **A Comparative Analysis of Transgender Experiences in Accessing Ontario Health Care Services in Single-tier vs. Upper-tier municipalities.**

I consent to the information contained in the Letter of Information and understand what is required for participation in the study. I understand that I will complete a secure online survey. I also understand that the investigator is available through e-mail should I have any questions or require further information about any aspect of the study. I understand that certain questions concern sensitive topics and may be quite personal in nature. I understand that my participation in the study is completely voluntary and that I am free to withdraw at any time. I understand that to withdraw, I can either: a) simply close my browser window, or b) select the 'decline response' option for any remaining questions. I also understand that my anonymity and confidentiality will be protected throughout the study, and that the responses I provide will only be available to the investigator.

Should I have further questions, I understand that I can contact any of the following individuals:

- Shannon Coyle (613-533-6233); [shannon.coyle@queensu.ca](mailto:shannon.coyle@queensu.ca), Master's Student, Department of Gender Studies, Queen's University, or
- Dr. Margaret Little (613-533-6000 ext 75670); [mjhl@queensu.ca](mailto:mjhl@queensu.ca), Professor, Department of Gender Studies, Queen's University, or
- Dr. Bev Baines (613-533-6000 ext. 75030); [bainesb@queensu.ca](mailto:bainesb@queensu.ca), Head of the Department of Gender Studies, Queen's University
- Dr. Joan Stevenson (613-533-6000 ext. 74579); [stevensj@queensu.ca](mailto:stevensj@queensu.ca), Chair of the General Research Ethics Board, Queen's University.

- I have read the above statements and freely consent to participate in this research project.
- I have read the above statements and do not wish to participate at this time.

## **Appendix D**

### **Debriefing Form**

#### Debriefing Form

#### **A Comparative Analysis of Transgender Experiences in Accessing Ontario Health Care Services in Single-tier vs. Upper-tier municipalities**

The purpose of this study was to examine the prevalence of negative and discriminatory experiences faced by transgender identified persons accessing Ontario Health Care services. Additionally, differences in the health care experiences of persons who identify differently from each other on the transgender spectrum, sexuality, racial and class categories were investigated. You have been invited to participate in this study because you are a trans-identified person 18 years of age who speaks, reads, and writes English fluently, and are currently or have previously accessed Ontario Health Care Services.

This study was conducted for educational purposes. Two main groups of participants were recruited in this study: trans persons who live in single tier municipalities (urban cities) and upper tier municipalities (rural cities). Participants were recruited via poster advertisements in the Kingston community, as well as through online sources. All participation was voluntary. Trans persons face numerous barriers to obtaining health care. Fear of discrimination, insensitivity of providers, for example, using the pronoun "he" for transsexual women, and financial reasons all may prevent trans persons from accessing health care (Kaiser, 2000 & Lombardi, 2001).

Most population-based surveys do not ask questions about gender and sexuality. Instead, most LGBT research available consists of self-reports of experienced discrimination with health care services, rather than quantitatively and qualitatively asking questions about what trans persons actually need in terms of standardized health care.

Much of the research in existence today totalizes and homogenizes trans people into one category – devoid of race, class, and personal history. Canadian scholars and health care professionals have only begun to address the health concerns of trans persons. Much of this research is

preliminary and focuses on trans persons in upper tier municipalities. There is a need to expand knowledge regarding trans persons actual health care needs so that can accurate and informed decisions can be made, not only for their basic health needs, but also for trans specific healthcare needs in both upper tier and single tier cities.

As stated previously, all information that you provided throughout the study is confidential. The research team members working directly on this project are the only individuals who have access to your responses, which are not connected with any identifying information.

Thank you for your participation in this study – it is greatly appreciated. Should you have any further questions, comments, or concerns, please do not hesitate to contact Shannon Coyle in the Gender Studies Department at 613-533-6233; [shannon.coyle@queensu.ca](mailto:shannon.coyle@queensu.ca), or Dr. Margaret Little at -613-533-6000 ext 75670; [mjhl@queensu.ca](mailto:mjhl@queensu.ca).

If you would like further information regarding this research topic or related topics, please consult the following articles:

1. Bauer et al. (2009). “I Don’t Think This Is Theoretical; This Is Our Lives’’: How Erasure Impacts Health Care for Transgender People. *Journal of the Assoc. of Nurses in AIDS Care*, 20 (5), 348- 361
2. Harcourt, J. (2006) *Current issues in lesbian, gay, bisexual, and transgender health*. New York: Harrington Park Press.
3. Kaiser Permanente National Diversity Council. (2000) *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population*. Oakland, CA. Kaiser Permanente.
4. Lombardi E. (2001) Enhancing Transgender Health Care. *American Journal of Public Health*. 91(6):869-872.
5. Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. Chicago: University of Chicago Press.

Some of the questions in this survey were sensitive in nature. If you are feeling distressed, please consult the following resources for help:

Telehealth Ontario: 1-866-797-0000

### Internet Resources

- **Trans-Health.com** [www.trans-health.com](http://www.trans-health.com)
- **TransGender Care** [www.transgendercare.com/default.asp](http://www.transgendercare.com/default.asp)
- **Canadian Rainbow Health Coalition** [www.rainbowhealth.ca](http://www.rainbowhealth.ca)
- **LGBT Health Channel** [www.gayhealthchannel.com](http://www.gayhealthchannel.com)
- **TGStation** [www.tgstation.com](http://www.tgstation.com)
- **Harry Benjamin's "Standards of Care for Gender Identity Disorders"** [http://symposion.com/ijt/soc\\_2001/index.htm](http://symposion.com/ijt/soc_2001/index.htm)
- **Intersex Society of North America** [www.isna.org](http://www.isna.org)
- **Intersexed and Transgendered People** [www.itpeople.org](http://www.itpeople.org)

### Hotline:

- **Lesbian, Gay, Bi Youth Hotline**, 1-800-268-9688, is a provincial hotline for gay, lesbian, bisexual, transexual, transgendered, two-spirited and unsure youth.

### Provincial Resources:

- **Rainbow Health Ontario (RHO)** [www.rainbowhealthontario.ca](http://www.rainbowhealthontario.ca) is a province-wide program that works to improve the health and well-being of lesbian, gay, bisexual and trans people in Ontario through education, research, outreach and public policy advocacy.
- **Centre for Addictions and Mental Health** <http://www.camh.net/>  
Provides a wide range of information on substance use and mental health issues.

### Toronto Resources

- **Sherbourne Health Centre** <http://sherbourne.on.ca/> is an urban primary health care centre serving the diverse communities of southeast Toronto since 2003.
- **Hassle Free Clinic** <http://www.hasslefreeclinic.org/> provides free medical and counseling services in many areas of sexual health. Located in downtown Toronto.