

Trans Needs Assessment Report



by Sue Scruton

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Glossary and Key Concepts

Trans – In our survey, and in this report, we use the term ‘trans’ as an umbrella term to include anyone whose gender identity differs from the one they were assigned at birth, including transgender, transsexual, genderqueer, gender fluid, intersex and otherwise gender non-conforming.¹

Androgyne - 1. A person whose biological sex is not readily apparent. 2. A person who is intermediate between the two traditional genders. 3. A person who rejects gender roles entirely.

ASO – AIDS Service Organization. Community-based organization that provides support primarily to individuals with HIV, as well as prevention, testing and referral resources.

Cisgender – A person who is not trans: whose gender identity, behaviours and appearance are in harmony with what their culture expects from a person with their external sex characteristics.

Genderqueer – An umbrella term used proudly by some people to defy gender restrictions and/or to deconstruct gender norms.

Gender identity – This is how we perceive our identities as men, women, both, or neither, regardless of our physical bodies. It is separate from “biological sex.”

Gender expression – The demonstration of one’s gender identity, often shown through clothing, behaviours, interests and/or chosen names.

Intersex – a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male.

Pangender - A person whose gender identity is comprised of many gender expressions.

Transphobia – The fear of, discomfort with, disrespect of, or dislike of transgender people and/or those with non-traditional gender identities or gender expressions.

Trans man (FTM) – A female-to-male trans person. FTM can also be used to denote a direction of transition.

Trans woman (MTF) – A male-to-female trans person. MTF can also be used to denote a direction of transition.

Some of these definitions are borrowed, with permission and thanks, from the 519 Church Street Community Centre’s Equity Glossary of Terms. The transphobia definition comes from the report Opening the Door to the Inclusion of Transgender People. The androgyne and pangender definitions come from Genderqueer Identities.

¹ Throughout the survey, we used the umbrella term ‘trans*’ (which includes the asterisk as part of the word). For the sake of readability, we have omitted the asterisk in the report.

Acknowledgements

This project owes a huge debt to the Trans Community Advisory Committee, a group of people from across Canada, who generously volunteered their time and expertise to ensure that this project would be credible, meaningful and culturally sensitive.

We also want to thank the people who took time out of their busy schedules to participate in key informant interviews and share their knowledge about trans health and social needs, issues and trans programming in Canada.

We are grateful to Robb Travers and Lauren Munro of TransPULSE in Ontario, Art Zoccole of 2-Spirited People of the First Nations, and Elijah Edelman of the Washington Transgender Needs Assessment, all of whom reviewed and provided useful feedback on drafts of the survey.

We are especially thankful and indebted to all the people who shared their first-hand knowledge, expertise, insight and understanding of the needs of trans people by participating in our survey. We hope this research will contribute to equity and inclusive services for trans people in Canada.

I want to extend my personal thanks and heartfelt appreciation to all my friends and colleagues at the Canadian AIDS Society, especially Bernice Aye, Monique Doolittle-Romas, Patrick McIntyre, John Sharp and Kim Thomas for their ongoing support, encouragement, and invaluable help with this project.

Funder

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Executive Summary

This Trans Needs Assessment was undertaken by the Canadian AIDS Society (CAS) between the Fall of 2012 and the Spring of 2014.

The primary objective of the research was to gain a better understanding of the needs of trans people (including transgender, transsexual, genderqueer, intersex, and otherwise gender non-conforming) in order to enhance capacity among AIDS service organizations (ASOs) to serve them.

Under the guidance of a National Community Advisory Committee, and with ethics approval from the Public Health Agency of Canada's Research Ethics Board, we conducted a bilingual national survey of trans people between September 2013 and January 2014. There were eighty-one questions on the survey, exploring gender, income, employment, housing, experiences of discrimination and harassment, support, health care, health status, transition, use of AIDS service organizations, and other needs.

Data from the 256 completed and 204 partially completed surveys were used in the analysis. Of respondents who identified as men or women, there was almost equal representation. Over one-quarter (26%) of respondents identified as genderqueer. The median age of respondents was 29. They were, on the whole, well-educated (43% had an undergraduate degree or college diploma, and 11% had a Master's Degree or a Ph.D). One-third were students at the time of the survey.

We also conducted key informant interviews with representatives from seven AIDS Service Organizations (ASOs) and two LGBTQ health services organizations, to explore trans needs from the service providers' perspectives, as well as challenges in service delivery.

Key Findings from the Trans Needs Assessment Survey

- Over half (51%) estimated their pre-tax income in the previous 12 months to be less than \$20,000. One person in five reported being under severe financial stress.
- 85% of survey respondents reported being harassed for being trans. 22% had been physically assaulted and 19% had been sexually assaulted. More than one in ten (11%) said they did not feel safe in their own homes.
- 19% of respondents had not revealed their gender identity to any of their health care providers. 15% had not told anyone in their immediate family.
- 23% of respondents did not want gender reassignment surgery; 28% had already undergone it, 9% were in progress, and 34% wanted it.
- 27% of respondents have children.
- 18% rated their mental health as poor, compared to only 6% who rated their physical health as poor. This has serious implications, given the known high rate of attempted suicide among the trans population and the shortage of trans-competent mental health resources.
- Despite very high estimates of HIV prevalence among trans women in other studies,² this did not appear to be the case among respondents of all genders to this survey. Only 0.8% reported being HIV positive, 1.9% said they'd prefer not to say, and 17.9% did not know their status. However,

2. Baral SD, Poteat T, Strömdahl S, et al. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2013 13(3): 214 – 222.

most respondents had either never been tested for HIV (39%) or had not been tested in over a year (35%). Of those who had not been tested within the previous twelve months, 68% said they were not at risk for HIV.

- One-third of respondents reported that they are not sexually active.

Key Findings from the Key Informant Interviews

Most of the seven AIDS Service Organizations (ASOs) we spoke with have taken some steps towards trying to be more trans-inclusive. Generally this involved making changes to mission statements, policies, washrooms, and being more inclusive with language. Some have trans volunteers, or, more rarely, staff.

While some ASOs offer trans-specific programming, they are the exception. It is more common for ASOs to include trans people in their general programming. This ranges from simply advertising that trans people are welcome at events, to making significant changes to the programs to make them relevant and inclusive of trans people.

Some challenges identified by ASOs in providing services to trans people included a need for more information, education and resources around trans issues generally and trans sexual health issues specifically; negative attitudes towards trans people on the part of some of their other clients; the diversity within and between the trans communities; and funding.

Discussion and Recommendations

The most pressing needs identified by trans people who responded to this survey were:

- Better access to trans-competent and respectful health care of all kinds, including primary care, mental health care, emergency care and trans-specific health care such as gender therapy, hormone therapy and gender reassignment surgeries.
- More public education, understanding and acceptance of people who are trans by people who are not trans people need an end to discrimination and transphobia.

The Canadian AIDS Society makes a number of recommendations to its member organizations:

- Partner with local trans communities and organizations. Know what resources are available locally.
- Include trans people on staff, boards and advisory committees. Strive for diversity (male-to-female, female-to-male, and genderqueer).
- Offer trans-led, trans-specific programming to people who identify as trans, so that they don't feel outnumbered or othered. Recognize that gender-segregated programs cause difficulty for many who identify as trans, genderqueer or non-binary.
- Where trans-specific programming is not feasible, adapt materials and resources to be meaningfully inclusive to trans lives and bodies, in consultation with relevant trans advisors.
- Ensure that all staff, clients and board members receive trans 101 training, and that service providers receive relevant trans training on an ongoing basis. Address any instances of disrespect or transphobia immediately.
- Be aware of the additional barriers trans people face in HIV testing, including avoidance of health care settings, dual stigma, and erasure.
- Ensure physical spaces are trans-inclusive, with posters, sexual health materials and other

resources. Convert single-user washrooms to all-gender washrooms (change the signage), and consider doing the same for multi-user washrooms.

- Update mission statements, human resource policies, and anti-harassment policies.
- Include larger-gauge needles for hormone injection in harm reduction materials.

The Canadian AIDS Society makes the following recommendations to governments with respect to epidemiological gaps:

- That the provinces, in collecting the epidemiological data they already capture for males and females, expand their collection tools to include people who identify as trans.
- That the Public Health Agency of Canada, in consultation with the trans communities, explore the best way of obtaining more detailed second-generation epidemiological data for the trans population. One possibility would be to conduct a series of cross-sectional HIV studies, which would allow for the epidemic to be monitored among this population, as it is among other vulnerable populations in Canada.
- That both the provinces and the Public Health Agency of Canada consult with the trans communities about how best to collect this information to ensure that the right questions are asked, that they are asked sensitively and respectfully, and that the process is community-driven. A critical part of this consultation would involve a discussion of how epidemiological data would benefit the trans communities.

Section 1: Background

Introduction

Recent studies have suggested alarming rates of HIV infection among trans women, both in the United States and internationally, and have concluded that “transgender women are a very high burden population for HIV and are in urgent need of prevention, treatment, and care services.”³

Because epidemiological surveillance data does not track HIV by gender identity, Canada does not yet have consistent, reliable HIV data for the trans population. As a result, we continue to rely on widely varying estimates from studies conducted by organizations in North America and elsewhere, and adapt them, with caveats and cautions, to the situation here in Canada.

Over the last few years, some of CAS’ member organizations have reported an increase in the number of trans people seeking services, and have expressed a need for building capacity to serve this community. At the same time, some of our other member organizations report that they haven’t seen an increase in the number of trans people coming through their doors, and they’re wondering why not, given the statistics they’ve been hearing.

Our original motivation for this initiative resulted from requests received from members of the trans communities at the Canadian AIDS Society (CAS) Forum discussions and Annual General Meetings in 2010 and 2011. They asked us to undertake a needs assessment to explore the needs of trans people vis-à-vis AIDS service organizations (ASOs).

Under the guidance of a National Community Advisory Committee, we’ve surveyed people who are trans, and we’ve interviewed representatives of ASOs, with the primary objective of gaining a better understanding of the needs of people who are trans in order to enhance our capacity to serve them.

Study Goal and Objectives

Goal

This project was undertaken to identify ways in which the Canadian AIDS Society (CAS) could support its member organizations in particular, and community-based organizations more generally, to enhance services for the trans communities.

Objectives

To understand, from the perspective of trans people, their needs and their challenges in accessing services from ASOs and other community-based organizations;

To understand, from the perspective of ASOs and other community-based service providers, their challenges in providing services to trans people;

To identify best practices, resources and potential next steps in building ASO capacity to provide services to people who are trans.

3. 21.6% in high-income countries, according to Baral et al, 2013.

Methods

Overview

This mixed-method, qualitative and quantitative research project took place between the fall of 2012 and the spring of 2014.

A National Community Advisory Committee (NCAC), comprised of individuals from across Canada, most of whom identified as trans, was recruited through an open call for members in 2012. The NCAC offered direction and input with all aspects of the process, including study methodology, survey design, survey promotion, key informant interview selection, interpretation of data and dissemination of findings.

A key component of the research was a bilingual, 81-question online survey focused on capturing, as much as possible, the breadth and diversity of trans needs, as well as those needs that seem to run common among so many trans people. The survey was online for 15 weeks between September 2013 and January 2014.

A series of nine key informant interview were conducted in November and December 2013. Seven of these interviews were conducted with representatives of AIDS Service Organizations (ASOs) and two were conducted with representatives of LGBTQ health organizations.

Phase I: National Trans Needs Assessment Survey

Data Collection

A bilingual, anonymous survey questionnaire was developed by the Canadian AIDS Society and the National Community Advisory Committee and approved by the Public Health Agency of Canada's Research Ethics Board. It was housed on FluidSurveys, an online survey design, management and analysis tool. The survey was only available online. All privacy and security settings were set to ensure maximum levels of anonymity. Fluid Surveys was selected as the survey tool because its servers are based in Canada and therefore not subject to the provisions of the U.S. Patriot Act.

There were a total of 81 questions on the survey, although skip logic generally resulted in most respondents being presented with fewer questions than this. The questions consisted of a variety of multiple choice, checkbox, and open-ended text responses.

We used a variety of methods to recruit respondents, including posting information on our website, emailing trans individuals and organizations, sending out a flyer and email to CAS members and networks, posting on social media and other websites, contacting specialized groups like labour and various LGBTQ committees, posting hard copies of flyers at various community health centres, sexual health centres and ASOs, publishing notices on Rainbow Health Ontario's research database, and publishing notices in online newsletters (our own and several others).

No incentives were offered to respondents for participating in this research.

Data Analysis

Data from the completed (256) and partially completed (204) surveys were used in the analysis.

Descriptive statistics were used to summarize the data. Tables and graphs were generated from the data to visually represent the findings. Where possible, FluidSurvey's built-in reporting functionality was used for charting.

Text responses were analyzed. Where appropriate, FluidSurveys' 'bucketing' feature was used to create categories for analysis.

Phase 2: Key Informant Interviews

Data Collection

In-depth, semi-structured, one-on-one interviews were conducted with seven service providers from AIDS Service Organizations who are members of the Canadian AIDS Society. Telephone interviews were conducted by the Principal Investigator and lasted approximately one hour. Interviews were recorded and transcribed by the Principal Investigator.

Interview questions explored: 1) the major issues and priorities for people who are trans, 2) the current organizational capacity for serving this population, and 3) the challenges and barriers, both for service providers and trans service users.

Data Analysis

The data was reviewed and analyzed for themes.

In addition to the seven member organizations, we also conducted similar interviews with two service providers from LGBTQ health organizations, both of whom have extensive experience providing services to trans people. The data from these two interviews are reported separately.

SECTION 2:

National Trans Needs Assessment Survey

Overview

The survey started with a fairly detailed consent form. If a respondent did not agree to the consent question, the survey terminated. The consent question was followed by two qualifying questions, both of which had to be answered affirmatively for the survey to continue.

The qualifying questions were:

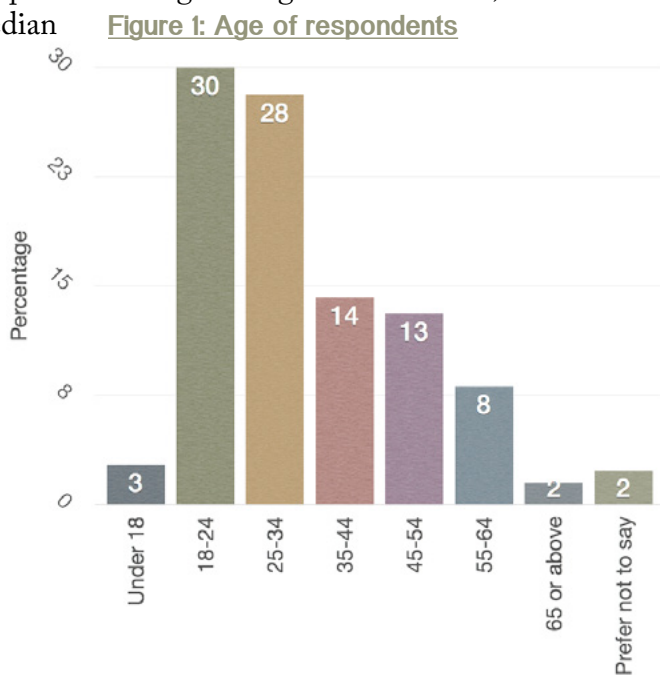
1. Do you currently live in Canada?
2. Do you now or have you ever considered yourself to be trans* (including transgender, transsexual, intersex, genderqueer or gender non-conforming in any way)?

These two questions were mandatory and established these two criteria. If either of these two criteria were not met, the survey was terminated. There were 515 respondents who started the survey. Of these, 256 completed it, 204 partially completed it, and 55 were terminated as a result of their responses to one of the first two questions. On average, the survey took 44:07 minutes to complete.

1. Demographic Overview of Respondents

Age

Respondents ranged in age from 15 to 79, with an average age of 33 and a median age of 29.



This skewing towards the youthful end of the age continuum is partially due to the fact that the survey was only accessible online. While the majority of Canadians in all age groups are online, the proportion does drop with age.

“I need my dad to allow me to take hormones. I need testosterone, top surgery and bottom surgery. I need the money for all of this and the money for university.”

“Though I’ve got a good income on paper, I’ve had to relocate to one of Canada’s most expensive cities to find a job that pays half as much. Add a failed relationship, due mainly to social pressures, and child support, and my effective wage is around 35k per year.”

Province/Territory

Respondents resided in all Canadian provinces and territories except Nunavut and the Yukon. Two provinces stood out as having an unexpected number of respondents. While 24% of the Canadian population resides in Quebec, only 14% of our survey respondents were from Quebec. The opposite situation prevailed in British Columbia: BC is home to 13% of the Canadian population, yet 25% of our respondents resided there.

Urban/Rural

Approximately half of our respondents lived in large cities, and the other half lived in smaller cities, towns and rural areas. This has implications for the services they can access, and the ways in which they can access them. For some trans people, there is significant and ongoing travel involved in ensuring that their health care needs are met. Several people indicated in the comments that they relocated to larger urban centres while they were actively transitioning and most in need of frequent health care services, and then returned to their home city or home town afterward.

Ethnicity

Respondents could select as many ethnicities as applied to them. Well over 90 per cent were Caucasian, six per cent were Aboriginal (predominantly Métis) and one per cent were African, Caribbean and Black. (Based on their responses to another question two per cent of our respondents live on a First Nations reserve or Métis community.)

Language

83% of respondents reported English as their first language, and 12% reported French. The remaining 5% were divided between ten European, African and Asian languages.

2. Economic Overview of Respondents

Education

Respondents to this survey had high levels of formal education. Over half (54%) had at least one post-secondary degree or diploma, with 43% having an undergraduate degree or college diploma, and 11% having a Master’s Degree or PhD. Another 27% had “some” post-secondary education; many of these were students at the time of the survey. Fully one-third of the survey respondents were students when they took the survey.

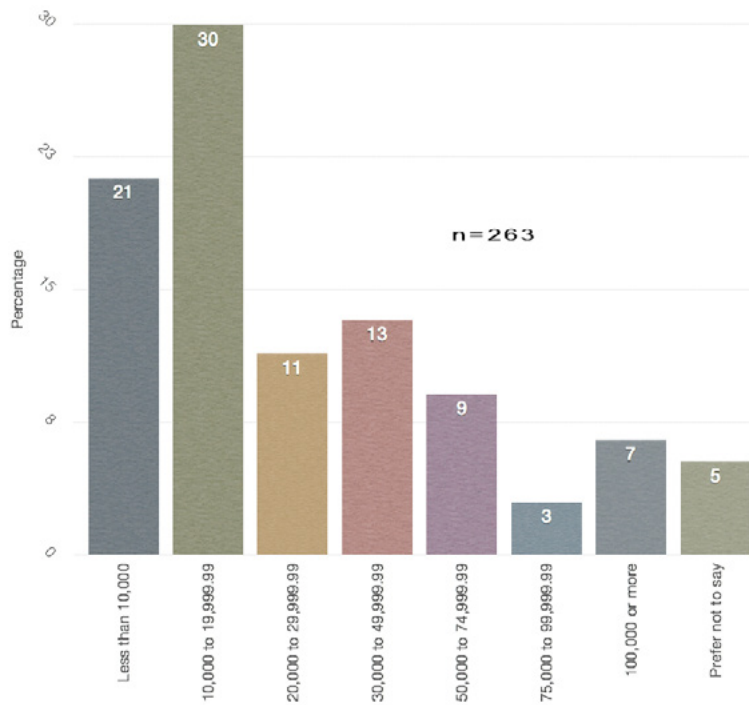
Income & Employment

Despite high levels of education, respondents did not have correspondingly high levels of income. Over half (51%) estimated their personal pre-tax income in the previous 12 months to be less than \$20,000.

Some of this income skewing towards the low end of the scale can be

attributed to the high number of students among our respondents. But this does not explain all of it.

Figure 2. Estimated personal before-tax income.



For every trans person in this survey who believed their income was higher than that of other people with similar skills, experience and education, four others believed their income was less than that of other people with similar skills, experience and education.

Although 73%

of respondents said they had some employment income in the previous twelve months, and 62% said it was their primary source of income, only 38% were currently employed full-time.

One respondent in five reported being under severe financial stress. While we did not research the economic impact of being trans on individuals, we know that for many people, there are economic impacts. Being trans can negatively affect earning potential⁴ while adding significantly to expenses. Poverty, as a social determinant of health, has a huge impact on people’s life chances and their potential risk for HIV/AIDS, Hepatitis C and a myriad of other health issues.

Housing

More than one-third of respondents (35%) reported having lived with a spouse or partner in the previous year, and almost a quarter (23%) reported living at home with family they’d grown up with.

A number of respondents report having spent time in the previous year homeless, living in institutions, or staying temporarily with friends or relatives. While these numbers are relatively low (ranging from 2% to 10%), they are very likely undercounted, as people in these circumstances are less likely to have had access to the survey. It is worth noting that up to 40-50%

“I need a weekly trans support group that is facilitated by a professional facilitator. I need trans-specific mental health care. I need trans-specific help in finding a job. This one is extremely important.”

4. Bauer G, Nussbaum N, Travers R, Munro L, Pyne J, Redman N. We’ve Got Work to Do: Workplace Discrimination and Employment Challenges for Trans People in Ontario. Trans PULSE e-Bulletin, 30 May, 2011.

“Greater sensitivity to trans issues from all health care providers. As a genderqueer, non-binary person who does not intend to use hormone therapy or surgically transition, what would help me most is a greater consciousness about gender issues, along with health care professionals making fewer assumptions and just asking what my needs are (instead of assuming).”

of homeless youth in urban areas report being LGBT⁵.

84% of respondents appear to have stable housing, having moved only once or not at all in the previous year. However 16%, or roughly one in six, moved at least twice, suggesting the possibility of some housing instability among that group.

A large majority of respondents report that their homes are safe (89%), adequate (85%) and affordable (69%).

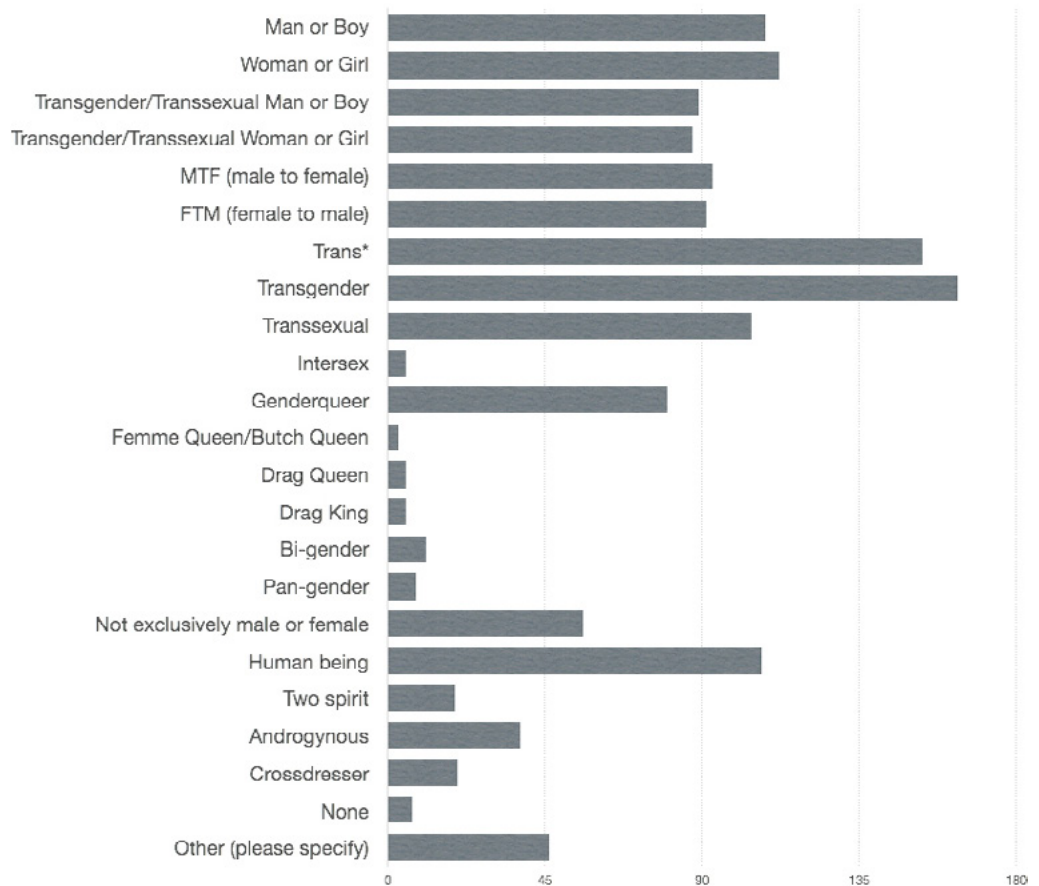
But the flip side is that 31% of respondents don't feel that their homes are affordable. More concerning, 11% of respondents report not feeling safe in their own homes. If you don't feel safe in your own home, where do you feel safe.

3. Gender Overview of Respondents

Gender

As expected, there is rich variation in the words people chose to describe their gender identities.

Figure 3. With which of the following genders do you identify, some or all of the time? (Please check all that apply.)



5. <http://www.cbc.ca/news/canada/ottawa/half-of-homeless-ottawa-youth-identify-as-lg-btq-1.1699604>

Given that respondents were encouraged to indicate all genders with which they identified, there was considerable overlap, with many people selecting more than one. The most commonly selected identities were trans, transgender and transsexual, and variations thereof. However this is partly due to the fact that these are gender-neutral terms and thus male-identified, female-identified and non-binary people could identify with them.

Terms that didn't specifically reference the trans aspect of one's gender identity were also frequently chosen, such as human being, man (or boy) and woman (or girl).

Of the respondents who indicated that they were MTF (male to female), FTM (female to male) or other binary identities, they were almost evenly split between women and men.

A number of respondents indicated gender identities outside of the binary – in other words, not exclusively male or female but elsewhere on the spectrum of gender possibilities. Over one-quarter (26%) of respondents identified as genderqueer. Some other non-binary identities included pan-gender, bi-gender, and androgynous.

In addition to the list of 22 terms we provided, we included an option for "Other (please specify)". Forty-six respondents specified genders not on our list, including non-binary, agender, genderfluid, transmasculine, neutrois, butch, questioning, transmasculine androgyne, fem/femme, and affirmed male.

Coming out and being out as trans

66% of respondents said that the first person they came out to as trans was a partner or a friend. Approximately 10% first told a family member, and 12% first told a health care professional, therapist or counselor.

People were most likely to be out to their friends and immediate family (spouse, parents, children, siblings), and least likely to be out at work and in their faith/spiritual communities. But 15% had not revealed their gender identity to anyone in their immediate family. Almost one in five (19%)

Figure 4. How many people know you are trans in each of the following groups of people?

	All or most	None
Immediate family	73%	15%
Non-trans friends	72%	3%
Trans friends	87%	2%
Health care providers	65%	19%
Colleagues at work	45%	31%
Online communities	65%	5%
Faith/spiritual communities	40%	45%

*Calculations included only those respondents who indicated they had these individuals or groups in their lives.

"I need people to know my gender exists, I suppose. Easier routes to transition? (with no mandatory real-life test even) Mental health resources I could access without having to worry it will result in education or or arguing about gender. I don't need much, the closet's pretty safe."



“The College of Physicians and Surgeons told me that any doctor can turn me away solely on the basis of being trans if they’re not comfortable working with me, even for things non-transition related, like antibiotics for a sinus infection. Doctors should not be allowed to discriminate!”

had not revealed their gender identity to any of their health care providers. Hiding trans identity from a health care provider can have significant implications for adverse interactions between medications and hormones⁶.

Support for gender identity and expression

We asked respondents how supportive different people and groups have been of their gender identity and gender expression.

Of the respondents who indicated that they had these individuals or groups in their lives, and that they were out as trans to them, the following table shows how they rated those people’s level of support for their gender identity and expression.

Figure 5. How supportive have different people and groups been of your gender identity and gender expression.

	Not at all supportive	Not very supportive	Somewhat supportive	Very supportive
Parents	8%	18%	31%	43%
Spouse	7%	1%	12%	80%
Children	11%	7%	21%	61%
Non-trans friends	1%	3%	36%	60%
Trans friends	1%	1%	8%	89%
Co-workers	6%	9%	43%	42%
Supervisor/boss	6%	10%	27%	57%
Teachers	8%	14%	26%	53%
Classmates	8%	13%	52%	27%
Mental Health Professionals	4%	4%	18%	74%
Doctors	6%	6%	30%	59%
Faith Community	14%	2%	30%	55%
Cultural Community	12%	11%	33%	44%

On the positive side, in almost every case – with the exception of classmates and coworkers – the highest percentage were considered “very supportive.” Nevertheless, the table reveals a disturbing lack of support of varying degrees from many directions.

Transitioning

Transitioning is the process of changing one’s gender expression to match one’s gender identity. Transition can be social or physical or some combination of both. It can include things like changing one’s name, changing pronouns, coming out as trans, starting hormone therapy and having surgeries. A person can be trans without ever undergoing any medical procedures.

Gender reassignment surgery (GRS - also known as sex reassignment

6. Bauer et al, 2009.

Figure 6. What actions, if any, have you taken to transition?

	Yes	In progress	Not yet, but want to	No, don't want to	Prefer not to say	Total Responses
Part-time, non-permanent alterations (eg binding, packing, clothes, makeup, etc.)	178 (80.9%)	15 (6.8%)	6 (2.7%)	16 (7.3%)	5 (2.3%)	220
Full-time, non-permanent alterations (eg binding, packing, clothes, makeup, etc.)	183 (72.0%)	24 (9.4%)	22 (8.7%)	21 (8.3%)	4 (1.6%)	254
Moved to a community with better trans* services and resources	79 (36.9%)	7 (3.3%)	42 (19.6%)	66 (30.8%)	20 (9.3%)	214
Hormonal therapy	173 (63.8%)	24 (8.9%)	46 (17.0%)	20 (7.4%)	8 (3.0%)	271
Sex reassignment surgery	71 (28.1%)	23 (9.1%)	86 (34.0%)	59 (23.3%)	14 (5.5%)	253
Other surgical interventions	53 (23.5%)	10 (4.4%)	97 (42.9%)	56 (24.8%)	10 (4.4%)	226
Psychiatric/psychological assessment	167 (64.2%)	34 (13.1%)	27 (10.4%)	26 (10.0%)	6 (2.3%)	260
Electrolysis	66 (28.4%)	20 (8.6%)	40 (17.2%)	94 (40.5%)	12 (5.2%)	232
Speech therapy	30 (14.2%)	15 (7.1%)	53 (25.0%)	106 (50.0%)	8 (3.8%)	212
Changed name informally	167 (72.9%)	21 (9.2%)	17 (7.4%)	21 (9.2%)	3 (1.3%)	229
Changed name legally	130 (49.4%)	19 (7.2%)	85 (32.3%)	24 (9.1%)	5 (1.9%)	263
Changed assignment sex on legal documents	78 (31.0%)	31 (12.3%)	101 (40.1%)	30 (11.9%)	12 (4.8%)	252

surgery, or SRS) is an array of optional procedures that differ between trans women and trans men and between individuals, depending on their circumstances and choices.

Not all trans people want to physically or surgically transition, and those who want to often encounter barriers. There are many factors to consider in deciding if, when, and how to transition, such as body image, sexuality, health, current relationships, future reproductive options, and economic circumstances.

Costs are often a significant barrier, as some provincial health plans don't cover GRS. Even among those that do, there are often qualifying criteria, waiting periods, resource shortages, and associated expenses that aren't covered.

In our survey, 23% of respondents did not want GRS, 28% of respondents had undergone GRS, 9% were in progress, and 34% wanted to have GRS but hadn't yet. (Note: 5.5% of respondents selected "prefer not to say" but several noted in the comments that they were actually undecided, and suggested that an 'undecided' response option would have been useful.)

“I need gender-affirming identification documents so that I may travel freely without fear or threat of border issues.”

Other transition-related needs were also identified by respondents, such as hormonal therapy (17%), speech therapy (25%), other surgical interventions (43%), legal name change (32%), and sex assignment change on legal documents (40%).

Based on the comments, we clearly missed “Laser Facial Hair Removal” which was specifically mentioned by eight respondents, and would likely have been selected by others had it been listed. Others suggested we could have distinguished between top and bottom surgery and added genital reconstruction rather than just sex reassignment surgery. Another suggestion was that we could have included “Live full time/fully out.”

Access to trans specific health care is very uneven across Canada. 37% of respondents have already moved to a community with better access to trans services, and another 20% want to do so.

The most commonly undertaken actions to transition - non-permanent alterations such as binding, packing, clothes, and makeup, and changing one’s name informally - are things that people can self-determine and undertake independently, without going through any medical or legal channels.

Many trans people encounter barriers and “Catch-22” situations in changing the assignment sex or gender marker on their legal identification documents such as passports and driver’s licenses. The ramifications of having one’s gender marker not match one’s gender presentation are not insignificant. Four out of ten respondents indicated that they wanted to change the assignment sex, or gender marker, on their legal documents, but had not yet been able to do so.

4. Relationships

Sexual Orientation

Because trans is part of the LGBTQ umbrella, people sometimes assume it has something to do with sexual orientation. It’s about gender identity, which is about what gender(s) you perceive yourself to fundamentally be (e.g. man, woman, both, or neither), which is quite distinct from sexual orientation.

However, sexual orientation may be a more complex thing to label or define for trans people. In our survey, 32% of respondents identified as lesbian, gay or queer, compared to 18% straight, 18% bisexual, 18% pansexual, 5% asexual and 8% other or unsure. But in the comments, people added plenty of explanatory text, such as:

- “Others see it as straight. I have no adequate description for it.”
- “Complicated.”
- “Formerly lesbian. Now technically heterosexual.”
- “No good term for MTF non-binary.”
- “Unsure of this since transitioning.”

- “Do not identify with any.”
- “Straight. But seen as a gay woman because I am closeted.”
- “Not sure what to put here.”
- “Straight as a trans man but gay as my birth gender”
- “Queer, this is complicated though, as I identify as male and date women, so it’s hard to say, who knows how I identify my orientation.”
- “Asexualish. Uncertain.”
- “Thought I was a gay man, but I am a straight trans woman.”

So when a trans person refers to their sexual orientation, it might not be that straightforward. Different trans people may use language differently, or may use the same language differently at different times in their lives.

Relationships

42% of respondents reported that their current relationship status was single, while 24% were married or living common-law. 28% were in a relationship with another person, and 4.5% were in a polyamorous relationship.

Parenting and Children

27% of respondents to this survey have children. 6% have children who live with them full time, 3% have children who live with them part time, 9% have adult children, 2% live with somebody else’s children, and 10% have children who do not live with them. (These add up to more than 27% because some people fell into more than one category.) Other family combinations were described in the comments, including current pregnancies, children who are “like my own but they are not mine and do not live with me” and adult children who share the home.

In some cases, the children came before the transition, and were a part of the change and adjustment. In other cases, the transition took place before the children were born. Given that the median age of our respondents is 29 it is likely that a number of them will go on to have children⁷.

“[I need] couples counselling with a practitioner who is familiar with the challenges faced in relationships where there is a non-transitioning partner. Support, also, in my relationships with my children.”

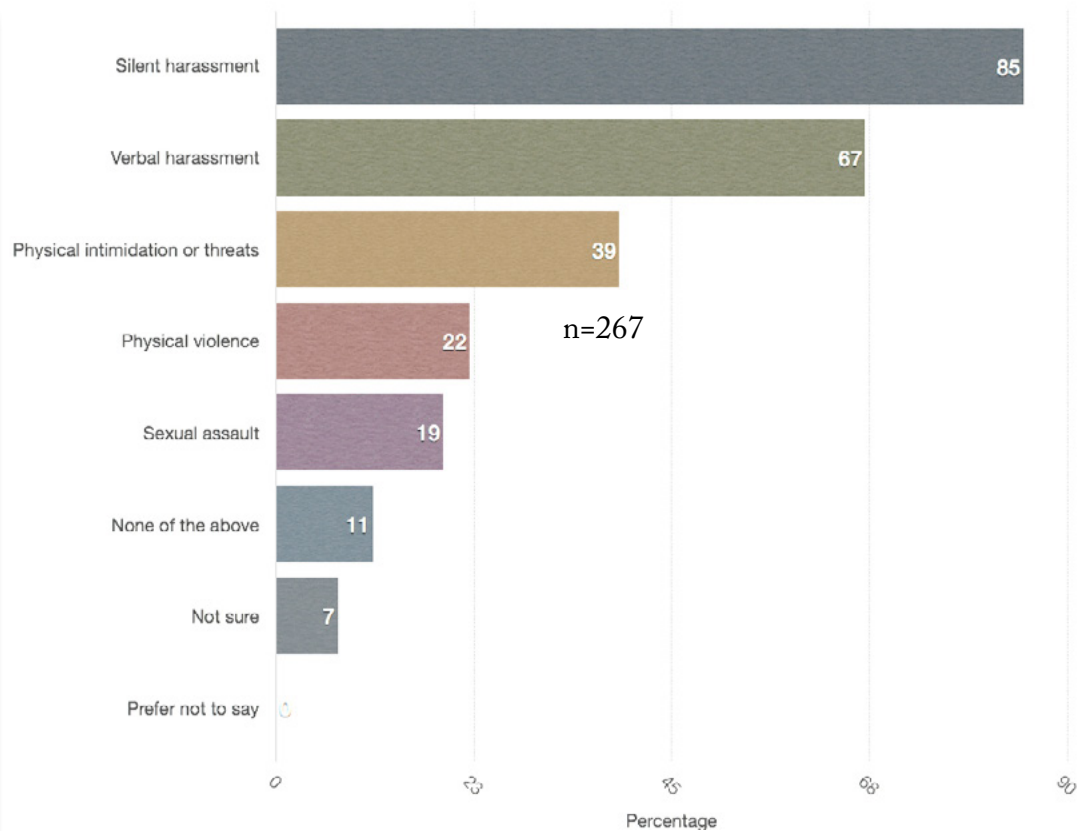
7. A useful resource: Birthing and Breastfeeding Transmen and Allies: https://www.facebook.com/groups/449750635045499/698114183542475/?notif_t=group_activity

Trans Communities

Approximately 70% of respondents said that it was very (39%) or somewhat (31%) important to them to be part of a trans community, yet only 46% felt that they were in fact part of such a community. These communities tended to be local informal networks of friends (63%), on the Internet (62%), or in LGBT centres (36%).

5. Harassment, Discrimination and Stigma

Figure 7. Have you ever experienced the following because you're trans or because of your gender expression?



13 years ago I was placed under the care of a doctor who didn't believe in all of the "gendermumbo jumbo." His bias against me led to my being forced to submit to a lengthy series of ECT treatments, which led to the loss of many of my childhood memories. Now I believe things have improved to where that would no longer happen, but there is still a big gap in knowledge for many doctors when it comes to transgender patients and their needs.

alarming majority – 85% – of respondents report being harassed, intimidated, threatened or assaulted for being trans. This is consistent with other recent research, some of which has also found that those who are seen to be expressing themselves outside of the gender binary may be at higher risk (i.e. genderqueer people report more experiences of violence than transgender/transsexual people)⁸. In our survey, one in five respondents have been physically assaulted, and almost as many have been sexually assaulted.

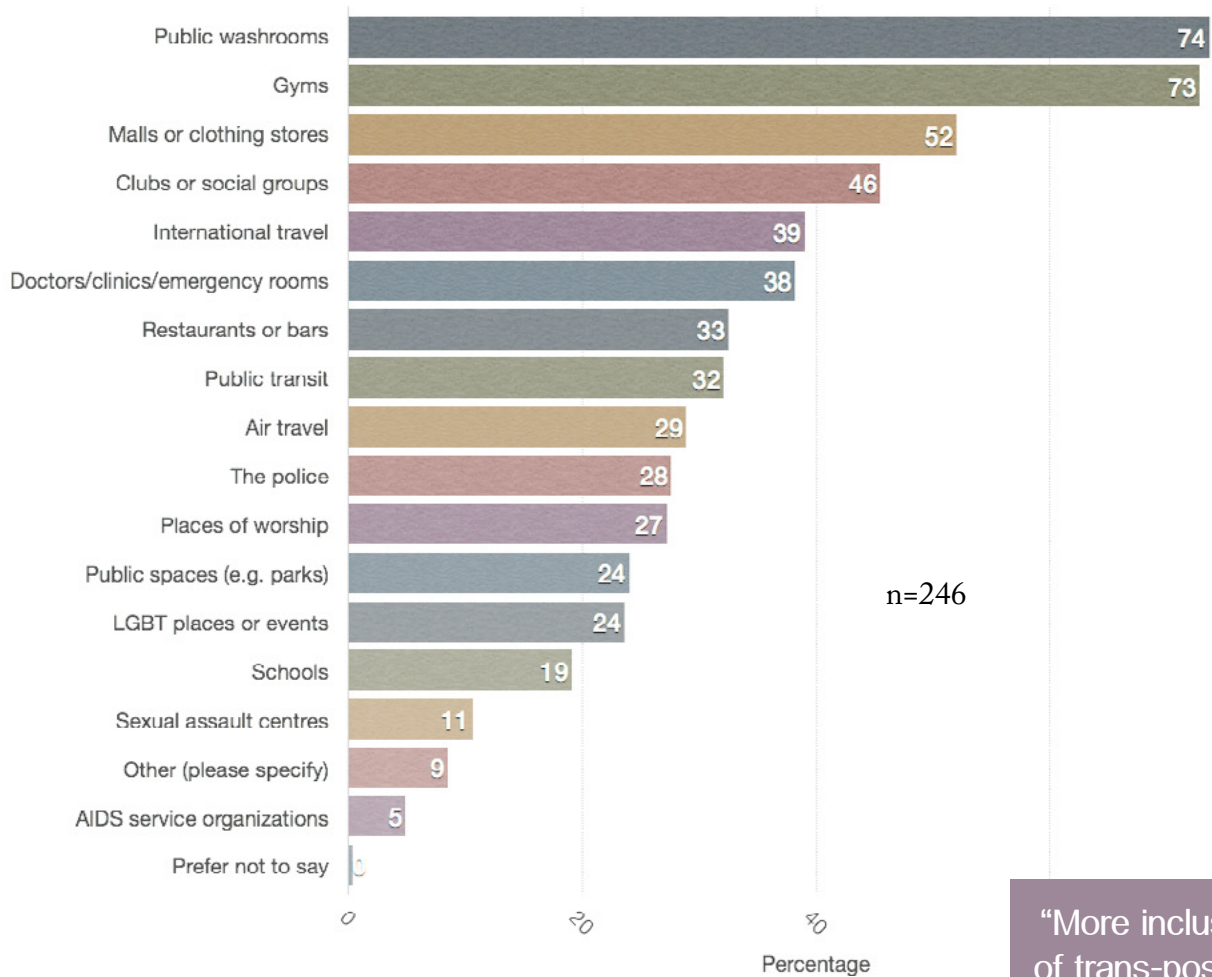
This is of grave concern, especially in light of recent American research

8. Harrison, J., Grant, J., & Herman, J. (2012). A Gender Not Listed Here: Genderqueers, Gender Rebels, and OtherWise in the National Transgender Discrimination Survey. *LGBTQ Policy Journal at the Harvard Kennedy School*, 2, 13-24. Retrieved from <http://escholarship.org/uc/item/2zj46213.pdf>

which reveals that the attempted suicide risk for trans people – already much greater than for their cisgender counterparts – is particularly severe for those who have suffered discrimination or violence^{9,10}.

Discrimination and Social Exclusion

Figure 8. Have you ever avoided any of the following situations or people for reasons related to being trans?



Large numbers of trans people avoid certain places, people and situations because they don't feel comfortable or safe using them.

A majority of respondents said they avoid using public washrooms (74%), gyms (73%), and clothing stores (52%). Other categories had somewhat smaller percentages but enormous implications for people's lives vis-à-vis their access to health care, justice, education and travel.

In the comments, a considerable number of people indicated they avoid swimming pools and change rooms of any kind. Individuals also specifically mentioned team sports, sexual health clinics, Pride events, family events,

9. Hass, Rodgers and Herman, 2014.

10. Testa, R.J. Sciacca, L.M., Wang, F., Hendricks, M.L., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*, 43(5), 452-459. doi:10.1037/a0029604

“More inclusion of trans-positive materials in high school and university curriculums. As a graduate student and teaching assistant I think it is imperative that youth and adults begin to learn more about trans individuals.”

“We need psychologists to be covered by OHIP and have a clue about transgender. We can’t afford \$120-\$180 an hour for a lifetime of help! Many of my friends are unemployed.”

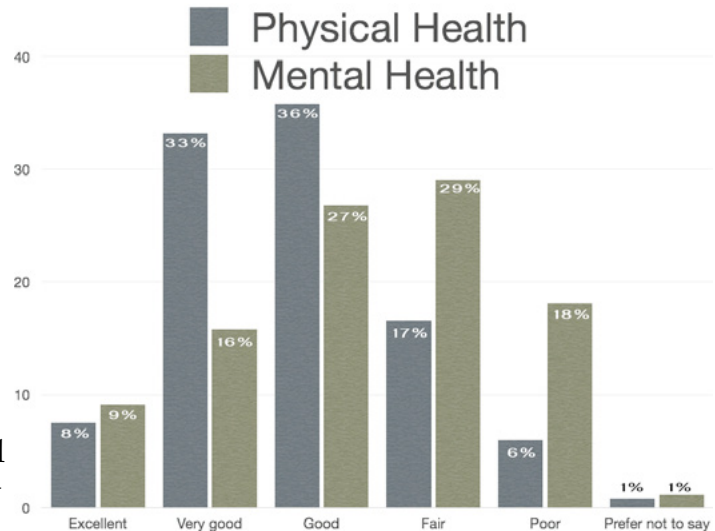
barbers, voting officials, people from the past, and non-trans-friendly businesses.

6. Health

Physical and Mental Health

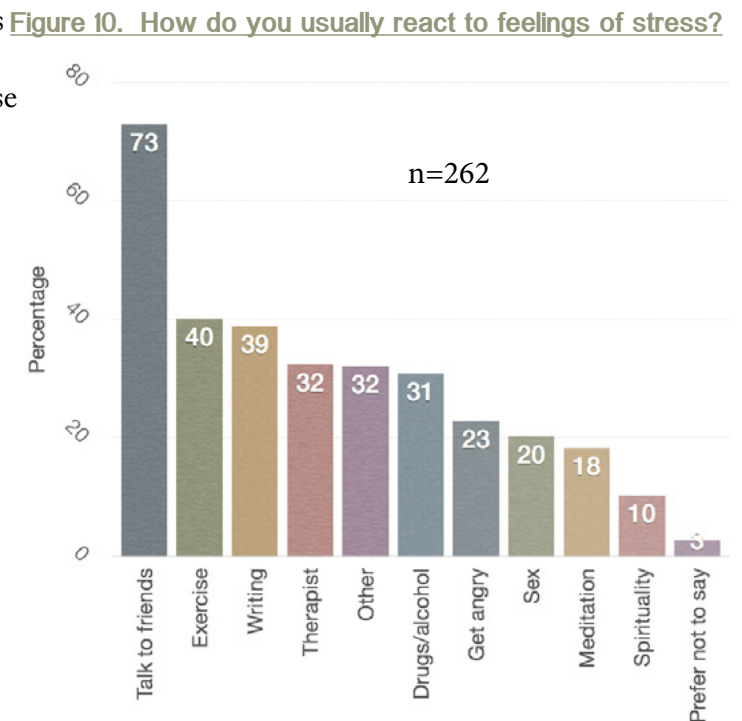
Respondents rated their overall physical health much higher than their overall mental or emotional health. Three out of four (77%) said their physical health was good, very good or excellent, compared to only half of respondents (52%) who said their mental health was good, very good or excellent.

Figure 9. Self-rated mental and physical health



Of particular concern, 18% of respondents rated their mental health as poor. It is known from other studies that trans people have exceptionally high rates of attempted suicide¹¹.

According to Hass, Rodgers and Herman (2014), while there are factors that increase suicide attempt risk, such as having a mental health condition, being HIV-positive, or being out to everyone as trans (or being noticeably trans), the most striking finding was just how high the risk was for all transgender and gender-nonconforming people, regardless of how much education they had, how much income they made, or whether or not they were married.



11. Scanlon K, Travers R, Coleman T, Bauer G, Boyce M. Ontario’s Trans Communities and Suicide: Transphobia is Bad for our Health. Trans PULSE e-Bulletin, 12 November, 2010. 1(2).

Stress

Trans people tend to be subject to additional stress, and are at higher risk for suicide, so their coping mechanisms for dealing with stress are critical. The most frequently reported responses to stress were talking to friends (73%), followed by exercise (40%), writing (39%), talking to a therapist or counselor (32%), and using drugs or alcohol (31%).

A number of responses (84) were added in the comments. Some that were frequently mentioned included: Distractions such as video games or social media (20), Creative pursuits (15), Withdrawing/avoiding people (12), Doing nothing/internalizing, or sleeping (12), Self-harm (5) or Suicide ideation or attempts (2). Had these options been included on the list, they likely would have been selected by more respondents.

Tobacco, Alcohol and Drugs

Figure 11. Frequency of tobacco, alcohol, and recreational drug use.

	Never	Used to use	Currently use less than one day per week	Currently use 1-4 days per week	Currently use 5 or more days per week
Tobacco	57.0%	19.4%	4.7%	3.1%	15.9%
Alcohol	18.2%	11.6%	42.2%	22.1%	5.8%
Injection drugs for recreational purposes	97.7%	1.9%	0.0%	0.0%	0.0%
Non-injection drugs for recreational purposes	54.4%	16.2%	15.4%	4.6%	8.1%

Healthy Lifestyle

Respondents said they tried to have a healthy lifestyle always (16%) or usually (56%).

People cited ‘more money,’ ‘more motivation,’ and ‘more time’ as the top three things that would help them live healthier lives. But in the comments, they added: “Having access to top surgery, so I can go to gyms/pools,” “Better access to trans-positive gyms and recreational opportunities,” and “Access to gyms with gender neutral changerooms.”

7. Health Care

We asked people how well they felt their health care needs were being met, with respect to dental health, mental health, transitioning, sexual health, emergency care, complementary care, patient advocacy and HIV-related health care. Fewer than half of respondents felt that their health care needs were being met ‘very well’ in any category that they considered applicable to their needs.

“Too many trans people take their own lives, too many feel they are dying a little every day, too many are murdered, too many slip through the cracks, and all of us carry that knowledge around every day.”



“Though I should access gynaecological resources, I am far too uncomfortable to access such exclusively cis women centric resources.”

The wording of this question in the present tense: ‘How well are your health care needs being met?’ may not have captured the full range of experience that we would have liked, particularly with health care experiences that tend to be more sporadic, such as emergency care, or time-limited, such as transitioning.

Interestingly, the category with the greatest level of satisfaction was transitioning: 45% of respondents to whom transitioning was applicable reported that their health care needs were being met very well. However, 26% of respondents indicated that their transitioning needs were being met poorly.

20% of respondents reported that their emergency health care needs were poorly met. We know from TransPULSE¹² that more than half of trans Ontarians surveyed have had negative experiences in emergency rooms. And, in the comments of our survey, a number of respondents specifically mentioned the need for emergency room care that is knowledgeable and respectful of trans people and bodies.

Respondents also encountered difficulties in accessing respectful care of all kinds. Doctors sometimes refused to treat them, even for conditions completely unrelated to their gender identity. People reported being misgendered, outed, embarrassed, humiliated, scorned, laughed at, and denied treatment.

We asked those who have regular doctors how knowledgeable their doctors are about trans-specific health matters. 26% said their doctor was very knowledgeable, 43% said moderately knowledgeable, and 32% said not very knowledgeable. (We did not ask, but have been told, that there is another category: Doctors who were not initially knowledgeable about trans-specific health matters, but who have been educated by their first trans patients.)

We asked those who did not have a regular doctor where they usually went for health care when the need arose. Sixty per cent went to walk-in clinics, 11% to other clinics, 5% to hospitals. Of the 22% who said “other”, references were made to trans specialists, HIV specialists, and informal health care connections. Most, however, said that they basically don’t get medical care; they handle it themselves.

Hormones

63% of our respondents currently take hormones to support their gender transition, and the great majority of these do so under medical supervision. 26% of respondents have never taken hormones, and another 3% used to but do not currently. Most of those who take hormones are obtaining them through prescriptions from a specialist or GP. However 5.2% have at some

12. Bauer, Greta R., PhD, MPH; Ayden I. Scheim, BA; Madeline B. Deutsch, MD; Carys Massarella, MD, FRCPC. 2014. *Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada: Results From a Respondent-Driven Sampling Survey*. *Annals of Emergency Medicine*. Retrieved from: <http://www.annemergmed.com/webfiles/images/journals/ymem/FA-YMEM5689.pdf>

point obtained hormones from an Internet pharmacy, 4.7% have obtained them from a friend or relative, and a small number of people have obtained them from the street, strangers, and health food stores.

8. Sexual Health

Sexually Transmitted Infections

96% of respondents had not been diagnosed with any STIs in the 12 months prior to the survey. Of those who had, gonorrhea led the way with three infections, followed by HPV and chlamydia with two each, and herpes with one.

HIV Status

Our survey results did not corroborate the alarmingly high rates of HIV infection that other studies have suggested. Fewer than 1% (0.8%) of respondents reported being HIV positive, with 1.9% preferring not to say, and 17.9% saying they did not know their status. However, HIV testing among respondents was low.

Given the very limited epidemiological data about HIV and trans people in Canada, the National Consensus Statement on Women, Trans People and Girls recommended that surveillance studies be undertaken to understand the prevalence of HIV infection among trans people, in a manner that is respectful of autonomy and privacy¹³.

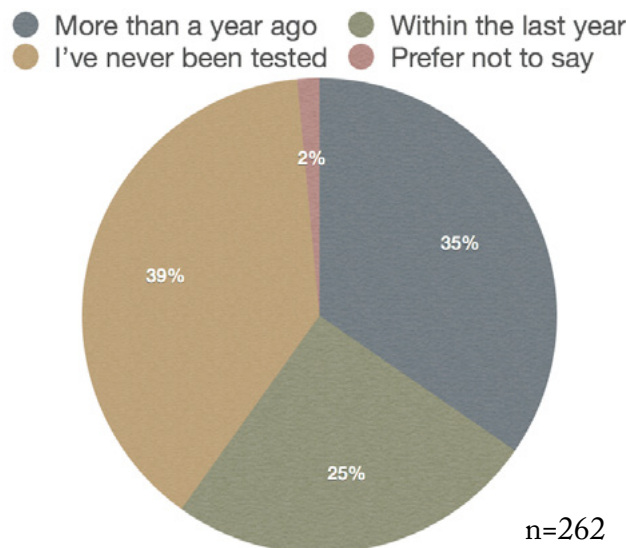
HIV Testing

Most respondents had either never been tested for HIV (39%), or had not been tested in over a year (35%). Only a quarter had been tested in the previous year.

Among those who had been tested, the top reasons for their last HIV test were:

- It was part of a routine medical checkup (36%)
- I just wanted to find out if I was infected or not (26%)
- It was required for hospitalization or a surgical procedure (19%)

Figure 11. When were you last tested for HIV?



“When you go from guy to girl, sex is kinda different and as such more information on staying safe would be awesome.”

13. Jacqueline Gahagan & the Gathering of Spirits Collaborative (2013). The National Consensus Statement on Women, Trans People and Girls and HIV Research. Halifax, NS: Dalhousie University, Gender and Health Promotion Studies Unit.



Among those who hadn't been tested recently, the most common reason by far was that they didn't consider themselves to be at risk for HIV (68%),

Figure 12. In the past twelve months, how frequently have you engaged in the following behaviours?

	Never	Once	2-6 times	12 times or more
Sharing needles (e.g. for drugs, hormones, silicone or saline)	99.6%	0.4%	0%	0%
Unprotected sex with a high-risk partner or a partner who does not know their HIV status	90.0%	3.9%	3.5%	2.7%
Casual sex while under the influence of drugs or alcohol	82.6%	6.6%	7.3%	3.5%

followed distantly by not having gotten around to testing (17%).

In the comments, a number of people reiterated that they had little or no risk of contracting HIV because they were not sexually active or they were in monogamous relationships. Others said that they

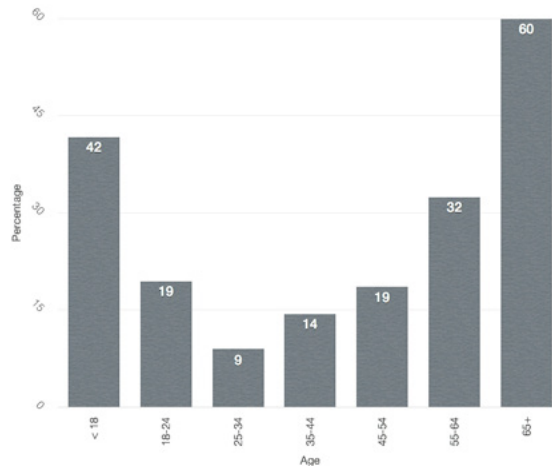
were uncomfortable asking for an HIV test, or that they avoided medical environments as much as possible.

Trans people face other barriers to HIV testing. They may feel 'othered' at places where testing is done, including AIDS Service Organizations, because of the cisnormative culture (i.e. assumptions that being cissexual, or non-trans, is normal). Further, some might choose not to know their status when considering the prospect of the dual stigma of being both trans and HIV-infected¹⁴.

Risk

More than a third (34%) of respondents report that they are not having sex. This is particularly the case towards both ends of the age continuum.

Figure 13. Percent of respondents not having sex by age group.



“...Walking into an ASO, whether to see an advocate, pick up free condoms, or seek out health information, is a very scary prospect for a lot of trans people, especially when you walk in and there’s only white, gay men and white, middle-class social workers.”

14. McWilliam, S., Leonard, L., Medd, E., & members of the Ontario Women and HIV Working Group. (2007). HIV prevention in Ontario: Transgendered people. Retrieved February 20, 2014, from http://www.health.gov.on.ca/english/providers/pub/aids/factsheets/hiv_web_fs_women_trans.pdf.

For some older trans people, this might be a choice. But for others, it's not. Being older shrinks the romantic and sexual pool of possibilities for many cisgender people as well, but trans people also have the effects of transphobia to contend with.

Of the two-thirds of trans respondents who are having sex, monogamy, condoms, lube and 'alternate sexual activity' are the most common ways in which they lower their own or their partners' risk of HIV infection.

AIDS Service Organizations

Fewer than one per cent of the respondents to this survey reported being HIV positive, so it wasn't surprising that 83% of them had never used the services of an AIDS Service Organization. Of those who had used an ASO, 17 were occasional users, nine were website users, six were former users, and one reported being a regular client. In the additional comments, four noted that they worked or volunteered at an ASO, one used the needle program, and one attended trans community meetings at an ASO.

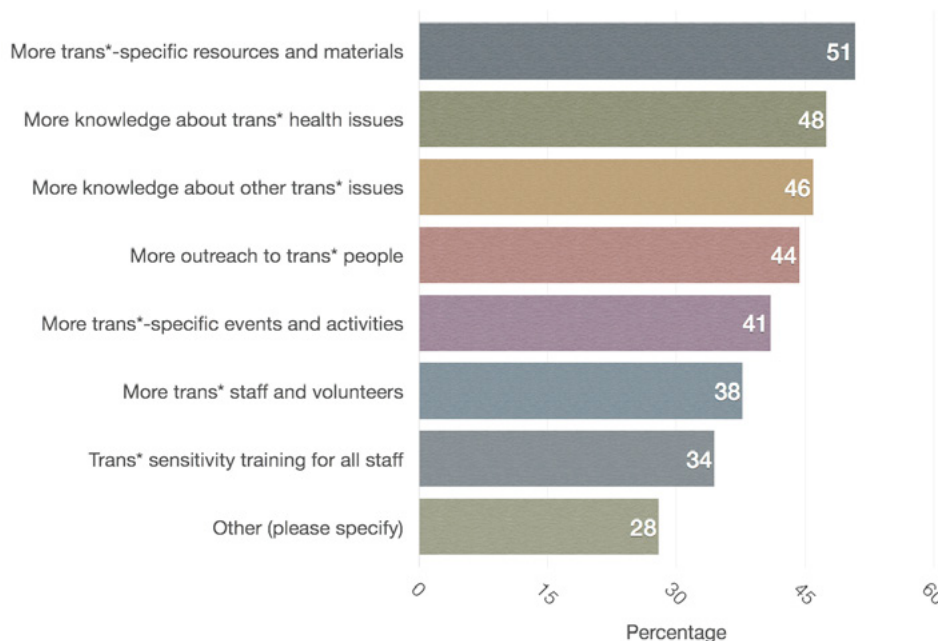
The most common reasons given for not using the services of an ASO were not being HIV positive (78%), not needing anything from an ASO (34%), or not knowing what services an ASO could offer (19%). A small percentage also indicated that they didn't think they'd feel welcome because of their gender (1.7%) or their trans status (5.2%).

There is a need for more sexual health materials and resources that are specifically inclusive and relevant to the bodies and lives of trans people, and a need for safer injection material that includes larger gauge needles for hormone injections.

"I need to know what kinds of safer sex materials work for MY body..."



Figure 14. What could your local ASO do (or improve) to better meet your needs as a trans client? (Please check all that apply.)





When presented with a list of services, the ones that were seen as potentially useful by the most respondents were:

Figure 15. Which services are (or would be) of use to you? (Please check all that apply.)

Trans-specific	64%
Information	54%
Social/recreational	43%
Health	41%
Access to safer sex materials	33%
Advocacy	29%
Education/Prevention	26%
Legal	21%
Referral	20%
HIV/STI testing	20%

“I think that while supporting trans people is definitely important, educating non-trans people is a priority.”

Based on the chart above, it would seem that trans respondents want ASOs to have more knowledge and understanding of them, and more useful information for them. As it currently stands, remarkably little is known about trans people and HIV in Canada.

Section 3: Key Informant Interviews

Overview

Key informant interviews were conducted with seven people who work in AIDS Service Organizations (ASOs), and two people who work in LGBTQ health organizations. They spoke from a broad range of perspectives and experiences, as they represent very diverse organizations in diverse regions of the country.

This section identifies the themes that emerged from the interviews with the ASOs. We'll examine:

1. Current capacity among ASOs to serve trans people, and
2. Challenges in providing services to people who are trans

In the next section we will look at the interviews with the LGBTQ health organizations.

Quotes are included to illustrate themes. Participants are not identified.

Current capacity among ASOs to serve trans people

Almost all of the ASOs we spoke with had made efforts to improve their organizational capacity to serve people who identify as trans. In order of frequency, these included 1) activities aimed at organizational capacity building and improving cultural competence, 2) adapting existing programming to include people who are trans, and 3) introducing trans-specific programming.

Organizational capacity-building and cultural competence

This included such actions as updating mission statements or anti-harassment policies, converting to gender-neutral washrooms, or providing cultural competency training to staff and/or clients.

"We put together a gender identity policy, and we do our very best to try to implement that policy at all different levels of the organization, to safeguard the rights of trans communities and to ensure that people do feel it's an organization that includes them."

"After we moved [to a safer building], the increase in the number of trans women was quite something."

Adapting existing programming for people who are trans

Some ASOs take the approach of trying to be more inclusive of and welcoming towards trans people in their existing programming, without making any changes to it. This might mean a line on a flyer for a women's event, for example, that trans women are welcome. Others look for innovative ways to expand and modify their programs so that they will have relevance to trans people. Many existing programs in ASOs are primarily gender segregated, which would still cause difficulty for many who identify as trans, genderqueer or non-binary.

"We don't have trans-specific programming, but about 7-10% of our clients for drop-ins and retreats are trans. Their needs are the same – housing, alcohol and drug treatment, safety. Trans women maybe have a greater need for safety because they're so visible and they're targets. Also, the ways they support themselves put them at risk. It's a women's organization, so safety is an issue for everybody, but particularly for trans women."

“We’re starting to include more language that’s relevant to trans men and their bodies, like ‘If you’re a trans man you need to consider the following.’ Without having trans specific programming, we’ve been including issues related to sexual health in our programming and messaging for gay men.”

“I recently took some workshop material that had been designed for gay and bi men as a way to teach HIV prevention in the context of anal pleasure and harm reduction, and challenged myself to also make it proactively inclusive for trans men. Then I went over it with a trans man who also does sexuality workshops, which was very, very informative because there were things that I would never have thought of but that were obvious to him of course.”

“There’s a laundry list of things you’ll want to do when you go for your physical with your doctor if you want to be proactive about your sexual health. So we developed this checklist with a bunch of community partners who also deal with queer issues or sexual health issues more broadly. But in having the discussions that led into that checklist, we asked the question, ‘If we’re designing this list specifically for men, what do we mean by men? Is that inclusive of trans men? How would this list have to be different for that?’ We realized that within the confines of timelines and other parameters of that project that we didn’t have time to do justice to what that would mean to be inclusive of trans men.... It is complicated and it’s going to take time but we’re going to make it part of the plan for the next phase – we’re going to develop lists specific to trans men and trans women for HIV prevention. I’m kind of excited about that. It’s definitely breaking new ground and I see it as something important.”

Trans-specific programming

A small number of ASOs offered or were planning to introduce trans-specific programs.

“We run a program for trans and gender diverse people. It’s run by a trans man, and it’s in its 5th year of operation. It provides peer support groups and resources for trans people throughout a large [mainly rural] area of the province. It also provides education to health care workers, police, social workers, mental health workers, front line workers, etc. We’ve provided Trans 101 to over 1,000 people in 18 different communities.”

“We’re starting a pilot project, an HIV prevention and sexual health group for trans gay men which will be meeting a huge need. It will give us more info about the sexual health needs of trans gay men and how their needs might be better reflected in the outreach that we do with gay men in general. We’re hearing from trans gay men that there’s a need for sexual health and prevention programming.”

Challenges for Service Providers

Service providers identified some challenges they’ve encountered in providing services to trans clients. These included 1) their own needs for more information, education and resources around trans issues, 2) attitudes of some of their other clients, 3) diversity within and between the trans communities, and 4) funding issues.

The need for more information, education and resources around trans issues

The challenge most frequently mentioned by service providers was the need for more information, education and resources around trans issues generally, and trans sexual health issues specifically.

“We need more core information and research about what the unique needs of the trans

population are.”

“My general sense is there isn’t a whole lot of trans-specific HIV prevention research and information out there.”

“We need up-to-date info, trans-specific training for board, staff and clients, trans-specific resources, especially local resources, more info about where to refer people for various things – quality local resources.”

“We may specialize in HIV/AIDS but we don’t specialize in trans needs. So connecting with the resources, say well-established models of trans care, having access to those would make a big difference.”

“It would be better if we knew more at a local level about what the situation is, the numbers of trans people living with HIV, who they are, men or women, is it particular groups. We need more local epi info....The information we’re getting from the City, from Public Health, we suspect there’s a lot of under-reporting of HIV in the trans population, maybe people aren’t identifying themselves as trans when they’re getting tested.”

One key informant felt that the presence of trans men in prevention workshops for men who have sex with men added a layer of complexity to the delivery of sexual health information.

“All of the presumptions I have about men having sex with men and the risks involved in those particular acts, I now have to add on every possible combination and permutation if I’m looking at trans people as a population. That’s far more complicated, and that’s because it deals with all the things about vaginal sex that I’ve never had to address directly....so clearly it’s going to be that much more complex and nuanced and have to cover that much more of a broader range of things.”

Attitudes of other clients

There was some discussion of the challenges of misogynistic and transphobic culture, and what’s involved in a space actually being inclusive.

“The biggest challenge has been around peer education. We can advertise a women’s social as being inclusive and friendly to trans women, and then a trans woman walks in and one of the clients says “What’s that man doing at our social?” It’s challenging.”

“Trans women have always been part of the gay community here, and have always been accepted as part of the fabric. But in the social hierarchy, trans women are perceived as crazy in general. The whole misogyny thing in the gay community is that the feminine men have less value than masculine men, and that would be even more extended if the feminine man was actually a woman. So they’re accepted as part of the community, but they’re certainly not respected.”

Diversity within and between the trans communities

Several service providers pointed out that it can sometimes be challenging to work with the trans communities, by virtue of their diversity.

“There is no homogeneous [trans] community that says ‘Here’s who we are and here’s what we think is important.’ That commonality of purpose just doesn’t exist. There are competing factions on just about everything you can think of, from what should be covered in SRS surgery, to what pronouns should be used, to what political tactics should be used, to what the health care system should or shouldn’t be doing, any number of things. So we know that when we do a community

consultation, it's important to get it right, but it's probably going to be challenging.”

“What are the gaps that we feel we as an organization have a history, have the capacity, and are best placed to fill? Because you can always say we're going to offer all these programs, but if for whatever reason you don't have a history or aren't seen to have competence in serving the community, people aren't going to come.”

Funding

“The funding agencies need to add trans to their list of priority groups. That would allow for more development of appropriate resources and tools and initiatives and research for the needs of the trans population.”

“ All of our work is supposed to be evidence-based, in terms of our funder’s priorities and assessments. It makes it very challenging to take on new pieces of work when the research hasn’t happened yet. The fact that trans populations need to be considered a high risk or priority population for programming also means that whatever the criteria are that fund that research also need to be brought on board identifying this as a priority area.”

“More funding would allow us to hire another [trans] person, preferably a youth to try and get into the schools.”

“ Any population specific initiative needs funding. There are no direct trans services or organizations in this province.”

“Some cities have lots of population-specific ASOs. Here, we’re the only one. We serve a very diverse cross-section of people. People’s needs are so vast and different....It creates an interesting culture in the organization because we have limited resources and everybody’s fighting for the same piece of the pie...The trans community is always outnumbered.”

Key Informant Interviews with trans-focused health organizations

We also conducted key informant interviews with people working in community-based health organizations that provide health care services to people who identify as LGBTQ. These key informants had extensive experience and knowledge of the health care gaps and needs of trans people generally. Some of the services offered by these organizations include: primary care, counseling, support groups, education and cultural competency training, capacity building, clinical training on trans health, maintaining trans referral lists and provider directories, and development of system navigation tools and public education materials. The themes that emerged from these interviews centered around health care gaps and cultural competence.

Health care service gaps

They identified access to primary care, mental health care, trans assessment processes, sex reassignment surgeries, endocrinologists, medically certified training for medical providers, and social supports as priorities.

“As well as groups, we have a lot of people who come here for individual counseling and mental health supports and trans people form a very large percentage of the people we see, mainly because they can’t find good services elsewhere.”

“[Trans people] are everywhere, as you would expect with any population. And there is need all over the province.”

“Sex is rarely talked about between trans people and service providers. Who talks about sex and having sex from a service provider perspective? They’re just trying to wrap their head around and get comfortable with someone who’s trans, and talking about sex is a whole other topic. They might have some discomfort with their own lack of knowledge, or with knowing what to call different body parts....But trans people are telling me that nobody’s talking to them about sex and STI and HIV testing. That’s a huge issue.”

Cultural Competence

“Trans people live with constant concern about what’s going to happen to them when they access health care services. For example, when they’re sitting in a waiting room waiting for an x-ray on their arm, what name is going to be called out? Are they going to be outed or stigmatized? Many have experienced that, and it stops them from going back to get more health care.”

“We do a lot of training with health care organizations, with long term care organizations and hospitals because of course people who are trans run into enormous barriers, particularly when they go into places that are segregated by gender or places where somebody is going to be caring for their physical body. And that might be more of an issue for somebody who has HIV, who might be entering the hospital more often.”

“There’s a lot of diversity in trans communities, and debates between them....It’s complicated. And how does it filter down to the ways we educate health and service providers? Where service providers are getting their information from impacts the way they interact with people who are very very diverse. How do they deal with the very diverse needs within trans communities?”

“How do service providers ensure that they understand the complexity of identity and deal with it? Service providers need to understand that if it says trans on somebody’s form, it doesn’t necessarily mean that they want to be called she or he or that they’re planning or are on hormones. They might just be where they’re at and plan on staying there in terms of their physical bodies.”

“I think it’s great that they [ASOs] are exploring those questions and it’s on their radar. In many ways there’s some great work happening. But I know that sometimes what happens is it becomes overwhelming...the complexity [of trans people] is a challenge, and sometimes it is felt as a burden.”

Section 4: Discussion and Recommendations

The primary objective of this research was to help gain a better understanding of the needs of people who identify as trans, so that AIDS service organizations can build their capacity to provide relevant services to the trans population. A key component of this research was to ask trans people what they need, and to listen and report on what they said.

The needs of trans people are diverse. Nevertheless, some of the same needs were identified by many of those who responded to this survey.

Chief among these was better access to competent and respectful health care of all kinds, including primary care, mental health care, emergency care and trans-specific health care such as gender therapy, hormone therapy and gender reassignment surgeries.

Some other needs that were identified by many respondents included human rights legislation to prohibit discrimination on the basis of gender identity, changes to the legal requirements for changing the gender markers on identification documents, and the need for more trans support groups.

One need that transcended and underscored all others was the need for more public education, understanding and acceptance of people who are trans by people who are not trans people need an end to discrimination and transphobia. Discrimination effectively excludes them from fair and equitable access to human rights, employment, income, health care, travel, and virtually all other aspects of civic life. Transphobia poses direct and ongoing threats to their safety, physical and mental health, and sometimes even their lives.

Over 85% of respondents to this survey report experiencing harassment, threats, violence or sexual assault because they are trans. Eleven per cent reported that they didn't even feel safe in their own homes. If you don't feel safe in your own home, where do you feel safe?

Given that trans people are a marginalized population and are frequently harassed, discriminated against and stigmatized in their day-to-day lives, and considering their increased vulnerability to other health risks such as poverty, it is hardly surprising that they report high rates of poor mental health - 18% in this survey. This is not helped by the shortage of affordable trans-competent mental health resources available to them. This was a need identified by many respondents.

There is an existing wealth of knowledge and expertise on trans health care, mental health care, support services, and culturally competent trans service provision in Canada. There are some phenomenal organizations, programs and services in Canada that are widely respected by the trans communities. Some of these organizations are helping other organizations build capacity; some are even helping other cities build capacity. Programs identified as

“I have faced severe discrimination at hospital and health care providers who have refused care to me because I'm trans, have laughed at me when they discover I'm trans and who have said hateful and hurtful comments. I now would rather accept death than go to any hospital and will never call 911 because of it.”

models of excellence in trans care should be funded to expand to other cities.

Recommendations for AIDS Service Organizations

There are well over a hundred ASOs in Canada, and there is a wide range of trans experience and cultural competence among them. Of the seven we conducted key informant interviews with, one has a dedicated trans program run by and for trans people. The other six report varying degrees of engagement with and services for people who are trans. Some report little to no demand for services from trans people, which may be indicative of avoidance of these agencies by trans people. In some cities there might be large trans populations but limited direct trans engagement at the ASO because trans-specific services are offered by other organizations in the city. Based on the survey and some of the key informant interviews, it would appear that most trans people prefer to receive trans-specific services rather than simply being included in the general (often gender-segregated) programming offered by ASOs.

Most of the ASOs we spoke with have been taking steps towards becoming more trans-aware and inclusive, but acknowledge that more work remains to be done, particularly in the areas of training and education for board, staff and clients, trans-specific resource development, and engagement with the trans communities.

In order to continue to build capacity to work with people who identify as trans, we recommend that AIDS Service Organizations:

- Partner with local trans communities and organizations. Know what resources are available locally.
- Include trans people on staff, boards and advisory committees. Strive for diversity (male-to-female, female-to-male, and genderqueer).
- Offer trans-led, trans-specific programming to people who identify as trans, so that they don't feel outnumbered or othered. Recognize that gender-segregated programs cause difficulty for many who identify as trans, genderqueer or non-binary.
- Where trans-specific programming is not feasible, adapt materials and resources to be meaningfully inclusive to trans lives and bodies, in consultation with relevant trans advisors.
- Ensure that all staff, clients and board members receive trans 101 training, and that service providers receive relevant trans training on an ongoing basis. Address any instances of disrespect or transphobia immediately.
- Be aware of the additional barriers trans people face in HIV testing, including avoidance of health care settings, dual stigma, and erasure.
- Ensure physical spaces are trans-inclusive, with posters, sexual health materials and other resources. Convert single-user washrooms to all-gender washrooms (change the signage), and consider doing the same for multi-user washrooms.
- Update mission statements, human resource policies, and anti-harassment policies.
- Include larger-gauge needles for hormone injection in harm reduction materials.

Epidemiological data

Accurate Canadian epidemiological data about HIV in the trans population are needed. We don't know how HIV, hepatitis C and other blood-borne diseases are affecting the trans population. How

many trans people are living with HIV in Canada? Are those numbers increasing over time? What are the risk factors and vulnerabilities of different groups of trans people? What kinds of prevention initiatives are needed?

Currently we rely on prevalence estimates from assorted studies conducted by various organizations in the United States and internationally. We adapt them, with caveats and cautions, to the vastly different Canadian context. But we don't know. In order to have an evidence-based response to HIV in the trans population, we need evidence. In order for the trans population to be prioritized and adequately resourced by funding bodies, accurate data are needed. Data would help define the problem and solutions, assist in planning, set priorities, help elicit opinions from the community, and stimulate awareness, support and action.

Recommendations:

- That the provinces, in collecting the epidemiological data they already capture for males and females, expand their collection tools to include people who identify as trans.
- That the Public Health Agency of Canada, in consultation with the trans communities, explore the best way of obtaining more detailed second-generation epidemiological data for the trans population. One possibility would be to conduct a series of cross-sectional HIV studies, which would allow for HIV to be monitored among this population, as it is among other vulnerable populations in Canada.
- That both the provinces and the Public Health Agency of Canada consult with the trans communities about how best to collect this information to ensure that the relevant questions are asked, that they are asked sensitively and respectfully, and that the process is community-driven. A critical part of this consultation would involve a discussion of how epidemiological data would benefit the trans communities.

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