LGTB Health Matters

An Education & Training Resource
for Health and Social Service Sectors

THE CENTRE
A Community Centre Serving and Supporting
Lesbian, Gay, Transgendered, Bisexual People
and their Allies

crhc
csac

The Centre:
A Community Centre Serving and Supporting
Lesbian, Gay, Transgender, Bisexual People and Their Allies

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This document has been developed with the assistance of many people. People who have given time, shared their ideas, enthusiasm, experiences and resources so that health and social service providers might be better informed about the needs and capacity of LGTB people, families and communities.

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Throughout the project and the development of this document I have had the opportunity to discuss the importance of LGTB-inclusion in health and social services with a variety of organisations. These ranged from universities and colleges to providers of health and social services, unions, government and community agencies, far too many to list individually, so I thank them all. I specifically want to thank the individuals within these organizations who facilitated these contacts and who supported the project.

As a part of fact-finding a number of small group discussions were conducted with LGTB community members. These groups included; lesbian, bi and trans women 55 years plus, LGTB youth, queer staff of Vancouver Coastal Health, community members in Kamloops, two-spirit people, queer families and the Chronically Queer group (queer people with a disability). Thank you to the people who attended and shared their experiences and ideas. I hope that you will see some of what you shared reflected in this document.

The LGTB Health Matters Working Group has been integral to the defining and guiding of this document. I am grateful to all of the participants for their time, energy and critical reflections. I hope that you will reap the benefits of your commitment to this work when you use this resource in your setting. The working group members were:

Donna Wilson, chair— The Centre
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Emily Falk, Fulbright Scholar— BC Centre of Excellence for Women's Health (until May 2005)
Jill Cory— BC Women's Hospital and Health Centre *(until March 2005)*

I particularly want to thank Mike Tarko and Heidi Walker. Mike co-authored module one and provided detailed editing advice throughout. Heidi wrote the section on Lesbian Health in module three.
Last but not least to the management and staff of The Centre; to Donna Wilson for her vision and guidance, my peers for their support and encouragement and the many volunteers who helped with photocopying and administrative tasks.

Brian Dunn,
LGTB Health Matters Project,
January 2006

LGTB Health Matters

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Introduction

The *LGTB Health Matters: An Education & Training Resource for Health and Social Service Sectors* has been developed as a convenient and practical resource for educators of health and social services personnel. It is a tool which can be used in part or its entirety. Constructed as four independent but inter-related modules, it uses a variety of methods to help the educator and learner to better understand LGTB communities, their experiences and their interaction with health and social service sectors.

This material has been developed in response to a deficit in the education of many health and social service professionals relating to the recognition and needs of LGTB people and communities. During preparation of this document, a number of professional schools for health and social services personnel from around the province were contacted to determine what LGTB-specific content was covered in their teaching. The scan indicated that most included none or what was included related predominantly to sexual health or HIV/AIDs. It was, however, heartening to speak with those colleges and universities that did feature some content specific to issues such as heterosexism and homophobia.

The need for this material goes beyond the knowledge and skill deficit within the service sector. The real issue is the health and well-being of LGTB people. Available health statistics indicate that LGTB Canadians are dying younger and experiencing poorer health than heterosexual and non-trans people. Excluding HIV/AIDs - which predominantly impacts gay and bisexual men - there is not a great deal to account for these epidemiological discrepancies. The fact that LGTB people experience higher rates of depression, smoke more cigarettes and possibly consume greater amounts of alcohol points to other causes, causes that might be socially or politically founded. Heterosexism and homophobia, transphobia and biphobia (LGTB-phobia) have a profound impact on individuals, families and communities and are, as a result, costing money and lives. The material in this document attempts to make connections between how society and systems are constructed to exclude LGTB people, what impact these exclusions have on their health and well-being and what needs to be done, particularly in the health and social service systems, to redress this.

Module one introduces the learner to terms, while exploring attitudes and knowledge the learner may possess relating to LGTB people and communities. Reference is also made to the historical background that has shaped LGTB people and communities. Finally, this module considers the various stages of life from youth to older adult, demonstrating how heterosexism and LGTB-phobia impacts on the lives of LGTB people.

Module two considers the diversity within LGTB communities and the factors which determine health. Using determinants developed by the World Health Organization and Health Canada, the author explores what these might mean for LGTB people and communities. Examining issues from social support through to housing, disability and employment the module attempts to demonstrate the unique experience of LGTB people within each of these determinants.

In module three, there is a move to more practical applications. The learner is introduced to materials which will assist them in better understanding LGTB communities and ways to facilitate greater LGTB inclusion within health and social service settings. Specific recognition has been given to individual components: lesbian, gay, transgender, bisexual and two-spirit health. These summaries are intended to alert the educator and learner to some of the health conditions, strengths and service considerations specific to each group.

The fourth and final module encourages the learner to consider their role as advocate. It proposes that health and social service personnel at all levels have some capacity to create more LGTB-inclusive service because of their positions within powerful and respected social institutions. It also explores practical actions which would assist with systemic changes and community engagement.

Using *LGTB Health Matters: An Education & Training Resource for Health and Social Service Sectors*

Terminology and language use can vary significantly within LGTB communities. What is accepted in one community as inclusive may not be so for another. For this reason it is important to clarify how some of these terms have been used within this document. Detailed definitions for most terms used can be found in the glossary attached as Appendix A.

The abbreviation LGTB has been used (in preference to some of the extended options such as LGTBTTSQQI) as it is the standard format used organisationally by The Centre. It is not intended to be exclusive and can be read as inclusive of the other communities which comprise the non-heterosexual and gender diverse communities. The underlying premise presupposes a common factor for each of these groups or communities: the experience of oppression and discrimination because of their minority status, whether it relates to their sexual orientation and/or gender identity. Where there are distinct issues - for example, under the law - they will be identified separately as LGB and trans. The term trans has been used in place of trans-gender or transgendered. Variations to the LGTB combination may be found in some quotes, i.e. GLBT. The term two-spirit is also included in specific sections to reflect the experience of sexual diversity among First Nations people.

The terms to describe fear and hatred toward LGTB people include homophobia, transphobia and biphobia. The term LGTB-phobia has been used to represent all three terms. Full definitions of homophobia, transphobia and biphobia can be found in the glossary.

A number of reclaimed terms such as dyke, fag and queer have been used. These will appear throughout the document. Queer has been used to replace LGTB in some instances. The author acknowledges that this is a term that not all members of the LGTB communities identify with or will agree upon as being synonymous.

The final clarification of terms refers not to LGTB-specific groups but to the service sectors. The term 'service provider' has been used as a generic term to describe a range of providers within the health and social service sectors. It can be read to include an individual service delivery person, management or an organisation responsible for the delivery of health and social services.

This document has been developed for a broad audience ranging from undergraduate health and social service education settings to continuing education, in-service and workshop settings. Because of the intended diversity of the learners, it is only a resource as opposed to self-learning modules or an activity book. This leaves adequate flexibility and scope for educators to pick and choose what areas they might cover. For example, as part of an undergraduate course, the document may be used in its entirety. If it is being employed as part of a three-hour workshop, on the other hand, only basic and key points may be highlighted. It is hoped that in the future teaching guides might be developed that will reflect a variety of lesson styles. Despite not having formal teaching guides, there are a number of aspects that will assist educators to implement the material. Each module contains a pre and post test, based on information covered in that module. There are numerous case examples to provide learners with realistic situations to support the text. Critical thinking questions and activities are provided to stimulate discussion and develop problem-solving skills. The author and working group encourage educators to use these examples, questions and activities liberally and creatively. For example, they may be applied as scenarios in other methods of assessment, such as examinations.

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Module 1
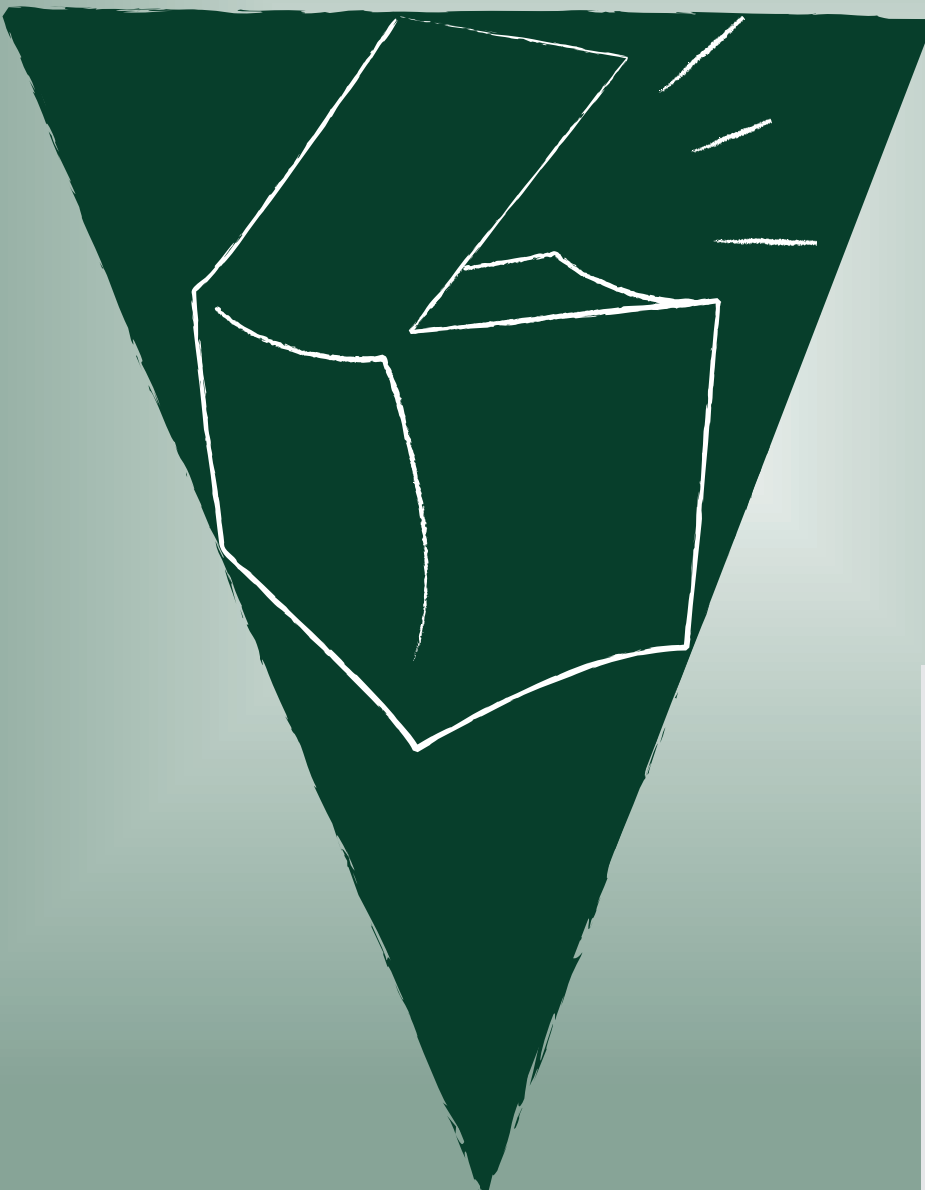
Introduction to Heterosexism and LGTB-Phobia and its Impact on the Health and Well-being of the Lesbian, Gay, Trans & Bisexual Populations

LGTB Health Matters

Introduction

Over the past three and a half decades there has been an increasing awareness and inclusion of lesbian, gay, transgender, bisexual (LGTB) people in Canada and much of the western world. In Canada, this has progressed from decriminalisation of homosexuality to the recognition of equality for same-sex people under the Canadian Charter of Rights and Freedoms.

Many people are now familiar with famous LGTB people through sport, media and politics. Gay men in particular have been consistently represented in popular television and movie culture. Lesbians, trans and bisexual people, on the other hand, continue to receive far less exposure in accessible mainstream culture. The frequent - but often stereotyped - depiction of Gay men in popular culture may lead some people to believe that they have a greater understanding of LGTB issues in general than they actually do. Likewise, the absence of Lesbian, trans and Bisexual people in such a format has possibly resulted in less comfort or assumed knowledge.

This module aims to introduce the learner to a broader understanding of LGTB issues and how these issues impact on the health and well-being of LGTB people. It provides definitions, exercises and examples of everyday experiences which will provide a context for the learner to better understand the experiences of LGTB people and how they - as service providers - can challenge their ideas and alter their practice to be more LGTB inclusive.

Learning Outcome

Learners will demonstrate knowledge of the nature and impact of LGTB-phobia and heterosexism on individuals, families, groups, and communities.

Learning Objectives

1. Participants will develop an awareness of issues related to LGTB-phobia and heterosexism from an individual to a societal perspective.
2. Participants will develop a working knowledge of common terms from the literature.
3. Participants will analyse case scenarios and critically reflect on their values, beliefs and attitudes.
4. Participants will explore factors and barriers that foster healthy growth and development across lifespan within the LGTB context.
5. Participants will discuss health and social service systems and the role of health providers in the provision of services to LGTB communities.

Background

The history of oppression and liberation of the LGTB communities continues to evolve globally with shifts in the landscape of left, centre, and right-swinging politics, community support and advocacy for equality of all citizens, and the passing of laws by governments to protect human and legal rights for LGTB communities. The document *"Critical Moments in the History of LGTB Persons"* chronicles critical moments from 1400 BC to July 2005. Please see Appendix B to access this document.

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Nature of Heterosexism and LGTB-phobia

↘Assumptions

Stephen Brookfield (1987) contends that trying to identify and describe "assumptions that underlie the ideas, beliefs, values, and actions that we and others take for granted is central to critical thinking… and once these assumptions are identified, critical thinkers examine their accuracy and validity" (p. 7). Brookfield notes that reflection on one's own ideas, beliefs, values, and actions, has the potential to increase awareness of how hidden and uncritically assimilated assumptions are - and how they contribute to creating our view of the world in shaping our perceptions, understandings, and interpretations of phenomena. Our daily practices with family, friends and co-workers, the structures we work within, and our actions with others are always context-driven. They are based upon the culture and time in which we live and have a critical influence on our thoughts and actions.

Brookfield reports that asking critical questions about previously accepted values, beliefs, and actions can be anxiety-producing. Individuals may experience feelings of uncertainty and fear as they consider the consequences that may emerge in relation to possible alternatives to their current beliefs and worldview. It is also noted that individuals may also experience a sense of joy, relief, and excitement associated with the liberation that comes from new ideas, values, and actions. Learning to view the world in new ways, they can abandon previously held assumptions that had been inhibiting their personal and professional growth and development.

Examples of some OLD taken-for-granted assumptions:
1.   Children should be seen and not heard.
2.   Women should be kept barefoot and pregnant.
3.   Decisions made by people in leadership and authority should never be challenged (Doctors, Priests, Chief Executive Officers / Directors, Parents, and Teachers).
4.   People should only marry within their own race, culture, ethnic and religious groups.

■**Exercise 1.1**

In relation to the LGTB communities, many assumptions are made about LGTB individuals, families, groups, and communities without checking out perceptions to verify if perceptions are accurate. *An example of one common assumption is that there is nobody in my family, school, neighbourhood, or church that is LGTB.*

1.) What assumptions do you have about people who are:

Lesbian: _____

_____

Gay: _____

_____

Trans: _____

_____

Bisexual: _____

Myths/Realities

*Instructors may wish to use either the myths and realities exercise or the word association, depending on time and the audience and instructors' level of comfort with administering the word association.

■**Exercise 1.2**

Word Association Exercise

1.) We live in a society in which there is an extensive and predominantly negative vocabulary used commonly to describe LGTB individuals. This is an exercise to help you reflect on how your own attitudes and beliefs may be informed by these words and what impact they may have on LGTB individuals.

2.) Write the terms Gay, Lesbian, Trans and Bisexual on a sheet of paper.

3.) Write down all the words you have heard used in association with these terms.
(Do not worry if you are not familiar with some of the terms.) Think back to when you were a child, a student in high school, a young adult. Think of the words used by family, friends, work colleagues, by community, political and spiritual leaders, and in the media.

4.) Give yourself permission to use slang or derogatory words.

5.) After a few minutes, stop writing and review the words you have written down. What themes do you see?

6.) How many of the words have a negative connotation? A positive one? Are there stronger associations for some of the terms than others?

7.) Ask yourself how these words inform your own attitudes and beliefs about LGTB people? What impacts would these words have on an LGTB person's self-concept?

If most of the words you have written down are negative, what are some positive words associated with LGTB individuals? Pride, diversity, resilience, courage and acceptance are examples of more positive words used to describe LGTB people and communities. Can you think of others?

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Exercise 1.3

Myths and Realities Exercise

Often the only information people have about LGTB communities are myths they have heard. When we work to understand how the myths affect others and ourselves, we begin to gain a better understanding of ourselves, and have empathy for others.

Here are some common myths about LGTB individuals, families, groups and communities. Although you may be able to find examples of individuals that live up to the myths described, it is important to acknowledge that LGTB communities are very diverse. The prominence of certain stereotypes or myths does not mean that they apply to all LGTB people.

1. Myth: *People choose to be LGTB*

   Reality: The nature of sexual orientation and gender identity has been the subject of endless debate. The majority of LGTB people agree that they do not choose their identities any more than straight people choose to be heterosexual. The choice is whether to accept it and live fully and openly, or to suppress the feelings. It may be helpful to ask why anyone would choose to be LGTB, given the rejection, discrimination and violence LGTB people face in their lives.

2. Myth: *I don't know anyone who is LGTB*

   Reality: LGTB people are everywhere. With as much as 10% of the population being LGTB, we all know people who are LGTB (although they may not be out to you.) Since LGTB people exist in every ethnic and economic group, and in every place, it would be exceptional if you had no LGTB acquaintances. You may ask yourself why LGTB people may not be disclosing their identities to you.

3. Myth: *There is a distinct LGTB lifestyle.*

   Reality: There is as much variety in LGTB communities as there is in heterosexual communities. LGTB people can be single, dating or involved in long-term relationships, or married. They can be monogamous, promiscuous or celibate. They can have children and grandchildren. They can live alone, with their partners, with their parents and siblings, or with friends. They can be middle-class, rich or poor. They can have a variety of occupations such as doctors, truck drivers, politicians, teachers, writers, cooks. . . or they can be unemployed. They can live in cities, towns and rural areas. There is no such thing as a distinct LGTB lifestyle, just as there is no such thing as a heterosexual lifestyle. Within all communities, individuals create their own lifestyles.

4. Myth: *LGTB people have nothing to offer society.*

   Reality: LGTB people have made major contributions to virtually all fields, from science and medicine to literature and music, from architecture to sports. The accomplishments of LGTB people have historically been invisible or ignored, and the LGTB identities of many well-known artists, politicians and scientists go unacknowledged.

   ### LGB

   Timothy Findley— Canadian Author and Playwright *
   Svend Robinson— Retired Federal MP
   Mark Tewksbury— Canadian Olympic Swimmer *
   Rosie O'Donell— American Comedian *
   Julius Caesar— Roman Emperor
   Alexander the Great— King of Macedonia, Soldier and Empire Builder
   Augustine (Saint)— English Roman Catholic Bishop & Religious Writer

Sandra Bernhardt— American Actress
Rita Mae Brown— American Writer
Leonardo da Vinci— Italian Artist, Painter, Sculptor and Scientist
Amelia Earhart— American Aviator
k.d. lang— Canadian Singer & Songwriter
Florence Nightingale— English Nursing Pioneer
Eleanor Roosevelt— American Social Activist and Diplomat
Sir Ian McKellen— British Actor

Gay and Lesbian Educators of British Columbian
[GALE of BC] (2000)
* reference Wikpedia (Sept 25, 2005)

Trans
Georgina Beyer— New Zealand Member of Parliament
Michelle Dumaresq— Canadian Professional Mountain Bicyclists
Andreas Krieger— German Swimmer
Renee Richards— American Professional Tennis Player
Billy Tipton— American Jazz Musician

Wikpedia (Sept 25, 2005)

5. Myth: *LGTB people are promiscuous and/or more sexual than heterosexuals.*
   Reality: This is a stereotype furthered by the fact that those individuals who are promiscuous are often the most visible members of the LGTB communities. Another issue around this myth is that being LGTB is only about sex. Being LGTB is about whom you love emotionally, intellectually, sexually and spiritually. LGTB people live full lives, doing things like groceries, laundry, raising children, going to work, etc. As more LGTB people come out, there are more visible examples of LGTB people and their relationships, and these stereotypes are diminished. Interestingly, the entire heterosexual population is not implicated by individuals who are promiscuous.

6. Myth*: Bisexuals are confused about their sexual identities, or unwilling to make a choice about whether they are gay/lesbian or straight.*
   Reality: Some bisexuals do go through a period of confusion because they are told that it is not possible to be attracted to more than one gender. Confusion is an appropriate reaction until one gains self-acceptance and finds a supportive environment.

7. Myth: *Bisexuals are incapable of lasting relationships; they cannot be satisfied with one partner.*
   Reality: While this may be true for some bisexuals, it is no truer for bisexuals than other groups. People's relationships, whether characterized by multiple partners, one partner, or periods of being single, are more reflective an individual's lifestyle choices than one's sexual orientation.

8. Myth*: LGTB people do not value family, or are anti-family.*
   Reality: LGTB people do not value family less than heterosexuals do. Those of us who are fortunate enough to have been accepted by our families of origin may have strong family ties (like any other family). Those who have been rejected by our families often work hard to re-establish these relationships, or create family-type relationships with our friends and partners (often referred to as "families of choice".) Many LGTB people struggle with the loss of their families of origin throughout our adult lives.

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9. Myth: *In a same-sex relationship, one partner usually plays the masculine role and the other plays the feminine role.*
Reality: In the past, when we had only the traditional heterosexual relationship as a model, it was common that same-sex couples would emulate those roles. Today, most same-sex couples work to develop relationships based on the principles of equality and mutuality, where they are loved/respected for "who they are." The majority of LGTB people in same-sex relationships are attracted to qualities of their own sex, and are not interested in creating a male/female dynamic. Roles are based on the individual preferences and abilities of each partner.

10. Myth: *LGTB people do not make good parents.*
Reality: Research has shown that children of same-sex parents do not show a higher incidence of emotional disturbance than children of heterosexual couples, nor are these children confused about their sexuality. The disadvantages they experience come from being stigmatized by their peers and communities.

11. Myth: *All lesbians are man-haters. All man-hating women are lesbians.*
Reality: Lesbians are women who form intimate relationships with women. Although not sexually attracted to men, many lesbians have male children and maintain close male friendships. Being a lesbian refers to how a woman feels about women, not how she feels about men. Some women are angry about heterosexual privilege, male control and power, but are not angry with individual men.

12. Myth: *LGTB people would change their sexuality if they could.*
Reality: The feeling that life would be easier or better if one was heterosexual comes from the constant approval and positive reinforcement of heterosexuality and the simultaneous rejection of homosexuality as "abnormal" or "wrong." If homosexuality/bisexuality were accepted and treated equally, most LGTB people would not feel a need to change. Most LGTB people are happy with their identities and lives and would not become heterosexual if it were possible to change.

13. Myth: *HIV/AIDS is a gay disease.*
Reality: Around the world, HIV/AIDS affects men and women, and their children. The risk of exposure to HIV is related to a person's behaviour, rather than their sexual orientation. It is important to remember that HIV/AIDS is a preventable disease and can be avoided through the use of safer sex practices and clean needles.

14. Myth: *Homosexuality is contrary to some Scripture.*
Reality: Actually this is true. So is shaving, eating pork, and wearing clothes of mixed fibres. Theologians have argued for hundred of years about which parts of the published bible are relevant to contemporary life. One of the problems with using the bible as a moral reference is that it is often selectively applied. Biblical arguments against homosexuality are only relevant to those who live according to that doctrine.

15. Myth: *The majority of pedophiles are gay.*
Reality: Sexual abuse of children occurs primarily within the family. Over 95% of abuse that is reported has been perpetrated by a male relative. A child is over one hundred times more likely to be sexually molested by a heterosexual relative than by a homosexual.

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16. Myth: *LGTB people can be identified by certain mannerisms, clothing or physical characteristics.*
Reality: LGTB people are as diverse as any other population group. Some LGTB people may be identified by stereotypical mannerisms and characteristics, but this may be based on a set of assumptions. Today fewer LGTB people feel they must dress to pass in the mainstream community, and some LGTB people choose to make a political statement through their appearance. For many, it is about acknowledging and celebrating LGTB culture.

17. Myth: *Sexual orientation and gender identity are the same.*
Reality: Sexual orientation refers to a person's deep-seated feelings of sexual attraction. The inclination or capacity to develop these intimate sexual and emotional bonds maybe with people of the same-sex (lesbian, gay), the other sex (heterosexual), or either sex (bisexual), and this is regardless of where a given individual lives on the gender continuum. Gender identity is one's internal and psychological sense of one's self as male or female, both or neither (regardless of sexual orientation). People who question gender identity may feel unsure of their gender or believe that they are not of the same gender as their physical body. It is important to note that one's gender identity is independent of one's sexual orientation.

18. Myth: *LGTB only exists in western cultures.*
Reality: LGTB are known to exist in most cultures. The degree of outward expression is determined by political, social and religious forces embedded within their societies.

19. Myth: *Trans people are a homogenous group.*
Reality: There are many variations of trans expression. For example, individuals may express themselves by dressing in clothing of another gender, choosing to undertake hormone therapy or under-going sex reassignment surgery. (The latter is a very small percentage of the population.)

20. Myth: *Heterosexuality is the only normal, right and moral expression of human sexuality.*
Reality: Heterosexuality may be the dominant expression; however LGB expressions of sexuality are equally legitimate and valid identities and experiences. This is recognized by the Canadian Charter of Rights and Freedoms.

Adapted from GALE of BC, 2000 and Toppings, 2004

Definitions

The following definitions have been identified as key primary definitions for module one. For further definitions refer to Appendix 1 to view full glossary. (Glossary could be pre-reading)

Gender— describes how we perceive ourselves (gender identity) and how we want to demonstrate that to others (gender expression). The most common gender identities are 'man' or 'woman', with many other variations included in the umbrella terms trans or transgender. Some other examples are third gender or bi-gender. Third gender is the term sometimes used to describe people who feel other than male or female, and bi-gender refers to people who feel they are both male and female. Often bi-gender people will spend some time presenting in one gender and some time in the other. Some people choose to present androgynously in a conscious attempt to challenge and expand traditional gender roles, even though they feel that their sex and gender identity are comfortably aligned. Throughout this curriculum the term 'trans' is used because some transsexuals feel the term 'transgender' does not accurately describe their experiences.

Gender Identity— one's internal and psychological sense of oneself as male or female, both or neither, regardless of sexual orientation or sex. People who question their gender identity may feel unsure of their gender or believe they are not of the same gender as their physical body. Third gender is the term sometimes used to describe people who feel other than male or female, and bi-gender refers to people who feel they are both male and female.

Gender Expression— relates to how we demonstrate our gender to others through our clothing, social roles, and language, and is often described in a polarity of 'feminine' or 'masculine'.

Sex— refers to physical aspects of our body: chromosomes, genitals, hormones, facial hair, etc. Within North America, the dominant cultural perception, reinforced and entrenched by medical/legal systems, is that one's sex determines one's gender.

Sexual Orientation— refers to a person's deep-seated feelings of sexual attraction. It includes who we desire sexually, with whom we want to become intimate, and with whom we want to form some of our strongest emotional relationships. The inclination or capacity to develop these intimate sexual and emotional bonds may be with people of the same gender (lesbian, gay), the other gender (heterosexual) or either gender (bisexual). Many people become aware of these feelings during adolescence or even earlier. Some do not realize or acknowledge their attractions (especially same-sex attractions) until much later in life. Orientation is not the same as behaviour since not everyone acts on his or her attractions. It is also important to note that one's gender identity or sex is totally independent of one's sexual orientation.

Ageism— a stereotypic and negative perception of ageing and older adults in society. It can include any attitude, action, or institutional structure that subordinates an individual or group on the basis of age.

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Biphobia— the fear and dislike of bisexuality. Biphobia exerts a powerful, negative force on the lives of bisexual people. It can include dismissing bisexuality as an inferior or irrelevant expression of sexuality. It can also take the form of disparaging jokes, verbal abuse and acts of violence. Bisexual women and men face biphobia and discrimination in mainstream society while also struggling for visibility and understanding from gay and lesbian communities.

Bisexual— an individual who is attracted to, and may form sexual and romantic relationships with both women and men. A bisexual may feel equally attracted to either sex, or may experience stronger attractions to one sex while still having feelings for the other. Degree of attraction may vary over time. Bisexuality, like homosexuality and heterosexuality, may be either a transitional step in the process of self-discovery or a stable, long-term identity.

Coming Out— "coming out" or "coming out of the closet" is the process of becoming aware of one's homosexual or bisexual orientation, or one's trans identity, accepting it and telling others about it. This is an ongoing process that may not include everybody in all aspects of one's life. "Coming out" usually occurs in stages and is a non-linear process. An individual may be "out" in only some situations or to certain family members or associates and not others. Some may never ''come out'' to anyone beside themselves.

Discrimination— dealing with people based on prejudicial attitudes and beliefs rather than on the basis of individual characteristics and merits. While prejudice is a state of mind, discrimination requires specific actions.

Gay— a person who forms sexual and affectionate relationships with those of the same gender; often used to refer to men only.

Heterosexism— the assumption that everyone is, or should be, heterosexual and that heterosexuality is inherently superior to and preferable to homosexuality or bisexuality; also refers to organizational discrimination against non-heterosexuals or behaviours not stereotypically heterosexual.

Homophobia— the irrational fear or hatred of, aversion to, and discrimination against, homosexuals or homosexual behaviour. There are many levels and forms of homophobia, including cultural/institutional homophobia, interpersonal homophobia, and internalized homophobia. Many of the problems faced by lesbian, gay, bisexual and trans people stem from homophobia and heterosexism. *See also biphobia and transphobia*

Internalized Homophobia— the experience of shame, guilt, or self-hatred in reaction to one's own feelings of sexual attraction for a person of the same-sex.

Interpersonal Homophobia— the fear, dislike or hatred of people who are in fact or are believed to be lesbian, gay, bisexual, or trans. This may be expressed by name-calling, ostracism, verbal and physical harassment and individual acts of discrimination.

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LGTB— abbreviated term used to refer to lesbian, gay, trans and bisexual people. Also interchangeable with GLBT, LGBT, etc.

LGTB-phobia— an inclusive term used to include all forms of homophobia, biphobia and transphobia.

Lesbian— a woman who forms sexual and romantic relationships with other women; the term originates from the Greek island of Lesbos which was home to Sappho, a poet, teacher and woman who loved other women. Although not as commonly used, some women who have intimate relationships with other women may prefer the term 'gay woman' instead of lesbian.

Out— to be open about one's sexual orientation or trans identity.

Outing Someone— publicly revealing another person's sexual orientation or trans identity without their permission.

Passing— a term used sometimes within LGTB communities to refer to people who are not visibly recognizable as LGTB. People who 'pass' may experience less LGTB-phobia and discrimination. Some LGTB people make considerable efforts to 'pass' while others choose to make a political statement through their appearance.

Queer— broad term rapidly becoming more wide-spread in use by LGTB communities. One reason it has gained in popularity is because of its inclusiveness. "Queer" usually refers to the complete range of non-heterosexual people and provides convenient shorthand for "lesbian, gay, bisexual." — see also ''reclaimed language."

Questioning— an apt term or self-label sometimes used by those exploring personal and political issues of sexual orientation and gender identity, and choosing not to identify with any other label.

Reclaimed Language— many LGTB people have chosen to positively use and hence reclaim terms that were previously used by others in only derogatory ways. Some examples are dyke, fag, faggot, queen, and queer. Although these terms are used positively by those reclaiming them, it is still offensive to have them used against LGTB people by others whose intent is to hurt. Although many LGTB people have reclaimed these terms, there are still other LGTB people who consider any usage of this language offensive.

Sexual Preference— refers to whom one prefers to have sexual and romantic relationships (homosexual, bisexual, heterosexual). It is sometimes used interchangeably with "sexual orientation", but is considered by many to be inaccurate (or even insulting) because the word "preference" implies choice, whereas the term "orientation" implies that a person is born heterosexual, homosexual or bisexual.

Stonewall— during a routine police raid of Stonewall Inn, a gay bar in New York, gay men and lesbians fought back for the first time in June 1969, touching off three days of riots and gaining national media attention. This event is considered by many to be the birth of the modern gay/lesbian liberation movement.

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Transgender/Trans— a trans person is someone whose gender identity or expression differs from conventional expectations of masculinity or femininity. Trans is also a broad term used to describe the continuum of individuals whose gender identity and expression, to varying degrees, does not correspond with their genetic or physical gender, or does not conform to society's assigned gender roles and expectations. Many researchers now believe that transgenderism is rooted in complex biological factors that are fixed at birth. Alternatively, 'trans' can be an umbrella term for people who have gender identities that are not as simple as "man" and "woman" or who express their gender in ways that contravene societal expectations of the range of possibilities for men and women.

Transition— the period during which transsexual and trans persons begin changing their appearances and bodies to match their internal gender identity. Transition may involve a change in physical appearance (hairstyle, clothing), behaviour (mannerisms, voice) and identification (name, pronoun). It is often accompanied by the use of hormones to change secondary sex characteristics (e.g. breasts, facial hair)

Transphobia— the fear and dislike of trans people. Transphobia can take the form of disparaging jokes, name-calling and violence such as sexual assaults and bashings. Rejection by family and friends, denial of services and job loss are ways transphobia exerts a toll on the health and well-being of trans people.

Transsexual— an individual who has a gender identity that is not in keeping with their physical body. Transsexuals typically experience discomfort with this disparity and seek to modify their body through hormones and/or surgical procedures in order to bring their body closer to their gender identity. Most want to be perceived as the gender that is congruent with their identity, regardless of what physical changes they have pursued.

Two-spirit— a term used by some North American aboriginal societies to describe what western societies call gay, lesbian, bisexual and trans. Many Aboriginal communities had Two-spirit people who were visionaries, were considered to be blessed, and were regarded as spiritual advisors. Often, two-spirit people were the mediators of the community/band because it was believed they understood both sides of the disagreement between women and men. Unfortunately, due to colonisation and its devastating effects, many aboriginal people have lost this part of their cultural history and two-spirit people may experience discrimination and violence within their own communities.

Adapted from GALE of BC, 2000 BC and
Transcend Transgender Support & Education Society, 2001 (as cited in Toppings, 2004)

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Case Example

Amata is a 28-year-old woman who has recently arrived as a refugee from a South American country. She has applied as a refugee to Canada based on persecution experienced by LGTB people in her country. It is a place where being 'out' can cost you your life. For this reason, she carefully guards her sexual orientation out of habit.

As a newly arrived refugee claimant, Amata is overwhelmed by the social structures and systems of Canada. As complex as they were at home, these are even more confusing — and they are compounded by a language barrier.

There are other demands such as housing. Amata has been staying with an acquaintance but that is only a short-term option and she is quickly realising how expensive housing is in Vancouver. She is worried about how she can best use her meagre savings in the expensive rental market.

In the time that Amata has been in Vancouver she has made some social contacts but for the most part has been reliant on people she has met through the Rainbow Refugee Committee (a voluntary group assisting her with her claim).

All of this in the shadow of a refugee claim that is open-ended, which means even greater uncertainty.

The entire process is turning out to be more stressful than Amata had anticipated. She is feeling homesick and most recently has lost her appetite and is feeling nauseated, particularly in the mornings. She is finding it difficult to get to sleep at night and is finding that she is tearful, which is not usual. Noticing this change in behaviour and mood, acquaintances encourage her to visit a doctor.

Amata, being new to the country doesn't have a GP but recalls seeing a sign for a clinic that said 'accepting new patients.' She goes in and makes an appointment for the next day.

She arrives for her appointment the following day with someone who can assist with translation. Amata completes a standard questionnaire about her physical health and returns it to the clinic nurse, who then asks her for a urine sample and then weighs her.

When Amata finally gets to see the doctor, there is little opportunity to engage with him as he rushes into the office, flips open her chart and starts to ask her questions about why she is there. She tells him her symptoms. He immediately focuses on the fact that she is feeling most nauseated in the morning and asks her when she last had her period, last had intercourse and what sort of contraception she is using. Feeling slightly embar-rassed by this line of questioning, Amata understands the doctor's assumption that she may be pregnant. Her only sexual experience with a man had been in her teenage years, at least 12 years ago. Understanding the inference she immediately feels seized by panic. She can feel her pulse quickening and all that she can think about is how she can get out of the doctor's office. She is left with a choice of either lying to the doctor or telling him that she is a lesbian.

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The following two scenarios take the learner through either option. They will then have an opportunity to discuss the implications of each.

Option A >
Amata decides that it is best to follow through with the doctor's line of questioning. Because she has understood the inferences of the doctor's questions Amata quickly chooses a date from several months earlier and states that she hasn't had sex with a man since then. This would make the implication of pregnancy and morning sickness redundant. Rather than elude the doctor regarding the nausea as she hopes, he launches into the issue of contraception and the fact that she isn't using any.

The doctor conducts a routine physical examination and suggests that Amata should reassess her diet and get more exercise. He sends her home with a prescription for an oral contraceptive and a minor sedative.

Critical Thinking Questions

1. What might be the health implications for Amata based on this scenario?

2. What could the doctor have done differently?

Option B >
Amata swallows deeply and says to the doctor "I am a lesbian and I haven't had sex with a man for many years." The doctor, noticeably uncomfortable with this, immediately drops his line of questioning relating to pregnancy and makes an "off the cuff" comment about not needing to waste a prescription on "the Pill". He seems unable to refocus on Amata's presenting problem and quickly conducts a routine physical examination before suggesting that she gets more exercise, reassess her diet and sends her on her way with a prescription for a minor sedative. As she is about to leave he also suggests that in the future she should visit a doctor at one of the local community health centres which he knows to have a large gay and lesbian clientele.

Critical Thinking Questions

1. What might the health outcomes be for Amata based on this scenario?

2. How might the doctor dealt with Amata's divulgence in a more satisfactory way?

Health Impacts and Service Provision

Conceptualisation of Issues Related to LGTB-phobia and Heterosexism across the Lifespan

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Homophobia and heterosexism have the potential to have a negative impact on the health and well-being of LGTB people in all stages of their life. This section will examine life stages from youth through to the older years, using examples of everyday events to contrast the experiences of heterosexual, male/female persons to those of the LGTB person.

Youth (The teenage years)

Key Messages
1.) Safe, LGTB-friendly schools play a vital role in the health and well-being of LGTB youth, now and in the future.
2.) LGTB youth need the same opportunities to enjoy age-appropriate experiences as their straight counterparts.

Heterosexism and LGTB-phobia for young people is experienced in many everyday events and activities. 'Faggot, homo, lezzie' are but a few of the terms routinely used by youth as a method to insult, demean or marginalise others. These terms are used indiscriminately and directed toward straight youth and LGTB youth alike. Beyond hurtful language, the experiences of LGTB youth are very different from those of their straight counterparts. Routine events for young people that impact on their health and well-being include school and social activities. Hetrick & Martin (as cited in Shortall, 2001)

"High school is a rite of passage for most adolescents. It is a time of dating, choosing colleges and careers, and learning to become an adult. At a time when heterosexual students are often learning to socialise, lesbian and gay students are learning how to hide. (p.2)."

Schools are a space that students should feel safe, but for LGTB students, bullying and discrimination often best describes their educational experience. Hillier, Turner & Mitchell, (2005) in their study of *Same Sex Attracted Young People in Australia* (n=1749) found that in excess of 40% of respondents did not feel safe in school.

There is also often no positive reference to LGTB people in formal learning for the student to identify with. The absence of LGTB content in British Columbia's school curriculum caused a gay couple (teacher Murray Corren and his partner Peter) to take the issue to the British Columbia Human Rights Tribunal (Peters, R., 2005, July 11)

Action like *Gay/Straight Alliances* are important peer and teacher supported initiatives which have emerged in schools to support LGTB students. As peer support initiatives, they need the sanctioning and resources of school administration because policy is not enough (Claveau, 2005, June 23).

Case Example

The following scenario considers both the positive and negative outcomes of the experience of a queer high school student.

Tracey is a 16-year-old grade 10 student. She presents with many features and behaviours atypical of other girls in her class, including dressing in boy's clothing, a short cropped haircut and refusal to participate in the traditional female roles and activities. These become the focus of taunting and result in isolation. No intervention or support is forthcoming in the school setting. She responds by withdrawing further and eventually missing those classes where the discrimination is greatest. This soon becomes days absent from school and eventually dropping out.

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Evidence shows that people with lower literacy rates and lower levels of education are less likely to consider themselves healthy, suffer poorer health and die younger (Public Health Agency of Canada [PHAC], 2004).

The following scenario might be the outcome if Tracey were in a school where anti LGTB-phobic policies and measures exist.

Students have received education about diversity and a zero tolerance exists around hateful or abusive language or behaviour. Teachers provide greater safety so that Tracey feels safe and is not persecuted by peers. Peer supports are in place and a knowledgeable counsellor is available. Tracey is supported through negative encounters and taught to develop techniques to deal with such events. She completes school and continues to either employment or further education, equipped with a greater resilience and a basic education. Both qualities enhance her health.

Creating school environments that provide safety and LGTB positive experiences will increase the likelihood of youth remaining in school and improving chances of better long-term health outcomes, not to mention a more enjoyable existence while in school.

> …Garofalo and colleagues (1998) found that adolescents who identified as lesbian, gay, or bisexual were more than four times as likely as their heterosexual peers to have skipped school during the past month because they felt unsafe or to have been injured or threatened with a weapon at school during the past year.
>
> *(As cited in Ryan & Rivers, 2003, p. 106)*

Higher rates of absenteeism were also identified in the same study by heterosexual students who were perceived to be queer and victimised as such.

Critical Thinking Questions

1. What might be some of the health implications for young LGTB people who experience marginalisation and discrimination in school settings, now and in their future life?

2. What role can schools and the education sector take to ensure that the rights of LGTB students are protected?

Social Activities

Many socially-sanctioned opportunities for youth in general are not available to LGTB youth. Opposite-sex attraction of youth is socially reinforced and exploited through popular media and marketing, with images of attractive young men and women as couples. Same-sex attracted or trans youth are discouraged and in some instances prohibited from engaging in 'normal' youth activities such as dating or attending a school dance as a couple. As reported on Canadian Broadcasting Corporation [CBC] (2005)

> May 10th, 2002 Ontario Superior Court Justice Robert McKinnon rules that a gay student has the right to take his boyfriend to the prom. Earlier, the Durham Catholic District School Board said student Marc Hall couldn't bring his 21-year-old boyfriend to the dance at Monsignor John Pereyma Catholic high school in Oshawa. Officials acknowledge that Hall has the right to be gay, but said permitting the date would send a message that the Church supports his "homosexual lifestyle." Hall went to the prom. (section, May 10, 2002)

LGTB Health Matters

Sport is another important social institution which has the potential to enhance youth health and well-being, but for many queer youth has been little more than another opportunity to be ridiculed or marginalised. Many male-dominated team sports reinforce stereotypes of masculinity and measure prowess against these qualities. A male youth who doesn't fulfill the prescribed stereotypes or who challenges the status quo may be at a greater risk for discrimination… or be less likely to expose themselves to the opportunity in the first place. Women who excel in sport are sometimes judged on their feminine or masculine traits rather than skill in the sport. Hillier and Harrison (2004) cites the following example:

> During the 1999 Australian Tennis Open championships, 19 year old unseeded French tennis player Amelie Mauresmo found herself in the media spotlight when she defeated number one player Lindsey Davenport in the women's semi-finals (Pierce,1999). Media interest was not primarily about her unexpected win, but about comments made by Davenport afterwards that playing Amelie was like playing a man. Martina Hingis, world number two player at the time was also reported as saying: 'She has a girlfriend, she must be half man'. (p.79)

Sport needs to find ways to provide supportive environments that include LGTB youth.

There are few 'out' LGTB athletes or sports heroes to provide positive role models for youth, which makes sporting options less attractive to youth.

At a time when as many as 25% of Canadian youth are obese, in part due to inactivity (Obesity Canada, June 2000) greater efforts need to be made to encourage participation, rather than to dissuade youth from participating in sport. Creating environments that are inclusive is an important step. As long as sport continues to be seen as exclusively based on gender identity and /or sexual orientation, there is little likelihood of increasing queer participants.

In addition to school and social activities there are many other important social and cultural opportunities which the LGTB youth is denied. Having the opportunity and right to experience or participate in such activities is an important part of a LGTB youth's development.

Critical Thinking Questions

1. How do you think social activities such as sport could be made more LGTB-inclusive?

2. Think of social activities that you or your children participate in. Is there any positive representation of LGTB people? If not, how could this be different?

Summary

This stage of life is a period marked by personal uncertainties, a high need for affirmation, peer pressure, the need to conform

The Public Health Agency of Canada's *Determinants of Health* speak of education and literacy, social support, physical and social environments and, finally, personal practices and coping skills as important factors in influencing one's health, both now and in the future. These are all concepts and activities that are key to the well being of youth and future adults. If LGTB youth feel unsafe in school, experience discrimination in social settings, and - due to lack of positive role models and acceptance - avoid participating in physical activities that can enhance health, what is the impact on their future?

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Young Adult

Key messages.

1.) Employment and further education can be a new source of oppression and marginalisation previously not experienced by the young LGTB adult.
2.) 'Coming out' occurs in many life stages but it is frequently associated with young adulthood.
3.) Queer community is an important source of identification and potential support available for young LGTB adults.
4.) Relationships often face added challenges due to heterosexism and homophobia.

As young LGTB people leave school and home to embark on their lives they are faced with additional challenges and barriers not felt by their straight counterparts. For some, they are unshackling the constraints of home life or school; others face discrimination in ways that they could never have anticipated. Young adult-hood is also frequently a time of acknowledging and exploring sexual orientations and gender identities which will introduce young LGTB people to new communities and opportunities.

Employment and education

Like all young people, LGTB youth will be faced with the challenges of new educational settings, establishing themselves in the workplace and building or expanding relationships.

Convincing that first employer to hire you despite inexperience or perhaps absence of formal qualifications is a big enough challenge, but what if your presentation isn't exactly consistent with the accepted stereotype for your age and gender? What experiences await in the education or employment setting if the applicant is suc-cessful? For example, a trans individual might have a successful written application for work. Upon presenting for their interview, they may face discrimination if an employer is biased by a presentation inconsistent with what they expected. Maintaining employment can also be difficult, when trans people face ridicule and discrimination. (Darke & Cope, 2002, pp.34-35) With limited formal protection of their rights, they may find themselves unemployed with no recourse.

Case Example

Jeremy has recently graduated with a Bachelor of Engineering. He completed his degree within the prescribed timeframe and maintained a high average academic standing. The faculty had its fair share of heterosexism and sadly homophobia, but Jeremy was able to establish himself as an out gay man and thrived in the university setting. A slightly built young man, he had been ridiculed about being 'effeminate' at different times in his life and mistaken for a woman, however to date he had not been aware of it being a barrier of access.

Jeremy has applied for several jobs but he has never managed to get past the interview stage. He consistently received letters of rejection stating that he lacked experience. This is despite the fact that some of the positions were filled by his fellow graduates.

Establishing and maintaining employment is an important part of good health. 'Job security increases health, well-being and job satisfaction. Higher rates of unemployment cause more illness and premature death' (Wilkinson & Marmot, 2003, p.20). The denial of employment to LGTB young adults because of discrimina-tory attitudes has the potential to harm their health in both the short and long-term.

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Critical Thinking Questions

1. How can work and learning settings be more welcoming of young LGTB employees?

2. What sort of challenges do you think young LGTB people might face in employment and education settings?

Coming Out

'Coming Out' — the process of acknowledging your sexual orientation or gender identity to yourself or others — is a process that may happen at any stage of the life cycle. However, it is common in young adulthood. This is such an important experience that some gay population health advocates propose that the 'Conditions that affirm choices of coming out' (Gay & Lesbian Health Service of Saskatoon, 2000, p.38) should be formalised as a determinant of gay men's health. While the process of coming out' may be liberating, it can also be one of the most stressful events in the life of an LGTB person. It is also not a static or one-off process but something that the person will have to repeat throughout their life, requiring the individual to continually assess their personal safety. This very important process for LGTB people may be met by acceptance and support; alternatively it may result in rejection, isolation and the beginning of a new and very different life. For most, the mere anticipation of a negative outcome is a major stressor. Heterosexual and/or non-trans people as part of the dominant group have no need to make such a proclamation about their sexual orientation or gender identity. Instead, it is constantly and positively reinforced.

Community

Social researchers such as Robert Putnam (2000) have drawn links between community participation, civil society and the health-enhancing outcomes. The LGTB communities, of which there are many, are no exception. The existence of identifiable LGTB communities in most large centres is an important element for support for younger adults as they establish their place in society. These centres of community may be visible and iconic such as Davie Street in Vancouver with its many LGTB-owned businesses and hot pink bus shelters. In smaller centres, it may be the monthly dances or similar events that provide the focus of community.

As a member of a minority group that is persecuted and vilified, it is important that the young adult find kindred spirits and a space where they are safe and valued. Here they have the opportunity to learn important coping skills. Numerous researchers have proposed that the solidarity of individuals who are experiencing a common stress has the potential to protect the individual's mental health (Meyer, 2003).

LGTB communities are not homogenous or without conflict, and face the downfalls of any other community. They are not a panacea for all young adults (or, for that matter, any age group). It is however important to be aware of the existence of these communities and the many roles and functions that they may fulfill for the young LGTB adult.

Relationships

Like so many things that young LGTB adults will face, interpersonal relationships take on an added complexity compared to those of their non-queer counterparts. A path has been set for the heterosexual non-trans cohort of society. If they choose to follow this route, they receive powerful reinforcement. If they vary, they may

receive minor condemnation or discrimination. For the young LGTB adult, relationships contain many other challenges, including the issue of acceptance of queer friends or lovers by long-standing non-queer friends and family, situations which may force the person to choose one group over the other. There is stress to establishing an intimate relationship in a social environment that condemns or at least doesn't value the relationship.

Heterosexism and homophobia have the potential to impact significantly on the establishment and maintenance of a relationship both now and throughout the lifespan.

There is no prescribed method or process for how a young LGTB adult goes about establishing a relationship and nor should there be. It is also important to understand that the process of establishing contacts, dating and coupling is as significant as within the non-queer population. These relationships need to be treated with the same respect and rights allowed to others and considered with regard to the many other variables impacting on their success.

Case Example

Monaca and Wendy have been a couple for two years and have lived together for 18 months. They attend each other's family functions and enjoy a comfortable relationship with siblings and parents alike. Monaca had previously been in a 2 year relationship with Peter. Peter wouldn't have been Monaca's parents' choice but they accepted him and secretly talked about the day that they would become grandparents.

Monaca's parents have invited Monaca and Wendy to their cottage for the weekend. Also invited are Monaca's younger brother James and his girlfriend of six months, Mandy. When the time comes to allocate sleeping quarters, Monaca and Wendy are shown to the guest bedroom with its bunk beds, a space usually reserved for visiting children. James and Mandy are shown to the other guest room with the double bed. Monaca recalls a previous invitation where she and Peter had been allocated the double bed.

Critical Thinking Questions

1. Why and how might the experience of 'coming out' be health-enhancing? Is there anytime when it might be health-harming?

2. In what ways do you think the existence of an identifiable LGTB community might benefit the health and well-being of a young adult?

3. What is the message in this act of bed allocation?

Summary

Developmental specialists have described the young adult stage of life based on tasks. These vary from selecting a mate, establishing one's self in the workforce through to relating to teenage children (Murray & Zentner, 2001). This evaluation is usually offered from the heterosexual perspective, based on assumptions that the

young adult will select an opposite sex partner and continue to live with the gender they were assigned at birth. Despite this heterosexist view, it is not completely at odds with the development or aspirations of many LGTB young adults. What is different though, are many variables which will impact on these tasks or aspirations along the way. It is therefore crucial to consider how heterosexism and/or homophobia may affect the everyday occurrences of the young LGTB adult. It is equally important to appreciate that there are experiences that are unique - such as 'coming out' - that may reshape the way in which the experience of young adulthood is lived. All of these experiences, whether they are considered developmentally standard or unique to LGTB people, have the capacity to both detract from and enhance the health and well-being of this age group.

Middle Adult

Key Messages
1.) Lack of legal protection and social acceptance in earlier life may influence this age group's interaction with systems.
2.) Many of the issues and tasks may present the same but the experience and how the LGTB person has arrived at this point may vary significantly.
3.) Physical changes of aging will not be different for LGTB people. How they are interpreted or serviced may be the key difference.

The middle years is a period where physical signs of aging become apparent; social and familial roles may shift and careers might take new directions. Like their heterosexual and non-trans middle adult counterparts, LGTB people are faced with these events and other challenges. Considering just a few of these with the over-lay of heterosexism and/or homophobia will provide the learner with an appreciation of how this might impact on the health and well-being of the LGTB person.
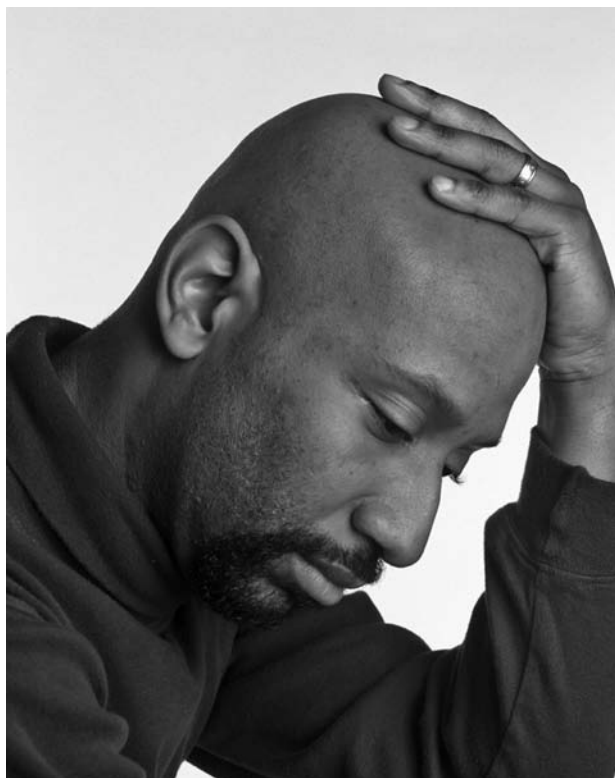
Career advancement or restriction
Most LGTB employees in this age group entered the work-force prior to any legal protection which may have in real or perceived terms impacted on their capacity to advance.

This is also a group who for survival and security in the workplace may not have been out, which meant living a dual life. (While this still may be the case for many people today, most at least have legal protection if they choose to be out). Leading this dual existence comes with its own stressors. Relationships can be devalued, for example: consider the gay man who always takes a female friend to the office Christmas party rather than his male partner, so not to harm his employment image. Sexual orientation is still seen as an impediment to promotion to higher paying jobs in many workplaces, despite legal protection (GLHSS, n.d.). In many parts of the U.S.A., LGTB people have not achieved the legal protections enjoyed by Canadians; in others, these protections are being rapidly eroded by the action of conservative governments.

Case Example

John is a 45-year old manager with a large multinational firm. He has been married to Karen for eighteen years. Karen became aware that John was trans three years after the marriage. They have a loving and supportive relationship and over recent years have worked towards John's dream of becoming the women he knows she is.

John is concerned about his career future because he knows that there is no legal protection for him as a trans person if his workplace chooses to terminate his employment.

John plans his transition and talks to his vice president and subordinates, about the process and what he anticipates. Despite some initial surprise, John's workplace proves to be very supportive. He plans to make the workplace transition on his return from his annual four week holiday.

John returns to work as Carolyn. She now wears women's clothing to work and asks that people assist by using the appropriate pronouns. Carolyn's transition is going well and her co-workers are quickly adjusting and have maintained support. She has, however, noticed that she is no longer being invited to the usual meetings in the company head offices in Osaka or subsidiary office in Chicago. Over the next year, Carolyn's career ascension also suffers an abrupt halt and she is passed over for two promotions. In her relief that the she hadn't been dismissed, Carolyn hadn't anticipated the more subtle discrimination that she is now experiencing.

Critical Thinking Questions

1. What role might the workplace take in enhancing the health and well-being of LGTB people in their middle years? What are some practical steps? How could you as an individual implement this?

Development of episodic or ongoing health conditions

This is a period of life when people may begin to experience age-related conditions such as arthritis, type two diabetes, hypertension and elevated cholesterol, to name but a few. This means people will begin to interact with health and social service systems in a way which they had not previously.

For LGTB individuals, accustomed to living in a world that makes assumptions about sexual orientation and gender identity, the health and social service's heterosexist operations will likely be no surprise. Unfortunately many are still confronted by LGTB-phobic attitudes, which they had not anticipated.

Sarah is 47 and recently diagnosed with type two diabetes. She has enjoyed excellent health up until recently. She has rarely visited a GP except for annual pap smears and a couple of employment-related physical examinations. On the recommendation of her GP, Sarah has made an appointment with the Diabetes Nurse Educator to learn more about management of her condition. On the day of her appointment she takes her partner Cathy (who is fifteen years her junior) along for support and to improve Cathy's knowledge of the condition they will be living with.

Case Example

As Sarah and Cathy sit in the waiting room completing the required forms, Sarah notes that the form asks the usual questions about age, marital status, etc. but does so in a manner that restricts the choices to husband or wife and makes no reference to gender identity. She makes the appropriate deletions and additions to reflect her life circumstances but is concerned by the lack of appropriate detail.

When the nurse comes to greet Sarah, she is friendly and welcomes her to the facility. She notes that Cathy is sitting beside Sarah and without first clarifying says, 'Is this your daughter? She can come in too if she likes.' Sarah corrects the misconception and explains Cathy's relationship to her. The somewhat embarrassed nurse apologises profusely about the assumption she has made, but the incident has established an uncomfortable beginning to the relationship.

Critical Thinking Questions

1. What are the assumptions made by this service and its providers?

2. How could this be done differently?

Social and familial

Children leaving home, caring for aging parents and early retirement are all possibilities for this stage of life. These all bring significant role changes for the adult in their middle years. Some of these are positive and create newfound freedoms. However, there is also a recorded increase in divorce in the over 40's age group (Murray and Zentner, 2001).

LGTB individuals of this age may experience some of the same changes as heterosexual non trans people with regard to family. It may sometimes be the case that children of LGTB people of this age have been the result of a previous heterosexual marital relationship, with separation occurring at a younger age. Alternatively, the children may be part of a single parent or reconstituted family, where only one of the couple has had parenting responsibility. Obviously a higher proportion of LGTB people will not have parented children, making this a less visible issue. The roles of parents and empty nesters are, however, issues that should not be assumed or overlooked. Further discussion of family and parenting will occur in module two.

Long-term relationships in the queer community are prone to the same challenges that heterosexual relationships face, but until recently have received little recognition of their legitimacy. Same-sex couples may have lived together for decades, but it was not until 1999 that their relationships were acknowledged as common-law, with the same rights as heterosexual couples. The recent passing of bill C-38 which defines marriage as being between 'two people' rather than man and woman has meant that same-sex couples now have the right to be legally married anywhere in the country. Unlike heterosexual couples who by this stage of their life have often been married for several years or multiple times, same-sex couples in longstanding relationships may be entering into marriage for the first time.

LGTB Health Matters

Case Example

Frank and Ian have lived together since 1972. In the early days of their relationship they were forced to live a very guarded and secretive life, but as the years passed they have enjoyed increasing freedom. This year they have retired and plan to marry and enjoy a honeymoon in a tropical location. As they enter into this, many of their straight friends who have been married many years (some on multiple occasions) are questioning as why they would bother to marry at this stage of their life. For Frank and Ian it is apparent that their long-standing friends are not aware of the social difference that has existed for them. Frank and Ian take their newly granted right seriously as they recall the days of having to lie about their relationship and pretend that they were roommates or brothers.

The image of youth and beauty, particularly in the gay community has been over-represented to the point where it has been misconstrued as the standard. Men in their middle years are confronted with ageing bodies that are incongruous with a narrow definition of gay image. This has the potential to impact on whom they socialise or identify with and where they choose to do that socialising. Important meeting places such as night clubs may no longer be welcoming. Ageism is sadly played out in all parts of society, but in a group that is so strongly identified with a youth image and culture the impact may be more harshly experienced.

Summary

LGTB in their middle years are prone to the same physical changes, illnesses, career ups and downs, family and social changes as heterosexual and non-trans people. But each of these is further impacted upon by an overlay of heterosexism and homophobia that has defined everything from relationships and careers to how they relate to or access services.

It is a group that, as young people, did not enjoy the rights which are experienced by today's youth. This will mean a different approach when dealing with the LGTB person in their middle years compared to the younger cohorts. It is important as service providers to be aware that, while this group of people may present with familiar issues and experiences to heterosexual and non-trans people, their view of the world has been shaped prior to achieving rights and freedoms or even seeing positive LGTB characters on television. This is a lesson as to why everyone can not be treated the same.

Older Adult

Key Messages
1.) The need to access services may result in older adults feeling that they once again need to hide their LGTB identity.
2.) The absence of children does not necessarily mean that older LGTB people will be more alone than their heterosexual or non-trans counterparts.
3.) Residential care settings need to take affirmative action to make their facilities LGTB positive.

The latter years of life are associated with retirement, changes to independence, illness and death. It is a time that may provide the freedom to follow dreams and revel in the achievements of life. It is also a stage that may require the person to care for an aging partner, manage ongoing health conditions, make decisions about living arrangements and deal with the loss of siblings, partner and friends.

When people bring to mind images of LGTB people, they usually think of youth. What is too often forgotten is that everyone who is older was once young. LGTB identity is not the sole domain of the younger generations. People in their sixties, seventies and beyond identify as or are LGTB. (There is little documentation available about the experiences of older trans people, so much of this life stage will refer to LGB.)

Like the previous life stage, this group's younger years predate the human rights and freedoms enjoyed in the 21st century. In fact, they will have lived their youth, younger adult years and possibly even some of their middle adult years in a society where homosexuality was illegal and was punishable by imprisonment. For example, Canadian Everett Klippert was jailed from 1967-1971 and labelled a "dangerous sex offender" because he admitted to having sex with men and that he was unlikely to change (CBC, 2005).

Managing ongoing health conditions

A part of normal aging is associated with an eventual decline in activity and age-related conditions, both physical (e.g. arthritis) or mental (e.g. memory deficits). In addition the older person will often develop long-term conditions which they will have to learn to manage, frequently with the assistance of health or social service providers.

For the older LGTB person, requiring this assistance or intervention may be the first time that they have had to interact closely with the service delivery system. For a group who has been accustomed to hiding their sexual orientation or gender identity for fear of repercussions, outside assistance may be a very difficult and stressful addition to their life.

Case Example

Mary is a 76 year old woman who has lived a quiet and self sufficient life with her partner Theresa for 38 years. Late last year Theresa died after a lengthy illness for which Mary had faithfully nursed her. Since Theresa's death, Mary has noticed a decline in her own health and her ability to care for herself, mostly with things like cleaning the house, getting in and out of the shower safely and doing the shopping. Mary has been assessed for home help. While she acknowledges the need she is very anxious about having a stranger come into her house and the potential for homophobic treatment. Prior to the first visit Mary goes through the house and removes visible indicators of relationship with Theresa and plans to tell the homecare worker that Theresa was her sister. Mary worries about getting her stories right and is saddened that she has had to hide away so many reminders of Theresa, like holiday photos, etc.

Critical Thinking Questions

1. How do you think the life events of their youth might impact on the health and well-being of older LGTB people?

2. What actions might the service provider take to engage the older LGTB person? For example in the case example what might a home support worker do?

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Family

There is an old myth that has been perpetuated about children and parents: that if you have children they will look after you in your old age and you won't be alone. Elder abuse, the death of children, busy lives, strained relationships and changing societal values have all been reasons why this belief is unfounded. There is a further myth applied to LGTB people that says because many of them will not have children that they will be lonely old people. This too is an unfounded and biased perspective.

Some older LGTB people will have children and those relationships may be as close or distant as those of heterosexual or non-trans parents and children. For others, a 'family of choice' has been a more significant support system throughout their life and there is no reason why this would not continue into the later years.

Health professionals who view family from a narrow biological perspective may do the LGTB client a disservice when planning care such as discharge from hospital. The absence of biological relatives and ignorance of other significant supports such as 'family of choice' could result in higher rates of institutionalisation for the LGTB individual.

Case Example

Claude had been happily married for 23 years and had a daughter and son. Sadly, his wife died in midlife from breast cancer. Claude had always known that he was bisexual but it wasn't until after his wife's death that he started having regular contact with gay and bisexual men. In 1980 Claude moved from Montreal to Vancouver and made many good friends in the LGTB community. He never established another long-term relationship but occasionally dated both men and women. He had a group of close friends, including some with children that he regards as family. With both of his children and all of his six grandchildren in Montreal, Claude enjoys the company of his friends, their children and now even some of their grandchildren.

Still a sprightly man at age 80, Claude now occasionally requires assistance with little jobs around the house and weekly shopping. Claude is fortunate that his friend Hilary is able to assist him with her car as they do their weekly grocery shopping together. His friend Bill's son Geoff is always happy to lend a hand with little tasks like lifting something up into the attic.

Claude enjoys the company and assistance of his 'family of choice' and when he can get to Montreal or his family can make it to visit him, he revels in the time that he has with his children and grandchildren.

Assisted living

For some older people, it may be necessary to move to an assisted living or extended care facility. The loss of independence and the association with end of life can be a distressing part of this transition. The older LGTB person may also be confronted by fears of how they will be received and treated in the facility. Their experience of overt discrimination in their younger years (City of Toronto, 2005) and knowledge of the hetero-sexism that exists in health and social service systems are genuine grounds for them to be concerned about the service they will receive. 'Making one's homosexuality known [in institutional care settings] can result in poor treatment or neglect by staff and ostracisation from other patients [residents]' Gentry; Kass et al (as cited in Sum Quad Sum, 1997).

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When anticipating their future, some people suggest that the solution is to build LGTB specific extended care facilities much as have many of the ethnic or faith communities (LGTB Health Matters Project, 2005). This approach could obviously provide an LGTB inclusive environment however it could also isolate community members. City of Toronto Homes for the Aged have attempted to address the gap in service to older LGTB people and provide a compromise by targeting services to the LGTB community. The City of Toronto (2005) states

> These developments in long-term care are revolutionary and profound," said Dick Moore, Coordinator of the Older GLBT Program at The 519. "Although there are gay-friendly retirement homes in the US and Holland, these are the only publicly-subsidized beds that I am aware of in Europe or North America. (¶ 4)

Case Example

Ruby and Jack have been married for 53 years. Like all couples they have had their good times and bad. Early in their marriage Ruby learned of Jack's need to cross dress for pleasure and also as a means to manage stress in his life. This was an issue that they were unable to openly discuss in 1950's society but they accommodated it within their relationship. They went about their business of raising three children, pursuing jobs and paying the mortgage. Having enjoyed several years of retirement and independent living, they now are experiencing several health issues such as failing eyesight and reduced mobility, which is forcing them to seek a supported living option.

One of their concerns, particularly for Jack, is how he will be able to continue to wear women's clothing in this far less private setting. The couple also worry that if the facility's staff is aware of Jack's cross-dressing that they may also discuss it with their children. Ruby and Jack do not want that to happen.

Critical Thinking Questions

1. In the absence of targeted services or LGTB-specific facilities, how could residential care facilities be more LGTB-inclusive?

2. Historically, health and social service systems have not adequately accommodated the sexuality of the older adult. In your attempts to right this, what considerations might you make for the LGTB client group?

Summary

Older LGTB adults came of age in a time when socially and legally sanctioned discrimination required them to be very discreet about their sexual orientation or gender identity. In their youth, being 'out' could lead to incarceration or forced medical treatment. The service provider must be respectful of this and of the fact that they will express their sexual orientation or gender identity differently than those junior to them.

Services for older LGTB adults need to be provided in a manner that positively reinforces their identity, without forcing them back into the closet. This applies to in-home services as well as residential care settings.

It is also important when planning service delivery to consider that biological family may or may not be a part of the individual's life and support network. Regardless, a 'family of choice' might exist and should be involved as any biological family would be.

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LGTB Elders

Key Messages

1.) Elders have been responsible for developing environments that determine and enhance the health and well-being of the entire LGTB community.
2.) Early youth marginalisation and discrimination may have built a resiliency within elders which will be an advantage for future life challenges.
3.) Elders experience ageism within the very communities they helped construct.

The term elder is one that is not much used in contemporary Canadian culture, with Aboriginal culture being the exception. For the purposes of this module, elder is not being defined by a specific age but as an acknowledgement of lived experience, which may include people aged in their forties or fifties and onward.

As described in the previous section, people in the older adult (and perhaps some of those is the middle years) stage spent their youth in hostile environments where they were often required to sublimate their true sexual or gender identities to survive. As difficult as this may have been, it has been posed that this oppression could have taught them important skills, which have protected them in other environments.

> …remaining invisible has been a strategy of survival for today's older gay men and lesbians, strategy that has often resulted in an increased capacity for resilience against the onslaught of additional forms of discrimination they experience as elders. Historical experiences of victimisation have led many older lesbians and gay men to develop skills that keep them safe from or help to deal with all kinds of hostile environments. (Brotman, Ryan & Cormier, 2003, p. 107)

This may also be the case for many trans people however some high profile exposure as early as the 1953, would also have helped their cause. Christine Jorgensen is possibly America's - if not the world's - most famous trans person, Stryker (as cited in Jorgensen 2000). Although not the first person to undergo sex reassignment surgery, her status as an entertainer arguably made her the most famous of her time. Her very public transition introduced the world to the transsexual identity. This step undoubtedly paved the way for many others to realise and express their true gender. Significant research, including that of Harry Benjamin, credited Jorgenson for the insights and assistance that she was able to provide (Jorgensen, 2000). Jorgensen spent many years following her transition as a high-profile symbol for trans people, providing elder status for many in her community. '…many trans people who consider Jorgensen a pioneering role model Stryker' (as cited in Jorgensen 2000, p.ix).

Some of the elders of today were the activists and 'voices of change' that brought about decriminalisation of homosexuality and the Gay and Lesbian rights movement. It was their action in the 1960's, 70's, 80's and even 90's (Egan and Nesbit vs. Canada 1995 –see Critical Moments in History of LGTB) that has resulted in the rights that are enjoyed - and too frequently taken for granted - today. They laid the groundwork for the most recent acquisition of rights, such as same-sex marriage.

Elders are also the people who organised the community, initially lesbian and gay and later including bisexual and trans. They established community centres such as The Centre in Vancouver (which has its roots in the 1970's), the 519 Centre in Toronto and many other similar organisations in smaller centres across the country.

The first Pride picnics and marches in the 1970's, along with the lobbying and political action that followed, were important efforts for equality taken by the elders of today. These achievements required collaboration and participation, which in turn resulted in the building of social capital and community. 'The social activism of the Sixties greatly expanded the repertoire of readily available and legitimate forms of civic engagement' (Putnam, 2000, p. 152). 'There is now evidence to suggest that that civic connections and social capital are linked to health and well-being '(Putnam, 2000, p. 287).

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Case Example

Virginia (aged 67) and Michael (aged 63) reminisce over a coffee about their secretive youths, political action and the joy and empowerment of eventually being part of an identified and legal community. They speak of attending women's or men's parties that were so secretive that addresses were closely guarded and escape plans were in place for fear of raids. They recall the first meetings which eventually led to Pride Celebrations. These were meetings to organise and lobby for rights; now, later generations celebrate those rights at Pride rather than fighting for them. They also talk of the emergence of LGTB-owned and identified business and social opportunities, which formed an integral part of community.

For Virginia and Michael, these are the experiences that have shaped their lives. Like many of their generation and sexual orientation, they were forced to be political by virtue of the era into which they were born. They have lived through a time in history which saw them and their peers move from being jailed because of their sexual orientation to a time when their government recognises them as full and equal citizens.

Unlike many of their heterosexual siblings and friends, they have developed skills to adapt in the presence of oppression and for self advocacy.

Elders in the LGTB Communities

The elders of the LGTB community, having lived through the legally sanctioned oppression of their youth, may once again find themselves marginalised as they age. This time the agent of oppression is not the government or society, but instead their own community - the very community they helped create. They are experiencing the same challenge as their heterosexual and non-trans counterparts – ageism. The youth-centric culture which typifies LGTB communities creates an identity that makes it difficult for older people to identify with (Brotman, et al., 2003).

Case Example

Jim has been a regular at gay venues in his neighbourhood for the past thirty-one years. He has seen the bars and various businesses come and go and watched too many friends cut down in their prime by the AIDS epidemic. He has witnessed a gradual change to a greater presence and acceptance of his community. He's seen a lot and knows a lot about being queer in this town.

As Jim waits to meet some friends at his local bar, he overhears one member of a group of young men saying: 'What's an old guy like him doing hanging out here?' Another one scoffs, 'yeah, shouldn't he be in an old folk's home or something?'

Despite feeling angry, Jim doesn't say anything. Instead he recalls his own youth and how things have changed. He remembers the raids on gay and lesbian venues, being arrested and ridiculed in court. He also remembers the exuberance that he and his friends felt when they won the right to congregate in a gay-identified bar. If it hadn't been for his generation, would these young fellows be enjoying the life they do?

Suddenly Jim feels very alone in a setting where he has always felt comfortable. A stranger in his own place, he has been sidelined by a group that has no understanding of what he has been a part of.

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1. How might the experiences of their youth positively and negatively impact on an elder's health and access to health and social service systems?

2. What role might intergenerational initiatives play in enhancing the health and well-being of older and younger LGTB people?

Summary

From an era of legally and medically-sanctioned marginalisation, LGTB elders have led and witnessed remarkable changes in LGTB human rights. They have formalised LGTB communities, influenced policy and created structures which are crucial to the enhancement of individual health - and, more importantly, to the health and well-being of the entire LGTB community.

It has been suggested that their early oppression may actually have strengthened them and developed adaptive skills that will continue to serve these elders as they move through their senior years.

Having survived the discrimination of their youth while working so hard to overcome it, they are now faced by discrimination from the younger generations of their own communities. The elders of the LGTB communities need to be acknowledged and honoured for their contribution in creating a healthier environment for the generations that have followed. There are lessons still to be learned from their experience of life and the many skills that have aided in their survival. As LGTB communities discuss the negative health impacts of heterosexism and homophobia, they must also consider their own role in oppression through ageism and the negative impact that their community structures and attitudes may be having on their elders.

End of Life

The notion of "End of Life" is a reality that all LGTB persons will face and may occur at any stage across the life span. The intent of this section is to provide basic factual information related to planning for "End of Life" and assisting LGTB individuals and their survivors through some of the issues associated with this process. The section will address legal issues that can be challenging to anyone, and even more so when one's health is compromised due to living with a chronic and terminal illness. Some of these issues include having a Representation Agreement, Will, and information related to Surviving the Death of a Partner, Death Benefit, Survivor Benefits, Allowance for the Survivor, and Beneficiaries.

Legal issues

LGTB persons have acquired the same legal rights and freedoms in BC and in Canada that the rest of Canadians enjoy as a society, despite the social discrimination that continues to co-exist in a variety of contexts. The following information provides LGTB individuals with the necessary working knowledge to ensure that their life choices are respected and their relationships safeguarded in times of wellness and through difficult times of illness and loss.

Representation agreements

It is important for LGTB individuals to know that in the event they are having difficulty managing their personal affairs related to illness, injury, disability, or age-related factors, a representation agreement is the best way to handle their situation. In 2000, new laws came into effect and a representation agreement now combines the scope of the Power of Attorney and Health Care Directives documents that were previously in place.

A representation agreement is a written document that outlines who a given LGTB individual has appointed (one or more representatives) to represent them. Representatives have the authority to handle the individual's financial and legal affairs, to make personal and healthcare decisions on their behalf — if and when necessary — and are binding upon everyone including doctors. A representation agreement ensures that the LGTB individual's wishes and values are honoured by people they choose and trust. Knowing they are following legal and health-related directives established by the LGTB individual may also assist to ease the burden of care upon family and friends. (For more information on drafting a representation agreement, contact the Representation Agreement Resource Centre (tel. 604.408.7414 or on the Web at www.rarc.ca) or discuss the issue with a lawyer.

Wills

Ensuring that LGTB individuals have a will is one of the most important things anyone can do in supporting their preparation for End of Life, irrespective of how large or small they perceive their estate to be, whether they are single, in a relationship, married, or divorced. A will ensures that their assets and personal belongings are distributed according to their wishes versus by the law. Wills are reported to reduce the time, financial hardship, and emotional stress to a decedent's survivors.

Developing a Will
A few key requirements for a will to be valid under the law in BC include:

1.) The will must be in writing.
2.) The will must be dated.
3.) The individual must agree with the contents of the will at the time they make it.
4.) The will must be signed at the end of the document.
5.) The will must be signed in front of two witnesses at the same time, and the witnesses must sign the will as well.

It is important that in a will, an executor is named. This may be the person's common-law partner, wife, husband, family member, close friend, or financial institution. The role of the executor is to carry out the wishes as outlined in the will. The executor ought to know where to locate the will and other important documents.

Having a lawyer prepare wills is always an option and will kits are available in many book stores. If the estate is complex or any questions arise, legal advice should be sought. Lawyers charge a fee for service, but there is security in knowing that having a properly drawn will is worth the extra cost.

Some benefits to having a will include:
▼ Ensuring that funeral arrangements reflect the person's life choices
▼ Appointing a guardian for biological or adopted children under the age of 19
▼ Supporting a LGTB person's common-law partner and ensuring their eligibility for pensions and benefits upon death, if they are named in the will

Surviving the death of a partner
It is important to educate LGTB persons that if they are in a same-sex relationship, that they may be eligible for benefits upon the death of a partner under the Canada Pensions Plan (CPP) and Old Age Security (OAS) programs. Inquiries can be made to the Canada Pension Plan & Old Age Security information toll free line (tel. 1-800-277-9914) or at their web address (www.hrdc-drhc.gc.ca).

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Death benefit

It is important to educate LGTB persons that if their partner contributed to CPP, they may be eligible for a death benefit upon the passing of their partner. This is a one time amount paid to the estate, usually to assist with funeral expenses.

Survivor benefits

It is also important to determine if the late partner has contributed to CPP, as surviving partners may be eligible for survivor benefits. Same-sex partners must be married or have lived together for a least one year before the date of death and be over the age of 35 to make a claim. If the surviving partner is under age 35, or if there are any surviving children who are either under 25 years of age and/or in a full time university program, then they too may make a claim.

Allowance for the survivor

Under the OAS program, the allowance for the surviving partner provides a modest income for low income 60 – 64 year olds whose partners have died. Surviving partners must be married or have lived together for a least one year before the date of death. This applies to anyone who has died since January 1, 1998. If a person died prior to this date, please encourage individuals to consult with a lawyer familiar with same-sex laws to discuss possible options.

Beneficiaries

Another important aspect of End of Life planning is to identify beneficiaries. If LGTB persons want their partners to receive the proceeds of insurance coverage, RRSPs, or benefits under a pension plan, then they must name them as beneficiaries with their respective plans. In doing so, the money is paid directly to the surviving partner immediately after their partners' death without delay while the will is being 'probated'. Where the beneficiary has been designated, there will likely be no need for probate.

Grief counselling

The surviving family members may benefit from grief counselling. As with other services, however, they may experience discrimination either in individual counselling or group settings. Heterosexuals may consider their loss or grief more legitimate or important than that of the LGTB person.

Summary

In this module the learner has been introduced to definitions relating to LGTB and provided with exercises to challenge their beliefs and knowledge about LGTB people. By examining the life stages from youth through to older adulthood, the learner has considered examples of everyday occurrences and decisions that LGTB people face, seeing how these may negatively or positively impact on their health and well-being. These experiences have been compared and reflected upon in contrast to the dominant population of heterosexual non-trans. In addition, the module considered two other life stages that are not necessarily strictly linear in time: elder and end of life. The former module considered the role of the elder LGTB in the achievement of human rights and their own well-being in later years. The latter provided practical steps to consider relating to end of life.

On completion of this module, the learner should possess adequate knowledge to progress to module two, which will examine diversity and the determining factors of LGTB health.

Knowledge Assessment — Pre and Post

The following statements are based on the material presented in module one. The statements are either true or false. Please read each statement and mark a T or an F beside the statement that best reflects your knowledge and understanding of the material. This tool should be used before delivery of the module content and again afterward. It is suggested that learners take some time to compare their answers and consider how their knowledge and attitudes have changed.

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		True or False			True or False
01.	Reflecting on one's own ideas, beliefs, values and actions has the potential to increase awareness of assumptions and expand one's view of the world.		11.	LGTB youth have full and easy access to sporting activities that are inclusive of their diversity.	
02.	People choose to become LGTB.		12.	LGTB adults who are denied employment because of discriminatory attitudes have the potential of experiencing negative effects to their overall health and wellness.	
03.	LGTB people are anti-family and are incapable of loving, caring relationships.		13.	Researchers contend that community presence and participation within a civil society will enhance the health of LGTB individuals and their families.	
04.	Most same-sex couples work to develop their relationships based on love, respect, and equality versus the traditional female/male stereotyped dynamic.		14.	The process of establishing contacts, dating, and coupling is as significant for LGTB individuals as within the non-queer population.	
05.	LGTB people do not make good parents.		15.	Sexual orientation is no longer an impediment to promotion of higher paying jobs.	
06.	HIV / AIDS is a gay disease.		16.	Health care and social service systems no longer provide heterosexist approaches in working with LGTB individuals and their families.	
07.	Sexual orientation and gender identity is the same thing.		17.	LGTB individuals will never experience the challenges associated with "empty nest" syndrome (adult children leaving home).	
08.	LGTB-phobia is a term used to include all forms of homophobia, biphobia, and transphobia.		18.	Older LGTB individuals living with ongoing health conditions are proud and confident in talking with health care/ social service providers about their experiences within a heterosexist culture.	
09.	LGTB students in high school feel safe and secure in their school environments.		19.	Elder LGTB individuals have survived the discrimination of their youth and have worked to overcome oppression, are now faced with discrimination from the younger generations of their own communities.	
10.	LGTB sport athletes who are "out" may be able to serve as role models to younger LGTB youth.		20.	LGTB individuals should concern themselves with end of life issues related to wills, survivor benefits, and beneficiaries.	

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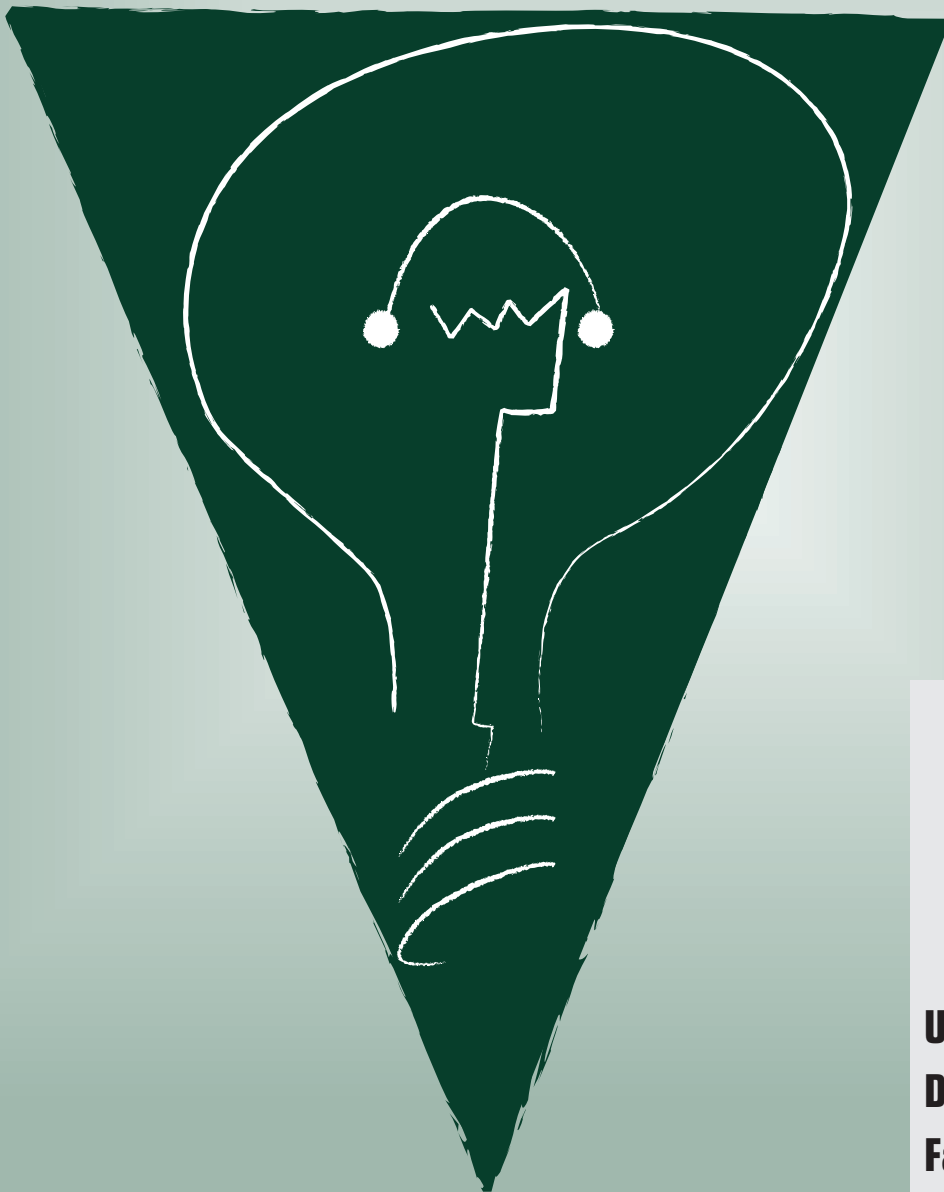Wilkinson, R. & Marmot, M. (Eds). (2003). *Social determinants of health: the solid facts second edition.* Copenhagen: World Health Organisation. [Electronic version]. Retrieved March 20, 2005 from http://www.euro.who.int/document/e81384.pdf

LGTB Health Matters

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Module 2

M2

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Understanding LGTB Diversity and the Factors Which Determine LGTB Health & Well-being

M2

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Introduction

In module one, the learner was introduced to a many factors relating to homophobia and heterosexism and how they impact on LGTB people through various stages of life.

Module two takes a more in-depth look at a range of health and illness determinants and applies them to the LGTB experience. It considers the variability and diversity which exists in LGTB communities, and how many other factors will impact and interact with a person's sexual orientation and gender identity. Some - but not all - will manifest as multiple oppressors.

Module two uses the World Health Organisation's *Social Determinants of Health* as well as Health Canada's *Determinants of Health and Social Determinants of Health* as frameworks to review health determinants from income and social support to housing and tobacco use. Like module one, the teacher and learner are provided with ample real life examples and questions to stimulate thought and discussion.

Preparation and Prerequisite

▼ Module one prerequisite
▼ Pre-reading -suggested
  ▼ *What Determines Health* (Public Health Agency of Canada
    http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html)
  ▼ *Social Determinants of Health: The Solid Facts Second Edition*
    http://www.euro.who.int/document/e81384.pdf

Learning Outcome

Learners will describe and differentiate the diversity within queer and trans communities. Learners will develop an understanding of the determinants of LGTB health, including those which marginalise them.

Learning Objectives

1.) Learners will develop an awareness of the diversity that exists within the LGTB communities.
2.) Learners will be able to identify other oppressing and/or impacting factors that intersect with sexual orientation and/or gender identity to determine the health and well-being of LGTB people and communities.
3.) Learners will possess an understanding of health determinants and how they impact on LGTB health
4.) Learners will view LGTB health assessment, planning and implementation from a perspective that considers the multiplicity of factors that influence and impact on the health and well-being of LGTB individuals, families and communities.

Diverse Populations

LGTB people account for as much as 10% of the population and exist in all groups within society: economic, ethnic, religious, political and geographic. They come from rural areas, big cities and all the countries of the globe. They are of every creed and colour. Some are well-educated and wealthy, others are not. They represent every stratum of society, wherever and however society is disaggregated. LGTB people are parents, children, siblings, old, young, people with disabilities… the variations are too great to list. The reality is that LGTB

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communities are as diverse as the world's population.

Despite all of the similarities, a very important aspect of an LGTB individual's life sets them aside, that being their sexual orientation and/or gender identity. Historically and sadly even today, the focus has been on these differences rather than the similarities that LGTB people share with members of their other communities, such as ethnicity, religion or geography. These differences have been moralised, legislated against and used as the basis for exclusion. Depending on where the person resides or originates, they may experience or fear legally-sanctioned abuse of their human rights. These abuses can range from refusal of employment or housing (as in some western countries) to the more extreme penalties of countries such as Saudi Arabia, Iran and Nigeria, where being homosexual is punishable by death.

LGTB (or its many variations i.e. GLBT, GLBTTQI, etc.) has been grouped this way through an affinity of lived experience in being a minority to the dominant sexual and gender majority. This does not imply homogeneity, for these groups are as different as any other group amalgamated based on limited similarities. For example, people from South Asia and Japan share little in common except the mega-region of the world from which they originate: Asia. The grouping of sexual orientation and gender is not a simple combination as these identities are not mutually exclusive. A person can be heterosexual and trans or they may be homosexual and trans. They may have been homosexual and transitioned, now identifying as heterosexual - or vice versa. There are also some people who have transitioned and then moved on to live their life exclusively as the other gender without relation to any of the LGTB components. For these reasons, there is debate amongst some quarters as to whether all LGTB people should be considered as a like group. While this is the accepted grouping in much of the English speaking world e.g. English Canada, U.S.A., UK, Australia (where they also include I for intersex) and New Zealand, other cultures such as Quebec have clear delineations between trans and same-sex identities.

Contrary to this is the argument that, although different, these groups share a common oppression and that overcoming it might best be achieved through a united front. This is not an assimilative position which requires one or the other of the representative interests to forgo its identity. It also recognises that people of trans identity may self select to relate to the LGB community.

Identifying with LGTB or any of its components

For every person who identifies as LGTB or who relates to those communities, there are many more who do not. These might be people who are same-sex attracted or trans but have never engaged in sexual activity with someone of the same-sex or publicly exhibited any trans behaviour or desires. There are also individuals who may engage in sex with people of the same gender or limit their cross-dressing to the confines of their own home, but do not consider themselves as LGTB.

This makes it impossible to accurately know just how many LGTB people there are and therefore how best to provide service. Not making assumptions about individuals and communities based on stereotypes is an important first step in recognising the diversity which exists for LGTB people. To highlight this point, the following stereo-types and realities have been provided to demonstrate why generalisations are inappropriate and inaccurate.

Stereotypes and realities about people who are LGTB

1. Gay men are easy to identify because of their effeminate actions and higher pitched voices.

Reality: Some gay men may possess these qualities or even choose to accentuate them as part of a particular role or identity, but this is not a definitive indicator of a person's sexual orientation. Some straight men may also possess these attributes.

Many gay men may also fit traditional stereotypes of the heterosexual male. Gay men are

found across every occupational group from teachers and politicians to loggers and farmers.
2. All lesbians like to wear men's clothes and work in male-dominated professions.

Reality: Some do, as do some straight women. Some lesbians may prefer to dress in more masculine clothing, not wear cosmetics and cut their hair short. Others may opt for a more traditional female look, wearing skirts and cosmetics. Some will dress differently depending on the occasion. Clothing and physical presentation is not a clear indicator if a woman is a lesbian. Lesbians occupy positions in all forms of employment ranging from traditional female roles such as nurses and secretaries to construction workers and gardeners.

3. You can always tell transgender people because they never really look like a 'real' man or woman.

Reality: A person's physical appearance may not be the best indicator of a person's gender. For some people who have completely transitioned it may be impossible to identify that their present gender is different from the gender they were assigned at birth. Conversely, there are people who are not trans but due to their physical features are mistaken for someone of the opposite gender. There are also people who do not identify as either of the two dominant genders and therefore might not possess or exhibit the socially assigned stereotypic characteristics.

4. Bisexual people are just the same as gay or lesbian people.

Reality: It might also be said that bisexual individuals are just the same as straight people but neither statement is accurate. Just like LGT people, bisexual people come from all walks of life. They may be partnered, single, professional or unskilled. There is no way to tell by looking at a person if they are bi and, unlike LGT, there are not necessarily any commonly held stereotypes as to how a 'bisexual' person may look or act in general community life.

Two-spirit

As a multicultural nation, Canada recognises and celebrates the diverse cultures and practices that have been introduced through centuries of immigration. It is, however, important to recognise that there are cultures and traditions that predate colonisation. First Nations people hold a unique position in Canadian culture because of their infinitely longer association with this land. Traditionally these cultures have also held — and some continue to hold — a different understanding of gender and sexual orientation than accepted western definitions. It has only recently been recognised (by some First Nations groups and by broader society) that prior to colonisation, at least some First Nations people had an understanding and recognition of gender and sexual orientation that was much more complex & inclusive than the European imposed ideas of gender and sexual orientation (Urban Native Youth Association, [UNYA], 2004).

Two-spirit will be considered in more detail later in this module in relation to culture and in other modules with particular reference to health.

Critical Thinking Questions

1. When thinking of diverse populations who do you usually consider and why?

2. How do you think your perception or stereotype of a person's sexual or gender identity informs

Oppression

Social and politically sanctioned discrimination against LGTB people has resulted in multiple and intersecting oppressions. This refers to people being excluded or discriminated against in many ways and areas of their lives, including but not limited to their sexual orientation or gender identity.

Oppression is a complex process based on misinformation, fear, beliefs and stereotypes. These are perpetuated by society and many of its institutions, including religious, political, educational, family and media. Legislating against discrimination can only go part of the way toward eliminating oppression. (McGrath, 2000)

For some, the primary source of oppression may in fact not be their sexual orientation or gender identity but other characteristics such as ethnicity or socioeconomic status. There may also be layers of oppression which emerge from within another oppressed group to which the person belongs. For example, an LGTB person may experience discrimination by an ethnic community to which they belong because of their sexual orientation or gender identity. The reverse may also then happen where the person is discriminated against by LGTB communities based on their ethnicity.

The intersectional nature of oppression in minority groups adds to the complexity for the service provider working with such individuals or groups. An individual may be oppressed because they are, for example, a lesbian of colour. This person may be disadvantaged because of her gender, her sexual orientation or her race and colour. Oppression could result from any of or all of these factors, or there could be no oppression that she identifies or in fact experiences. It may be the fact that for her, a primary form of oppression relates to poverty or lack of housing which in turn could be the result of the contributing factors identified above.

Case Example

Ly comes from a traditional culture which does not acknowledge homosexuality. Her cultural community is an important part of her support system. She is aware of their cultural position on homosexuality, knowing that it would be very difficult to come out to them and remain connected in the way that she currently is. For this reason, no one in her community knows that she is a lesbian. When Ly goes out with other dyke friends she is often aware of her ethnic minority status in gay and lesbian venues. On occasions she has even overheard racist remarks made about her.

Critical Thinking Questions

1. In what other ways beside sexual orientation or gender identity do you think LGTB people might experience oppression?

2. What do you think some of the impacts of these other oppressions might be?

LGTB people posses a significant capacity to create wellness through the social structures they have created, their resilience and experiences. While they may be oppressed, they are not absolute victims.

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Determinants of LGTB Health

This section will consider LGTB health and well-being based on the factors which determine it. Most of these are related to exclusion and oppression — which ultimately relate to illness and social problems — but some also focus on the positive constructs or the potential that exists to create well-being and ultimately health. These determinants are an amalgam of three documents: the World Health Organization's *Social Determinants of Health: the Solid Facts Second Edition (2003)*, and Health Canada/PHAC's *Determinants of Health (2004)* as well as *The Social Determinants of Health: an Overview of the Implications for Policy and the Role of the Health Sector(2005)*. The 12 Health Canada Determinants of Health are used in their entirety and form the core of the determinants discussed.

1. Social Gradient/Income and Social Status

'Poor social and economic circumstances affect health throughout life'(Wilkinson & Marmot, 2003, p. 11)

It has long been known that there is a link between poverty and illness or, conversely, between wealth and the absence of illness. It is also now proposed that distribution of wealth may be more important to the health and well-being of a society than the total wealth of that society (PHAC, 2004, key determinant 2). Monetary wealth, however, does not stand alone as it is linked to factors which determine social status.

Evidence supports that there is a correlation between where people fall on the social gradient and their health and well-being (Wilkinson and Marmot, 2003). This is partially determined by income but also other social circumstances, such as class structures, policy and discrimination.

Social Status

The decriminalisation of homosexuality in 1969 and the removal of homosexuality as a psychiatric diagnosis in 1973 (CBC, 2005) eliminated two major barriers which had legitimised marginalisation of LGB people. These are both recent events with regard to society's collective memory. It has only been since 1992 and 1995 that British Columbia and Canada, respectively, amended their human rights codes to prohibit discrimination based on sexual orientation (trans people still have no specific protection under the Charter of Rights and Freedoms or the BC Human-Rights Code). Contrasted with these significant changes of the past four decades are centuries of institutional persecution and oppression of LGTB people - persecution which has allowed and encouraged society to consign them [LGB] to the lowest rungs of the social ladder. One of the most extreme examples was the treatment of homosexuals by the Nazis, who sent them to concentration camps along with other so called 'undesirables'.

Underpinning the political and structural legitimisation of this discrimination is a perception that LGTB people are immoral. The most recent example has been the debate over equal rights for marriage, in which many religious conservatives argued against equal rights by stating that homosexuality was immoral.

The absence of rights or status has meant that LGTB people have not had the freedom to identify their sexual orientation or gender identity if they hoped to progress up the social ladder. Improvements to one's social status usually had to be achieved at the cost of hiding or even denouncing one's sexual orientation or gender identity. For example, many of the first openly LGTB parliamentarians in the world came out after they had been elected, like Svend Robinson in the Canadian House of Commons and Bob Brown in the Australian Senate. It is questionable as to whether they would originally have been elected at that time if they had openly identified or campaigned as gay, something many politicians now do. This is still the case in many other parts of the world.

A member [Kanako Otsuji] of the Osaka regional Assembly announced she is a lesbian Saturday during gay pride celebrations in Tokyo. … Otsuji said she had not come out earlier because she was uncertain she could win election in conservative Japan. She is only one of a handful of openly gay politicians in the country. (Japanese Legislator comes Out, 2005).

Recent legislative amendments toward greater inclusion have started the process of social change which will ultimately challenge the ranking of LGTB people as lower on the social ladder. This could be likened to certain ethnic minorities that have risen from legislated marginalisation to become higher-ranking groups.

As members of a marginalised community, LGTB people experience many of the disadvantages which attribute to poorer health. Prolonged exposure to these elements further compromises their health and well-being, 'The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age'(Wilkinson & Marmot, 2003, p.10). Therefore part of improving the health and well-being of LGTB Canadians is to further remove structural and attitudinal barriers that currently restrict their ability to progress in society.

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Case Example

Jack left school in grade ten because he couldn't stand the taunting and teasing any longer. Other kids singled him out because of his masculine traits. That was when Jack still went by the name Kerri. There is not much work to be had when you are a fifteen-year old girl who was made to feel that she didn't belong, so Kerri drifted from low paid job to low paid job. Kerri never found employment that she liked or that had any decent health benefits. It was within this employment environment that she transitioned, leaving one job before starting the next as Jack. It was hard because he had to explain to his new boss why all of his referees referred to him as Kerri.

Jack's new job wasn't very different than the other crummy jobs. He suffered some humiliating comments and harassment based on his appearance. Despite this, he was afraid to speak up or for that matter to change jobs. He believes his only option is to keep his head low and try not to be noticed. Some days Jack believes that the only choice he has in his employment environment is whether he goes to work that day or not.

Income

To consider these determinants within the LGTB context it is important to dispel the myth of the 'wealthy gay' and the 'pink dollar,' a phenomenon which is usually only associated with white gay males. Perceptions of gay wealth have been the result of popular media and shrewd marketers stalking the disposable income of a specific segment of the LGTB community. They take no account of the poverty which exists in other groups. Burnham (as cited Darke & Cope 2002) reported that in research with transsexual and transgender people (n=152) '...71% earned incomes well below, or within the "low income" range set by the federal government.'

Gay men who enjoy the benefits of higher incomes and greater social status may do so due to other privileges or attributes such as ethnicity, gender and education. Sexual orientation is still seen as an impediment to promotion to higher paying jobs in many workplaces, despite legal protection (GLHSS, n.d.)

Meyer (2003) reports 'Badget's (1995) analysis of national [US] data showed that gay and bisexual male workers earned 11% to 27% less than heterosexual male workers with the same experience, education, occupation, marital status, and region of residence' (p.9). Note that this is a U.S. study, one that is now ten years old. As there are significant cultural and human rights differences between the US and Canada, this data can not be

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assumed to be the same for Canada. It does however support the argument of disparity between queer and non-queer incomes, which can be assumed to exist in other similar countries. The age of the data may not be indicative as American LGTB people still are not recognised as equal in many employment settings.

When considering the income of this population, one must also consider other factors which could reduce an individual's capacity to generate a liveable income. For example if the person possesses other marginalising characteristics — such as having a disability or being from a visible ethnic minority group — they could be at greater disadvantage.

Case Example

Rob came from a 'nice' middle class home: annual holidays, spending money and computer games, that was until his parents found out he was gay. At seventeen, Rob now stays on a friend's couch and is trying to finish high school while working part-time to support himself. Rob has been reluctant to approach the provincial government for assistance as he is afraid that they may try to force him home or involve his parents in some way. From his minimum wage job on weekends, he earns enough to buy food and when possible contribute to some of the household expenses. Being seventeen, Rob also tries to juggle a social life, but this usually means choosing between being able to eat or party. Sometimes the latter wins out.

An important factor relating to income is the employment which people are engaged in. This will be discussed further under employment and working conditions.

Critical Thinking Questions

1. What might be the cause for the discrepancy of income between LGTB people and other employees?

2. How do you think the experience of marginalisation and victimisation impacts on the lives of LGTB people and their health & well-being?

3. How do you think the repositioning of LGTB people on the social ladder would impact on their health & well-being? What other factors might affect this besides gender identity and sexual orientation?

2. Social Support Network

'*Friendship, good social relations and strong supportive networks improve health at home, at work and in the community*' *(Wilkinson & Marmot, 2003, p. 22)*

Social support has been identified as being an important preventative and curative factor for one's health (Wilkinson & Marmot, 2003, PHAC, 2004). Social relationships, be they familial, community-based or other social structures can be as important a protective factor as physical activity, not smoking or maintaining a healthy body weight (PHAC, 2004, key determinant 2). The absence of social support can equally have a deleterious effect on one's health.

'Social exclusion is exacerbated by gender, age, ability, sexual orientation, race, ethnicity and religion.'
de Wolff, 2000 (as cited in PHAC, n.d., p. 4).

Many LGTB people are forced to choose between their traditional support networks such as family, friends or community and their sexual orientation or gender identity. For some, the choice delivers acceptance and inclusion with the resultant health-enhancing social cohesion, but for others it can mean partial or absolute rejection. This may translate to a person being 'out' to their family or friends but not to other support networks, including geographic or religious communities. This isolation, either partial or total, can remove the protective qualities of social support.

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Case Example

Chris is a 23 year old man who, to date, has enjoyed approval and support from his family and community. After considerable soul-searching, he has come out to his family and a close friend. Although his family initially rejected him, they soon accepted him for who he is. There was much greater concern about extended family and the community with whom they associate. There were concerns about the repercussions for Chris and also for his family. It was feared that the label of 'gay son' could isolate them from family and community. For this reason Chris remains out to only his immediate family and the one friend.

Family

Family is an important institution and like many of societies other major constructs has the potential to be both health-enhancing and health-harming in relation to the LGTB individual.

For the LGTB person, family of origin may be a source of great support; alternatively it can be an isolating and punishing force. This may be related to coming out or based on stereotypes of expected behaviours or family roles. It is still not uncommon to hear stories of LGTB people (young and old) who are estranged from their families because those families have rejected them due to their sexual orientation or gender identity. While this is an important consideration when dealing with LGTB people, there are also increasing numbers of families who have embraced their LGTB family member and offer support, even participating in celebrations such as Pride events. Organisations such as PFLAG (formerly Parents, Families and Friends of lesbians and gays) have been an important part of greater acceptance of LGTB family members, particularly LGTB children.

Many LGTB people have either through necessity or choice created alternatives to family of origin. Referred to as 'families of choice', these may operate in lieu of or addition to family of origin. Families of choice may be founded on any number of commonalities ranging from sexual orientation to geography. These families

provide many important social functions, including support and should be acknowledged and treated as legitimate family options.

The term 'family' also represents a more negative connotation within the contemporary discourse surrounding LGTB rights. Certain conservative groups have seized the term 'family' and misuse it to defend traditional conservative values at the exclusion of LGTB people. Under this guise, claims are made that LGTB people threaten the family structure.

In addition to the usual complexities of family, the LGTB individual or community has other considerations: who is family, for example, and is their family of origin a support or perhaps a threat?

The appropriation of the term 'family' by conservative factions may mean that for some people, 'family values' have become the basis for exclusion.

Support for 'Coming Out' or Transitioning

The processes of 'coming out' and/or transitioning are unique to LGTB people. Because of strongly-held social views on sexuality and gender conformity, the fear of loss of social supports associated with non-compliance is great. Concern about the loss of friends, families or other institutions such as faith communities is a very legitimate fear, one founded on the experiences of others. For some, coming out may result in a rejection that is temporary; for others, it is a permanent exile. The grief associated with this isolation may be no different than any other significant loss, such as a relationship break-up or even the death of a loved one.

The coming out or transitioning processes can be made more difficult if conducted in isolation. Meyer (2003) refers to the importance of group solidarity in situations of minority stress. The experience of coming out within a setting of heterosexual and non-trans support qualifies as minority stress.

Case Example

Raj is 19 and wants to come out to his family. He doesn't know of anyone else in his family or community for that matter who is queer. He knows that there are other gay Indian guys but nobody that he really associates with is out. He feels alone and unsure as to whether he really wants to risk his security and maybe family. At the same time he feels a strong desire to be honest to himself and those he cares about.

Raj knows the feeling of being different all too well, having grown up as part of the only Indian family in a small town in the Interior of BC. But in that case everyone else in the family could understand his feeling of being different and the ways those feelings could be compensated for. Besides, he was born Indian. His earliest memories included his cultural identity. People could tell that he was Indian by looking at him. He never had to declare that he was Indian, and despite having experienced some racism, he suspects that being an ethnic minority might be easier than being gay - or gay and an ethnic minority.

Support Within the LGTB Communities

LGTB communities have the capacity to significantly impact on the wellness of community members because of the support structures they create. This includes formalised supports such as Prideline (a peer support/information/referral phone line) as well as community initiatives like sporting or recreational groups and celebrations like Pride Day and Stonewall. Other formalised support opportunities include coming out groups and social support groups that target specific segments of the LGTB communities. Health Canada has identified that 'Such social support networks [families, friends and communities] could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances' (PHAC, 2004, key determinant 2) .

Many of these resources and services have been developed by the LGTB community for the LGTB community and are dependent upon committed volunteers. An act such as volunteering is in itself health-enhancing as 'social or community responses can add resources to an individual's repertoire of strategies to cope with change and foster health' (PHAC, 2004, key determinant 5)

For many LGTB people, the LGTB community may also be the source of other supports such as family of choice or a point of connection for other common interests or experiences such as ethnicity, age, sport or disability.

Case Example

Jacquie moved to Vancouver 6 months ago from Fredericton. She busied herself getting established in a new job and apartment. After the first couple of months, she noticed that she hadn't made many social contacts and was spending an increasing amount of time on the couch in front of the television or playing computer games. Jacquie knew that this was not what she wanted from her new life and was starting to feel dissatisfied. Jacquie has always known that she was attracted to women as well as men, but despite a few short-term romances with women her longer-term relationships had been with men. Knowing that Vancouver had a large LGTB community, Jacquie thought that maybe it might be a good place to make some social connections. She joined the gay badminton club and has started volunteering with a local community event committee. She has found that her days stuck on the couch are a thing of the past. She has met new friends and is contributing to the community. She can't believe the difference that this has made to her outlook on life and how she is feeling about herself.

Exclusion Within the LGTB Communities

Despite a perceived unity based on common oppression due to gender identity and/or sexual orientation, the differences in the LGTB community are as varied as within society in general. LGTB communities are divided by the same social factors as the rest of the population: race, age, income status, education, geography, politics, language, etc. therefore the grounds for exclusion are similar.

This means that in addition to the oppression imposed due to heterosexism and LGTB-phobia, the LGTB community is in turn further marginalising certain members of its community based on other attributes. For example people with a disability or people from ethnic minority groups may find themselves not being welcomed or accommodated in gay and lesbian venues.

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Case Example

Doug is new to the gay community. He is transitioning and although he has some gay male friends he previously hasn't had a great deal of contact with the gay community. Although he now dresses as a man and has altered other physical characteristics like his hair, he still feels like he is looked upon differently when he is in social settings with other gay men. Doug finds that his attempts to integrate with gay culture are being consistently thwarted. He had hoped that when he had undergone the physical transition to being a gay man that he would experience a sense of belonging that he had never known in a female body.

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Critical Thinking Questions

1. How do you think the experience of family might be different for LGTB people from that of heterosexual or non-trans people? How might this impact on their health and well-being?

> *Activity*
> If you are not LGTB participate in this exercise. If you are LGTB reflect on your experience of coming out or choosing not to in comparison to this activity.

2. Choose events in your life that best describe the following times. Make a mental note or jot down a note for yourself. This **is not** an exercise for you to share with others.

> *A time when:*
>
> ▼ You had a secret about yourself that you didn't or couldn't tell anyone.
>
> ▼ You did something that you felt guilty about, but couldn't change.
>
> ▼ You feared losing a close friend or family member because of something you did or believed that you knew they would not approve of. E.g., it might have been a secret you shared that you weren't meant to.
>
> ▼ You felt most isolated or alone.
>
> ▼ People who were important to you ridiculed something that you secretly possessed or believed but were too afraid to admit to. It might have been a belonging, piece of clothing or favourite band.

> Now try to imagine what it would be like to have all of these as one overall experience.
> Allow time for discussion.

3. How do you think the experience of LGTB communities might enhance or detract from the health and well-being of LGTB people?

3. Culture

Some cultural groups will experience compromised health outcomes because of their exclusion from other social determinants of health such as education, income and the experience of discrimination.

Health Canada's consideration of culture as a determinant of health adopts a health-harming view of culture, focusing on marginalisation and culture as defined mostly by ethnicity.

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Is there an LGTB Culture?

There are divergent views on whether LGTB can be defined as a culture or cultures. Opponents would argue that it lacks many of the defining characteristics of a culture, such as common traditions, origins and customs and that its only commonalities are sexual orientation and/or gender identity. Advocates of a cultural defini-tion would, however, propose that the common experience of oppression, the fight for rights and the tradi-tions, celebrations and events that have grown from this constitute the basis of a culture. This section will consider the application of culture based on ethnicity as well as making some reference to LGTB cultures.

Whether LGTB experience is a culture or a movement, it has delivered outcomes that have enhanced the health of community members. In winning greater equality, it achieved better access to those services and life options that improve the health and well-being of LGTB people. LGTB history as described in module one is an important part of understanding the oppression and exclusion of LGTB people that has negatively impacted on their health and perhaps shaped their identities. Some cultural groups, such as Jewish groups, consider their historical experiences of oppression as significant to their culture.

Ethnic Perspectives

LGTB people come from all ethnic back grounds. Some are more inclusive of LGTB people than others and in some instances this extends to specific acknowledgement of LGTB people. Sadly these cultures are very few. Within most cultural groups, being LGTB is taboo. This includes the dominant western cultures.

Aboriginal Culture

An important cultural consideration is that of the First Nations people. Earlier in this module it was mentioned that First Nations people had understandings of gender and sexuality that were not understood by the colonial powers. The conquerors effectively quashed much of this heritage through religious and education practices.

Tafoya and Roscoe (as cited in Ryan, Brotman &Rowe, 2000) report that two-thirds of North American Aboriginal languages had a word or words to describe people as being neither man nor woman and that in excess of 200 such terms existed. The term two-spirit is a modern term used to replace many of the traditional words that have been lost from indigenous languages. 'Being two-spirit means that an individual possesses the female and male spirit' (Ryan et al., 2000, p. 117) Module three will examine two-spiritedness in greater detail, but it is important to first understand some of the issues and effects of multiple oppressions on this group.

The experience of First Nations people as the result of residential schools has become better known by the broader Canadian community in recent years. It is now known that many young people experienced abuse at the hands of those responsible for their care. Additional damage was done by the trauma and loss of culture

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related to the removal of children from family and country. This shameful part of Canadian history has another chapter which relates specifically to two-spirit people. The residential schools - and the many religious organisations that ran them - rejected those people who identified as two-spirit, instead teaching homophobic beliefs associated with Christianity. These beliefs were then transported to the students' home Aboriginal communities, resulting in homophobia that had not previously existed. As a result, some two-spirit people have experienced greater homophobia in Aboriginal communities than in mainstream society (UNYA, 2004). This is a sad and ironic twist.

Many two-spirit people who find themselves rejected by their Aboriginal communities experience further alienation within the gay and lesbian communities. Maxwell (as cited in Le Duigou , 2000,) asserts, 'For Aboriginal gay men, there is little support, and in addition, they man not be welcome in mainstream gay (mostly white) organizations because of racism'(p. 203).

The cultural implications for two-spirit people are complex. Their tradition of acceptance and celebration of sexual diversity has been devastated by colonisation, which has not only quashed this view but imposed one which is diametrically opposed. As a result, 'There is much interlocking oppression, which have an impact upon two-spirited Aboriginal men [and women]'(Le Duigou, 2000, p. 203).

Despite the efforts of religion and government to subvert beliefs and understanding of sexual diversity and two-spirit persons, there still exists in some an understanding of two-spiritedness. This coupled with an organised effort to recognise two-spiritedness will hopefully see a change for future generations.

Case Example

Terry is a housing worker at a local social service agency. He has met Tanya for the first time. She has just arrived from a reserve in northern Saskatchewan and is in need of housing. Tanya has many male features but dresses and presents as a woman. Her identification makes reference to her birth name, Dwayne. She tells Terry that she had to flee her home because of persecution because she is two-spirited. Terry isn't familiar with the term and asks Tanya to explain.

Terry grew up in north-central British Columbia and recalled the elders talking about this phenomenon, though 'two-spirit' was not the term they had used. Terry's only real reference to what Tanya was identifying was the LGTB population in Vancouver. He knew about them because they were part of his client group.

Other Cultural Perspectives

There are other cultures that have a different and accepting understanding of sexual and gender diversity, such as the Samoans.

Fa'afafine (fah-fah-fee-neh) is a Samoan word which literally means "like a woman". A fa'afafine is identified as a male who takes on the identity of a female (Schmidt, 2001). Fa'afafine live as a part of Samoan community. They do not identify as gay and in fact there are very conservative views in this country toward homosexuality, to the extent that it is still illegal (International Lesbian & Gay Assoc, 2000).

Health and social service providers must understand that there are different cultural perspectives with varying degrees of tolerance, understanding and cultural significance when it comes to LGTB people. These do not always fall neatly into the confines of the western European definitions of gender or sexual orientation.

Multiculturalism

Canada prides itself on its multicultural population and encourages newcomers to bring their cultural experiences, share them and preserve them within a tolerant and liberal society. This is what Canadians celebrate when they acknowledge multiculturalism: the dances, cultural exhibitions, etc. Many of these cultures also bring their biases and bigotry, a side of multicultural populations that must too be acknowledged. Whether as a result of religious teaching, national policy, ignorance or a combination of the preceding factors, most peoples of the world do not live in countries whose LGTB citizens share the rights and freedoms of LGTB Canadians. People new to Canada may not have been exposed to 'out' LGTB people and may even have been part of systems that actively persecuted them. They may also bring with them cultural practices that in this country are associated with being queer and, as a result, experience homophobia themselves. An example of this is the practice in many Asian countries of men holding hands when they walk down the street.

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Although Canada is no queer utopia, a great deal has been achieved to assure rights and to improve the quality of life of LGTB people. This has meant that the mainstream Canadian population has come a long way toward greater LGTB inclusion. It is therefore important that newcomers to Canada understand that LGTB people's rights are not up for consideration, that this is part of the Canadian package for which a mutual respect must develop.

LGTB People of Other Ethnicities

Immigrants arrive in Canada from all countries of the world, some from countries who do not protect LGTB people. Included in this migrant population are LGTB people. Some will be seeking immigration based on persecution in their own countries as a result of their sexual orientation or gender identity, but many will arrive as part of family migration or under other migrant classifications. Regardless of the grounds under which they have migrated many will be at a dual disadvantage, being LGTB and migrant.

Canadian women, aboriginal people, Canadians of colour, and New Canadians are especially vulnerable to the health-threatening effects of these deteriorating conditions. This is most clear regarding income and its distribution, employment and working conditions, housing affordability, and the state of the social safety net (Centre for Social Justice, 2003).

What About Everybody Else?

There are also the people who are second, third, or many-generation Canadian who belong to cultural groups that hold strong beliefs about LGTB people and their inclusion. Being LGTB and a member of some of these groups might mean the person has to choose between expression of their gender identity or sexual orientation and their cultural group.

Identifying the difficulties encountered by many minority groups does not mean that the dominant cultures of Canada such as the Anglo/Celtic, Francophone, eastern or other western Europeans are without their challenges. In fact, it is important to remember that it was in within these cultural groups that the fight for rights was mostly fought… and those rights did not come easily. It should never be assumed that because a person's background is of a dominant cultural group in Canada that their experience is any easier than someone from a visible minority. That person may have other cultural implications that influence their experience of being LGTB e.g. religion or geography i.e. rural or small communities.

Case Example

Jakob grew up on a Hutterite colony in central Manitoba, the same one that his father, grandfather and great grandfather had lived on, along with pretty much his whole family. He knew little of the outside world, but from an early age he knew that he was attracted to men and in his community this was a problem. Upon reaching nineteen years of age — when planning would start for his marriage — Jakob decided his only option was to leave the colony.

Life outside the close and supportive community is tough. Jakob has difficulty getting a job, because his skills are related to agriculture and he has few real supports except the friends he made in the gay bars. Bar life had become his sole activity and within a year he has noticed the important role that alcohol is playing in his life. At twenty-one years of age, Jakob has presented to the local community health centre asking to speak to a counsellor about his alcohol use.

Critical Thinking Questions

1. In what ways could the mix of culture and sexual orientation or gender identity impact on an individual's health?

2. How could a person's cultural identity shape their view of their own sexuality? As a service provider how might this determine the way in which you deliver your service?

4. Gender

'"Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles' (PHAC, 2004, key determinant 11)

'Unlike sex, which is biologically determined, gender is considered to be a social construct' (Peterkin & Risdon, 2003, p. 6).

There are obvious biological differences between males and females that influence their health and access to the health services sector, but there are also social factors which impact differently on the sexes. Sexist environments, policies and practices all work to detract from the well-being of an individual. This might include derogatory comments which threaten an individual's sense of safety or well-being through to discrepancies in income. Women have and continue to experience this with greater frequency than men, and trans people face it in many areas of their life because of the lack of specific legal protections (Darke & Cope, 2002).

Society usually views gender as a dichotomous phenomenon: male and female. Not surprisingly, that too is how the health and social service sector is constructed. Everything — from the information on an intake or admission form to the room that a person occupies in a hospital ward — views gender as male or female. This has specific relevance to people who do not identify with either of the gender identities or are in transition from one to the other. This will be considered in greater detail in module three.

Social norms applied to gender may be in conflict with the experiences within the queer community. In addition to the obvious differences for trans people, gender roles for LGB people vary from those of hetero-sexual people. This is not always considered when viewed from a stereotyped perspective of gender. It is not simply a matter of health and social service at an individual level, but also in population health terms. For example, when comparing the rates of smoking of the general population with the LGTB community, which is reported to be up to1.6 times greater (GLHSS, 2003), gender should be considered as part of the causal equation.

There are many different experiences of trans, in fact every individual's experience is unique. On a continuum, these would range from either end of the gender spectrum, from masculine to feminine, so how an individual expresses their gender identity will be equally diverse. For some, this will be more limited expressions or interpretations of their gender identity which may not be publicly witnessed or shared. Others will undergo complete transition including sex reassignment surgery, although this is a small minority. People elsewhere on the continuum may use hormones, may have one or more surgeries or make very little or no modifications to their physical body. The individual practitioner needs to understand that a person's expression of gender is not an absolute or static event. This is not necessarily unique to people who are trans-identified, even though these individuals may be the people most challenging convention.

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Case Example

Sophie and Trish are meeting the midwife as they are expecting their first child. She is putting them through a battery of questions about their preparedness for the arrival of the baby. When they begin to talk about their roles as parents, the midwife asks about the current division of labour, etc. in the household. She asks Sophie and Trish if one of them takes on more of the husband role and the other the wife and if so, would this translate into mother and father roles. Shocked by the naiveté of the question, Sophie and Trish are immediately concerned about the midwife's capacity to work with their family. They politely outline their previously-discussed roles as parents, explaining that they will be the mothers and that neither of them would be 'playing a paternal role'.

Critical Thinking Questions

1. How might societal views of gender roles negatively impact the health or social service experience of the LGTB person?

2. Why might it be important to consider gender when assessing the health of the LGTB population?

5. Disability

Social and organisational structures - especially when coupled with negative stereotypes and attitudes toward them — are some of the biggest barriers faced by people with a disability.

A person's sexuality and gender identity are an important building block in their overall identity and well-being.

Disability has many causes and manifestations. It can be congenital, the result of an accident at birth or later in life or the outcome of a medical condition. It affects people of all walks of life, age, ethnicity, nationality, etc. Disabilities include intellectual, sensory and physical disability, which all may impact on a person's life to varying degrees. As diverse as this group is, they do share one common factor: they are a minority because of the way in which society restricts their participation. As such, this group shares many commonalities with the LGTB communities, whose members are all very different but linked by one common feature.

Because disability is so varied, how it impacts on any one person's health and well-being will be unpredictable. Although the person's disability will often be a consideration in the equation of their health and well-being, it is not always the deciding factor. People with a disability can live healthy, productive lives given the right opportunity to participate.

People with a disability have often not been seen as sexual beings, particularly those with obvious and severe types of disability. This has resulted in inadequate service provision. In other instances, persons with a disability have received punitive or punishing treatment for any expression of sexuality. This is usually the result of care-providers (either formal of informal) not being comfortable in dealing with matters of sex and sexual identity.

If sexuality in general has been dealt with in such a way, one can only imagine what the LGTB person with a disability has experienced. '…there is some evidence that men with learning disabilities [British term for intellectual disability] who seek or have had same-gender relationships face criticism or 'reprisals''(Hodges & Parkes, 2005, p. 12). It is also important to remember that a person's sexuality is not limited to their capacity to engage in genital sex.

Intellectual Disabilities

The LGTB person with an intellectual disability has many other factors that impact on their experience of sexual orientation or gender identity and ultimately health.

Many people with an intellectual disability will have some sort of guardian or care-giver. This person or persons [caregivers] have immense opportunities to influence an individual's life and how they live it, whether it is through daily supervision, control of assets and money, or indoctrination of values and beliefs.

More direct impacts for physical health also include the person's capacity to comprehend and negotiate in sexual relationships. Hodges and Parkes (2005) identify two areas where this may have clear health outcomes for men. Men with intellectual disabilities who do not have the capacity to understand preventative messages about safe sex might be coerced into unsafe sex practices because of power imbalances in their relationships. Of course, this does not suggest that fault lies solely with the gay or bisexual man with an intellectual disability. Broader structural and organisational difficulties, i.e. such as health education, must also be addressed.

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Physical Disabilities

The LGTB person with a physical disability has the same need to be recognised and treated as a sexual being whether it is in the service sector or as a part of community. As identified earlier, attitudes can represent some of the biggest barriers. However, for people with a physical disability there are also environmental barriers.

The attitudinal barriers that people face when receiving health and social services are based on a one-dimensional view that is frequently held by these professionals, i.e. they deliver a service to this person for their specific disability or 'problem.' They fail to see that this is only one part of the person's entire make-up. When these relationships are based on specific needs, it is often difficult for the person to articulate other needs. For example, the person who would like to be able to talk to his/her specialist about how their disability impacts on their sexual activity may be fearful because that falls outside the role of their relationship. Some people may require medical intervention to engage in physical sex, which is undoubtedly difficult for many people to request. Having to ask for this assistance if your relationship is seen to be immoral or not valued puts the LGTB individual in a vulnerable situation with their care provider.

The service sector is not alone in their exclusionary practices. Like other minority groups within the broader LGTB community, people with a disability are often shut out. This might be due to physical barriers such as being excluded because venues do not provide adequate access or facilities, i.e. washrooms and parking. Exclusion also occurs when people with a disability are made to feel unwelcome. For example, in gay groups where a high value is put on youthfulness and physical attractiveness, a person with a physical disability who can not fit the stereotype might be excluded.

People with disabilities who identify as queer are starting to take action in response to exclusion and are calling on the queer community as well as society in general to ensure that their rights are upheld. In Vancouver a group, called Building Accessibility Together — a group of people with disabilities and chronic conditions — meet to provide support and to advocate for greater inclusion in the LGTB community

Sensory Disabilities

Disabilities such as hearing and vision impairment may have similar impacts as other disability types when dealing with the service sector or with the LGTB community. In some instances people with specific disabilities, such as hearing impairments, have organised around this to create groups for people who are deaf and queer.

Case Example

Cathy has a physical disability which requires her to use a wheelchair. She is independent in most things she does in her life. She has a career and is currently buying a condo. Sex has been a problem for her in the past because of her limited range of motion. She has recently met a woman and would like to extend their relationship to include sex, but doesn't know how she might overcome the limitations she has previously experienced. She would like to talk with her physiotherapist about this but their relationship has always been very practical and focused on exercise. Cathy also knows that her physiotherapist has a very heterosexist view of the world and is fearful that she might not be understanding or respectful.

Critical Thinking Questions

1. Why do you think it is that health and social service providers might not consider sexuality when working with people with a disability? How can this be overcome?

2. The LGTB person with a disability is a double minority. What do you think this might mean for their health and well-being and their experience of interacting with the health sector?
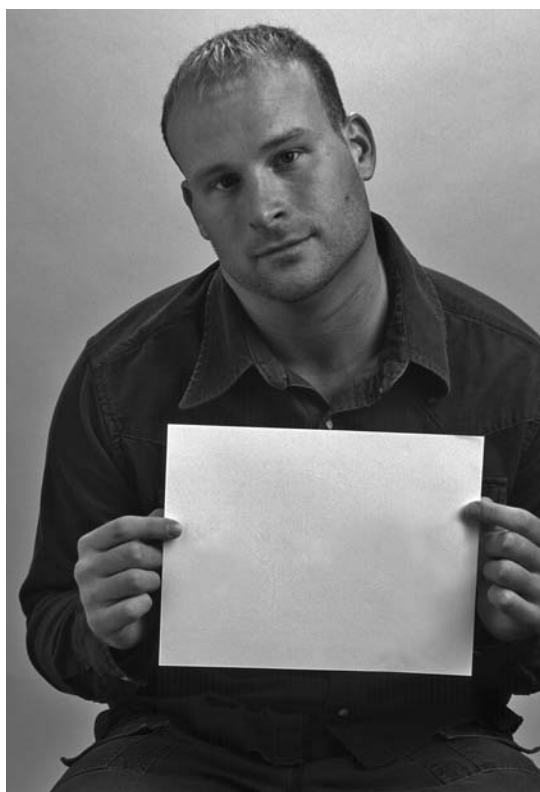
6. Education and Literacy

'*Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances'(PHAC, 2004, key determinant 3).*

There is a positive correlation between people who have access to formal education and literacy and better health outcomes. This translates to lower smoking rates, fewer days of work lost, better access to healthy physical environments, including healthier foods and physical activities (PHAC, 2004, key determinant 3). Conversely, people with less education and lower rates of literacy are more likely to have poorer health outcomes. Ensuring that youth remain in formal and productive education longer should therefore result in longer, healthier, and more productive lives.

In module one, reference was made to the school setting and its impact on the experience of education for LGTB youth. It is often in the middle and secondary school years that youth will become aware of and exhibit their sexual orientation (some may recognize or achieve this earlier). For some trans people who state that they have always been aware of the discrepancy between their gender identity and physical or assigned gender, this may be apparent earlier.

A significant amount of the schoolyard sexual harassment is rooted in terms assigned to or relating to LGTB people. 'Faggot, lezzie, queer, you're so gay' - these terms can be heard in use by children as young as elementary-aged, as terms of general denigration where no association is actually made to sexual orientation or gender identity. Regardless of any other social conditioning the child may be experiencing, this association between perceived negative characteristics or behaviours and terms relating to LGTB people, is a powerful one. Regardless of the targets of the harassment i.e. heterosexual, homosexual, trans or non-trans students, these terms as derogatory labels are some of the most powerful to be levelled against students.

…AAUW Educational Foundation(1993) findings. Eighty-six percent of all students sexually harassed stated that being labelled as gay or lesbian created the most distress for them. For boys, in particular, this finding was severe. The report stated that "no other type of harassment, including actual physical abuse, provoked a reaction this strong among boys (Finernan, 2002, p.66).

Attempts to reduce heterosexism and overcome homophobia in schools by organisations like GALE-BC have included the development of extensive education tools on the issue. While these tools exist, they may only be as good as the environment in which they are to be delivered. Some school and/or districts have been very LGTB-positive whereas others have defied attempts to make the school setting more LGTB-inclusive.

Students leaving school prematurely will obviously not have adequate formal skills such as literacy and numeracy. They may also lack many of the psycho-social skills which will help them in their later years.

One obvious result of the heterosexism and homophobia which exists in educational settings is for LGTB students to absent themselves either temporarily or permanently. 'Ramafedi (1994) cited in an American study found the high-school drop out rate for GLB youth was 28% compared to 9% for their heterosexual counterparts (Gay and Lesbian Health Services of Saskatoon [GLHSS], 2001, p. 38).' If queer Canadian youth were leaving school at that time [1994] at similar or even lower rates it could mean that $1/4$ of the LGB (and possibly T) population aged 25 years and older did not complete high school when they should have. As a result, these individuals probably did not go on to further education or higher-skilled jobs. Although this is a crude interpretation, when considered in the context of the public health links between education and health, it could mean that at least $1/4$ of the LGB (T) groups will have poorer health outcomes based on their educational status alone. A significant number on its own, this becomes even more relevant when considered in relation to other factors which negatively impact on health and well-being.

Case Example

Brent is twenty-three years old and left school when he was sixteen, after years of taunting about being gay. He never felt like he belonged anyway as there was really nothing about school that seemed very welcoming for him as a queer kid. He got his first job in a fast food chain and gradually moved around in the hospitality industry, including bar work. He has never liked it much but doesn't know how he would make a change with only a grade 10 education; what's more, he doesn't believe he is really up to it.

Brent started smoking about the time that he left school and knows that he probably drinks too much, but feels more confident and a bit happier when he has had a few too many drinks. When asked about his future, Brent shrugs and says he can't really see much changing for him. This has been a big issue for Brent lately, so much so that he is now being treated by his doctor for depression. At his lowest, Brent has wondered why he even bothers living, but has not yet actively contemplated suicide.

Critical Thinking Questions

1. What is the relationship between a child's literacy and numeracy and their health throughout the life cycle?

2. In what ways do you think an LGTB child's school experience might be different from that of other children?

▼ Prompts for discussion

▼ Name calling

▼ Physical abuse

▼ Inappropriate facilities, i.e. washrooms

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▼ Absence of positive role models – denigration of LGTB people

▼ Little or no positive reference to LGTB people in course materials, etc.

3. Discrimination and abuse based on sexual orientation and gender identity (real or perceived) is a very powerful source of discrimination. As a health or social service provider what signs might you look for that a young person is being persecuted based on their sexual orientation or gender identity?

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7. Employment/Working Conditions

Unemployment, underemployment, stressful and unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands on the job are healthier and live longer than those in more stressful or riskier work and activities. (PHAC, 2004)

Not enough work, too much work or not enough control over work have all been found to impact negatively on a person's health (Wilkinson & Marmot, 2003). Employment and the benefits of buying power - which employment brings with it - make it a very important determinant. There is also the relationship between what people do and their identity. For example, ask a person to describe themselves and they will often start with, 'I am a (insert profession)!' This ties a person's sense (or lack) of well-being to their occupation.

How does this interact with sexual orientation or gender identity? Despite many advances in industrial laws and attitudes, there are still strong links between gender and particular jobs. There are also professions where queer people may be more evident, but this doesn't mean that they are not represented in all walks of life. Gay men are not just hairdressers or nurses, but farmers, engineers, pilots, soldiers… and on the list go. Lesbians, trans people and bisexual people also occupy a range of professions. Their presence, however, does not necessarily mean that they can safely identify as LGTB for fear of discrimination in career advancement or personal injury. Even those working in areas considered more LGTB-friendly may not experience the same treatment as their heterosexual or non-trans co-workers. For some people this means living a divided life, queer outside work and 'asexual' or perceived heterosexual or non-trans at work.

Case Example	Karen is a nurse in a large metropolitan hospital where she has worked for 5 years. She says "My co-workers all know I'm a Dyke but nobody mentions it. Everyone else talks about their children and husbands (mostly) and what they get up to on the weekend. I have never felt comfortable being able to talk about my partner and our life because nobody ever asks. I am made to feel like I have some dirty secret to hide."

Being Out in the Workplace

As identified in module one, coming out is not a one-time occurrence. The workplace is a setting in which LGTB people may have to 'out themselves' repeatedly. For many people, being out in the workplace may be a choice they have to make or a process they have to endure. As in any other setting, the person has to assess their safety, level of comfort and a host of other variables before they do so. Some people are confident to be 'out' regardless of their setting. For those who are not confident either personally or within their employment (which could be justifiable), they may have the added stress of concealment. This might involve either negating any sign or reference to one's sexual orientation or gender identity or presenting as heterosexual or non-

trans. '…studies of the workplace experience of LGB people found that fear of discrimination and concealment of sexual orientation are prevalent (Croteau, 1996) and that they have adverse psychological, health, and job-related outcomes (Waldo, 1999)'(Meyer, 2003, p. 11)

Case Example

Scott lives with his partner Mark, in a large regional centre and is employed at a local sawmill. He is aware that his workplace is quite homophobic and so makes only guarded reference to his home life. He tries to engage in the usual lunch room chatter of what people got up to on the weekend, etc. , but to avoid any potential 'sticky situations' Scott never refers to his partner as such. In fact he goes to great lengths to disguise his relationship, by substituting his partners name with that of other people and referring to them as friends. He might refer to going camping with his friend Mark but next time talks about a hike he did with Peter (Peter being an alias assigned to Mark). Scott's group of 'imaginary friends' created to protect himself and his relationship gets pretty difficult to manage. In fact it's sometimes downright stressful, especially if some astute listener questions him on his activities. Scott recognises that the whole situation has spiralled out of control but sees no other way to manage the intersection of home and work-life.

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■ Employment Protection & Discrimination

The BC Human Rights Code and the Canadian Charter of Rights and Freedoms provide protection to LGB people including employment. This is not the case for trans people who are not identified specifically along with other minorities.

> Keith Norton, Chief Commissioner of the Ontario Human Rights Commission, has stated, 'Discrimination against transgendered persons is systemic. Human rights violations are both varied and widespread across geographic and class boundaries.... Transgendered persons have been an especially marginalised group' (Egale Canada, 2005, a)

The high-profile Kimberly Nixon case brought this to the fore in British Columbia in 2002. Nixon alleged that she had been discriminated against as a potential volunteer with Vancouver Rape Relief, based on her gender identity (MTF trans). The accused argued that this case could not be heard, as 'gender identity' was not included under the human rights legislation. The complaint lodged with the BC Human Rights Tribunal was in favour of Ms Nixon. The ruling was overturned by the BC Superior Court. The case then went to the BC Court of Appeal in 2005 (Egale Canada, 2005, b).

Many unions have taken up the fight to protect and advance the rights of LGTB Workers. In British Columbia, the Hospital Employees Union (HEU) has a Lesbian and Gay Standing Committee, which is active in promoting the rights and profile of queer health care employees. The Canadian Union of Public Employees (CUPE) national and BC branches campaigned for equal marriage rights of same-sex couples (CUPE, 2004) These are only a couple of examples of how the unions have and continue to recognise and advocate for LGTB employees.

■ Unemployment and Underemployment

The existence of policy does not necessarily mean fair and just treatment in the workplace. Many people's fears of discrimination are sadly justified.

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'The Glasgow Women's library (1999) reported that forty two percent of unemployed GL [gay and lesbian] survey respondents perceived that their unemployment was related to their sexuality, and twenty percent of respondents stated that they had had to leave employment or had been refused work due to their sexuality or homophobia of others'(GLHSS, 2001, p. 34).

Other forms of indirect discrimination may also impact on the employment of the LGTB person. '…gay men avoiding jobs in which they anticipate victimisation and instead choose fields in which they are tolerated, often below their educational qualifications' (GLHSS, n.d., p. 29).

There is no definitive data available on unemployment or underemployment of LGTB Canadians, but the 1996 New Zealand census reported a correlation between sexual orientation and unemployment. '…unemployment rate was 1.32 times higher for lesbians as compared to heterosexual women (6.2% versus 4.7%) and 1.38 times higher for gay men as compared to heterosexual men (5.5% versus 4.0%)'(GLHSS, 2001, p. 34). As Canada and New Zealand share many cultural and social similarities, it would be fair to conclude that similar ratios may have applied for Canadians. With the inclusion of specific questions about sexual orientation on the Canadian Census since 2001, it is to be hoped that more accurate data will be available in the coming years.

Case Example

Lesley has worked behind a bar for most of her ten-year working life. She has often thought about making a change and even made a few attempts, but they were never that successful. There was the time that she was working as a sales representative for the liquor wholesaler, for example, and the boss started to make comments about her being 'too butch,' asking whether she couldn't be 'more feminine.' Lesley said she couldn't and was told that she should 'find another job, because we don't want your type around here.' Lesley knew that this was wrong and that legally she could pursue this, but she didn't feel she had the capacity to do so. She went back to what she knew, working behind the bar. Unfortunately, even with tips she isn't making as much as she earned as a sales rep.

Critical Thinking Questions

1. Why might there seem to be greater representation of LGTB people in some employment types and settings?

2. What workplace conditions could create a more LGTB
   i) exclusionary workplace   ii) inclusive workplace?

3. How might the workplace experience vary for?

   ▼ Trans people versus LGB

   ▼ Large organisations versus small employers

   ▼ Rural versus urban?

8. Social Environments

'The more integrated we are with our community, the less likely we are to experience colds, heart attacks, strokes, cancer, depression, and premature death of all sorts. Such protective effects have been confirmed for close family ties, for friendship networks…'(Putnam, 2000, p. 326).

The social environment in which people live, work and play has a significant capacity to influence their health and well-being. At times, health is enhanced by community connectedness. At others, it is negatively impacted by exclusion or discriminatory attitudes and behaviours. Some of the factors influencing these outcomes will be organisations or social structures, while others may be individual or group attitudes and behaviours.

LGTB people, like many other minority groups, have established communities of their own. These have often been born out of necessity and non-compliance with the dominant culture. These communities can provide many of the social and or cultural needs of families, groups and individuals, but they do not exist within a vacuum. Members of these communities must still interact with the dominant social group and its many institutions.

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Political

LGTB people have always existed in a political reality that has at best tolerated them and at worst persecuted them. Most of the rights that have been granted in Canada have been done so grudgingly or following lengthy court battles, such as equal access to partner's old age pension or same-sex marriage. The latter has been so hotly contested that the Conservative Party is vowing to overturn such rights. This gives an unequivocal message to LGTB Canadians that they have not been/are not valued members of society. The lacklustre commitment to LGTB inclusion sets a national example that can be played out locally in small towns and urban neighbourhoods.

LGTB communities worldwide have and continue to be political in order to win greater equality. Most of the rights that have been achieved in Canada for LGTB people have been the result of political action: lobbying, rallying and protesting. For examples, refer to Critical Moments in the History of LGTB, specifically events within the past four decades, in appendix B. The achievement of rights has obvious health-enhancing benefits. Other benefits include the individual skills and strategies that are gained through such community action (PHAC, 2004)

As minority groups, LGTB communities can struggle with internal politics but also must be prepared to be political in order to assert their rights. Threats by political leaders to enact the 'notwithstanding' clause of the Canadian Constitution in order to deny same-sex couples the rights of heterosexuals send a powerful message to LGTB people about the political environment in which they could live. It also demands a certain degree of preparedness and vigilance if human rights are not to be over-ridden. The need to constantly monitor and assert the interests of LGTB communities is a stressor that should not be required of queer Canadians.

Faith Communities

Faith communities, like family, are a powerful factor for many members of the LGTB communities. For some, deeply-held religious beliefs or customs may determine the degree to which they identify or express their sexual orientation or gender identity. Others may face the sanctioned exclusion of LGTB people from religious institutions, such as the refusal by some churches (i.e. Roman Catholic) to give communion to queer people.

In many cultures, the religious interpretation of homosexuality is what informs the social position on exclusion of LGTB people. For example, countries governed by strict interpretation of Muslim doctrine will not

have an inclusive social position on LGTB issues. It could also be argued that the strong ties between the Christian right and the Republican Party in the U.S.A. provide a similar social policy relationship in the Western Christian context.

In Canada, Christianity remains the largest religious group with 72% of the population identifying as either Roman Catholic or Protestant (Statistics Canada, 2001).

Within the Christian community, religious institutions vary on their position of inclusion of LGTB persons. These differences have been brought to the fore through debate on issues such as same-sex marriage.

There are gross inconsistencies within faith communities on their position toward LGTB people. For example, the Church of England's position on civil unions, which will 'allow' homosexual priests to register under the UK's Civil Partnership Act, still requires that as a queer priest they remain celibate. This is of course not the case for heterosexual priests in the Church of England (Church of England, 2005).

The Catholic Church's Teaching on Homosexuality (Canadian Conference of Catholic Bishop, 1997) views homosexuality from a narrow definition of sexuality based on sexual behaviour. Believing the only legitimate sexual relationship is one which can result in the 'eventual creation of new life', these teachings state that as sex between people of the same gender does not trigger reproduction it is not an acceptable sexual orientation. Many Roman Catholics across the world are challenging their church's exclusionary practices, including refusal of communion to homosexuals. However, there has been no concession from the church to date on such issues.

Dominant Protestant religions in Canada such as the United Church of Canada have, over the years, adopted a more liberal approach to homosexuality including the ordination of gay and lesbian clergy and the blessing of same-sex relationships and, more recently, marriages. Some dioceses of the Anglican Church of Canada, such as the Diocese of New Westminster BC, have offered a limited recognition of same-sex relationships which has angered many of their national and international brethren who adopt a much more conservative view. Despite the organisational commitment by some of these more moderate institutions, there have been deep divides within and between congregations of the various denominations, which may result in some being less LGTB-friendly than expected.

The view of Christian religious organisations on LGTB is too varied to even attempt to consider, ranging from extreme denial of rights and excommunication of members through to welcoming allies who have actively advocated for greater LGTB rights on many fronts. Churches that have positively advocated or taken action on LGTB human rights in Canada are the United Church of Canada, The Unitarian Church and Metropolitan Community Church. The latter conducted the first same-sex marriage in Toronto which led to legalised same-sex marriage in Ontario.

Similar dichotomies exist within the Jewish faith communities in Canada. The more liberal factions have taken a lead on issues such as same-sex marriage, while the orthodox communities adhere to more conservative interpretations of their religious teachings (Cohen, 2005).

Whatever the religious affiliation, be it Christian, Jewish, Muslim, Buddhist or any other of the many faith communities that comprise our national community, there will be differing interpretations of LGTB issues and therefore varying degrees of support.

Case Example

Petra grew up in a Christian household, attending church weekly, participating in church-run activities such as volunteering at bake sales. Most of her friends and social contacts were in the church. Despite the church's negative position on homosexuality, Petra decided to speak to her Pastor about the fact that she is a lesbian. She wanted to be honest and open with family and friends. Her Pastor ordered her to receive professional help by means of reparative therapy so that she could become a 'normal' heterosexual. He also said that Petra should tell the congregation so that they could pray for her. Petra felt uncomfortable with this action but wanted to comply with the Pastor's advice. Although she did not follow through with the reparative therapy, she did, with the help of her Pastor reluctantly 'out' herself to the congregation of 40 people. It was a very traumatic experience. The following week Petra was summoned to the Pastor's office and met by church elders. She was excommunicated and told that she was not to make contact with the church or anyone in the congregation, henceforth.

Violence and Hate Crimes

Violence or fear of violence is a powerful factor in a person's well-being and the choices they make. For example, it is beneficial to live in a neighbourhood or area where the person feels safe from physical violence or other forms of persecution. Social environment is an important variable in the all types of crime, be it relationship violence or crime committed outside the home/relationship.

Terms such as bashing or gay bashing are associated with violent crime directed toward the LGTB community. These can refer to physical or verbal assault of LGTB people. A hate crime is a criminal act directed toward a person based on who they are rather than anything that they have done. Since 2004, the Criminal Code of Canada has included sexual orientation under the federal hate crime laws (CBC, 2004). There is no specific reference, however, to trans people. Members of the LGTB communities warrant protection under this legislation as they are frequently targeted for both physical and verbal assaults based on their sexual orientation, gender identity, perceived sexual orientation or association with LGTB groups or areas.

It has been suggested that hate crimes toward lesbians and gay men have grown over the past 20 years (GLHSS, 2001). 'Roberts reported that eleven percent of all hate crimes [in Canada] are directed against gays and lesbians' (GLHSS, 2001, p. 39). This refers to physical assault only, and of course only refers to reported crimes. Many assaults undoubtedly go unreported for fear of reprisals; in others that are reported, the victims are not identified as LGTB. Numerous studies with varying sample sizes from across Canada indicate that the prevalence of hate crimes is a serous problem for LGTB people (Toppings, 2004). Youth may be at an even higher risk and in settings which should be safe, such as school. An Australian study of LGTB youth aged 14-21 years (n=1749), 44% reported having been verbally abused and 15% having been physically abused due to their LGTB identity (Hillier, Turner & Mitchell, 2005).

The impact of violence on individuals and communities is evident in the immediate injury that may occur. Longer-term affects, such as fear, withdrawal and depression may be the most difficult to quantify. 'Vincke, DeRycke and Bolton found that chronic stress experienced by gay men lead to greater levels of depression', (GLHSS, 2003, p. 33). This is just one example of a health-harming outcome.

Kevin lives in the west end of Vancouver, a place he considers relatively gay-friendly. He has been there for eleven years without experiencing any homophobic comments or actions, but he knows that such things happen. In August he and his partner are walking home from the fireworks when they experience a disturbing incident. A young man is running through the crowded street post-fireworks, yelling 'kill the faggots, death to all faggots.' Kevin has always felt pretty safe in his neighbourhood, but suddenly he feels very vulnerable. Incensed by what he is hearing, Kevin wants to confront the young man but in view of the threatening nature of this person, he feels it is unsafe to do so. Almost more disturbing is the crowd's indifference to the behaviour, the lack of response. Kevin asks himself: would they have responded in the same fashion if this person was running through a predominantly ethnic neighbourhood making threats about the local ethnic community?

Kevin has rethought his safety and comfort in his own neighbourhood, especially in cases where large crowds invade.

Relationship violence occurs in LGTB relationships as it does in heterosexual and non trans relationships. In fact 'An increasing number of studies indicate that relationship violence within LGTB communities is occurring at significant rates and is a serious health and social problem' (Toppings, 2004, p. 3.2). Additional factors that might impact on LGTB relationships, such as discrimination, are an added burden to these relationships. There are also confounding variables for the service provider who works within a heterosexist framework, such as identifying the perpetrator and the victim, especially in same-sex couples. This may be the case for police who are accustomed to the male being the perpetrator. This is problematic if both are men.

Lyn and Margot have been in a domestic relationship for 8 years. The relationship has not been without its problems but in the past these difficulties usually took the form of arguments. There has been significant strain on the relationship over the past twelve months and Margot has taken to striking out at Lyn. Last week, during one of these domestic disputes, Margot started throwing objects at Lyn, knocking down pictures and wall hangings. Hearing this, the neighbours called 911. On arrival the police found Margot and Lyn yelling abuse at each other. They immediately restrained Lyn and removed her to another room, leaving Margot on her own. After getting both versions of the story, it was unclear to police which partner they should charge, so each was given a stern lecture and left to their own devices.

LGTB Health Matters

Critical Thinking Questions

1. In what way do you think factors from the social environment such as politics, religion and violence impact on the health and well-being of LGTB individuals and groups? Consider both positive and negative impacts where possible.

2. Exercise — Think about another minority group that you are familiar with or perhaps that you are a member of, e.g. faith, ethnic, age, education, income, geography, etc. Now consider the following questions

▼Should they be allowed to belong to any faith group that they choose?

▼ Should all citizens be allowed to decide through referendum whether or not they have the right to marry?

▼Should they be able to adopt children?

▼Should they be able to expect to safely live where they choose?

▼ Should everyone else in society decide how they act/present based on whether or not it makes the majority feel comfortable?

▼Is it okay to exclude them from some protective legislation or rights?

Have a discussion with the group and draw the parallels with the LGTB experience.

9. Physical Environments

In the public health context, physical environments generally refer to those elements in the person's or community's life such as air and water quality and other related disease processes commonly associated with the discourse of the 'old public health.'

For the purposes of this module, physical environments impacting and influencing LGTB health will include such factors as safety, geographic location and isolation.

Geographic Location and Isolation

As identified earlier, LGTB people live in all geographic communities and regions. Some people identify as LGTB, while others do not. Most Canadian cities, particularly the large centres, have readily identified geographic communities. Sometimes these are urban villages such as Vancouver's Davie Village or Toronto's Church Street. In other centres, particularly smaller cities, communities may be focused around a single entertainment venue or a few LGTB-owned businesses. They may also include queers' spaces within certain environments such as universities, colleges or workplaces. These geographic communities may provide some LGTB people with the total immersion in LGTB lifestyle which they seek. Others may see this as "ghettoizing" and choose not to be associated with these areas. The benefit of these communities, whether people are wholly or partially associated with them, is that they provide a point of contact and an environment where people can more freely express themselves. They provide a sense of place and belonging, attributes that are important factors in a person's well-being and increasingly recognised as an important factor to better health.

People living in remote areas or neighbourhoods where they may not have access to LGTB community or services may experience isolation and ultimately 'minority stress'(Meyer, 2003, p. 4). The lack of opportunity to identify and interact with likeness may lead to stress; the presence of excessive stress can be a determinant of illness.

LGTB Health Matters

Case Example

Richard lives in a remote First Nations community in northern British Columbia. Richard's community was established as a result of religious mission activity in the early 20th century and retains a strong religious affiliation. Richard has read about the two-spirit beliefs of First Nations people prior to colonisation and identifies with the notion of two-spirit. Unfortunately, this part of his culture has been lost to his community and anything akin to homosexuality or non-compliance with gender roles is deeply chastised. Within his small community Richard knows of no other queer people. He feels alone, confused and under constant pressure to guard his secret. He loves his community and family but sees no option but to leave if he is to survive.

Safety

The previous section referred to violence from a social perspective and the impact of attitudes and heterosexism. The physical environment is an important factor in safety, prevention and - ironically - targeting of violence toward the LGTB community. Geographic communities such as the west end of Vancouver may provide a safer environment for LGTB people to interact or socialise, drawing people from suburbs and more distant locations. Unfortunately, the sense of security offered by such communities is sometimes false, as these clearly identified areas also make it easier for targeted assaults of all types. In other words, some people visit these areas specifically intending to assault members of the LGTB community.

Safety and the threat of violence is an everyday reality but is greater in areas where there is less regard for diversity. This can apply to cities, towns, suburbs, workplaces or wherever people travel. For many LGTB people, this can mean constantly monitoring and adjusting their behaviour or expression of their sexuality or gender identity. For example it is unlikely that two men holding hands, walking down Davie Street will even warrant notice, but if this behaviour was expressed in many other areas of the province the couple could expect at least verbal assaults.

There are also many restrictions on where LGTB people can safely travel outside of Canada. Many countries do not provide the same protections against human rights abuses of LGTB people as Canada, therefore putting queer Canadians at risk when visiting those countries. After the passing of bill C-38 allowing same-sex marriage, Foreign Affairs Canada issued travel advisories for same-sex couples traveling to many of these countries, encouraging caution as they may be targeted because of their sexual orientation. Many countries are not available for LGTB people to visit, live, or work due to safety issues. For some countries the risk is not limited to persecution on the street but enshrined within the judiciary and penal system. For example, in countries such as Saudi Arabia, Iran and Nigeria, admitting to or being found guilty of a homosexual act is punishable by death. While this is the extreme, in many other countries homosexuality is punishable by lengthy jail-terms.

LGTB people arriving from some of these countries to live in Canada may continue to fear for their safety even within Canada because of their experience of persecution, making safety an issue of perception more than a reality for some.

Threats to personal safety impose significant restrictions on the movement of LGTB people and many of the life choices they make. Limiting where people can safely live, work, or recreate has the potential to impact on other determinants of health such as housing availability and affordability, income, accessibility to employment and social supports.

Case Example

Lucy is a trans woman who lives in a regional centre in western Canada. She has spent most of her life here, but she is now considering moving. Most of her friends and family live in or around the area and she has had the support of a good employer throughout her transition. Sadly though, Lucy has been the recipient of a significant amount of violence. In addition to experiencing verbal abuse, she has twice been physically assaulted - seriously enough to require medical intervention. The assaults have been reported to the local police but little action has been taken. Lucy sees no option but to move to Vancouver in hope that she may not be such a target. This will mean giving up her job and moving away from her family supports.

Critical Thinking Questions

1. In what ways do you think where an LGTB person lives restricts or enhances their health and well-being?

2. What elements pertaining to personal safety do you think LGTB persons must consider in relation to their physical environment that might be different than the heterosexual or non-trans person?

10. Personal Health Practices, Coping Skills and Stress

'Effective coping skills, along with people's knowledge and intentions, are seen within a Population Health approach as essential in enabling people to be self-reliant, solve problems and make choices that increase health'(GLHSS, n.d., p. 30).

Personal health practices, including how individuals and communities manage stress, are shaped by social, psychological and environmental factors, some learned, others imposed. Some have an intrinsic locus of control while others are extrinsically controlled.

This section will consider personal health practices and coping skills in the LGTB context. Issues relating to tobacco, alcohol and other drugs will be considered under the Addiction section number three.

Transmission of Disease

One of the best examples of changing health practices within the LGTB community has been the response to HIV infection by gay men. Massive education campaigns and public health practices over two decades did much to stem the spread of HIV. Because of the specificity of the population, it has meant relatively easy targeting of health education, but '…gay men [in Canada] will continue to be, by far the group most affected by HIV and AIDS' (GLHSS, n.d., p. 13). The impact of homophobia on HIV/AIDS has meant that many men, in particular those who should have been the recipients of education and other services, have been missed. Research indicates that men with higher levels of internalized homophobia are less engaged with the LGTB community and therefore less likely to have access to education and prevention (GLHSS, 2003). In addition, 'Cole and colleagues (Cole, Kemeny, Taylor, & Visscher, 1996) found that HIV infection advanced more rapidly among men who concealed their sexual orientation than those who were open about their sexual identity'

(Meyer, 2003, p. 12). Attempts to include this group by using terminology such as 'men who have sex with men' or MSM (versus gay or bisexual) are now being challenged for their lack of cultural relativity to the LGTB community (Young & Meyer, 2005). Whatever the politic, the issue remains that it is sexual behaviour rather than sexual orientation that puts people at risk for HIV infection and while there is a relationship for many gay and bisexual men, it is not mutually exclusive.

Body Image

The heightened awareness - verging on obsession over past decades - with body image has not bypassed the LGTB communities. Interestingly though, it plays out in quite different ways between men and women. Throughout western society thinness, at times in the extreme, has become synonymous with beauty and fat has become evil. This is despite the growing girths of western cultures. These values have resulted in increased gym attendance and an awareness of what people consume and how they do it, i.e. low fat foods and fad diets.

Gay men exist within a culture that highly values youth and beauty. This has the potential to influence their personal health practices, which may result in exceeding healthy exercise levels or pursuing restrictive dietary practices in an attempt to achieve a certain image or look. Such extreme behaviours can lead to eating disorders. 'Sexual orientation has been found to be a significant predicator of eating disorders among men, but not among women' (Peterkin & Risdon, 2003, p. 211).

'Gay men report significantly higher levels of body dissatisfaction and related psychological distress than heterosexual men' (Beren, Hayden, Wilfley, & Grilo as cited in Peterkin & Risdon, 2003, p. 211). Other behaviours associated with body image in gay men include steroid use as a means of building a more stereo-typed 'ideal' body. This combination of influences and behaviours could mean that gay men are at a higher risk of body image-related physiological and psychological illness than heterosexual men.

The other extreme of body image within the gay male culture is represented by the Bears. This group does not comply with the gay male stereotype of fit, trim and cleanly shaven. Bears are generally big, heavy set or 'chubby'. While this might have a protective quality in terms of decreasing the risk to this group of eating disorders in comparison to the gay men described above, they may possess qualities that put them at greater risk of obesity-related illness such as diabetes mellitus and cardiovascular disease, because of where they carry body fat, i.e. girth.

'Lesbian women are significantly heavier, have a significantly higher weight ideal and aspire less to thinness

than do heterosexual women' (Herzog, Newman, Yeh & Warshaw,1992) in Peterkin and Risdon, (2003, p. 210). Lesbians are also more likely to be satisfied with their body image than heterosexual women or gay men and therefore at less risk of obsessive behaviours such as exercise and eating disorders Peterkin and Risdon, (2003, p. 211). They may be at lower risk of eating disorders or excessive exercise because of their health practices, but lesbians' greater average body weight puts them at risk of other physical illness.

Body image in relation to the dominant culture is closely linked to gender identity and is therefore significant for trans people. The relationship to personal health practices is less well-documented for this population. The health care provider should consider variations between a person's physical body and their identity, when examining such issues as exercise or weight loss/gain patterns. Other considerations include the use of non-prescribed hormones, which some trans people may use if they do not have access to medically supervised and prescribed hormones. Unsupervised or non-prescribed hormone use may not have the desired effect.

It is important to understand that these issues do not apply to all LGTB people and that those most likely to be affected by practices that negatively impact health are those whose self esteem is dependent on their physical presentation (Peterkin & Risdon, 2003).

Stress Response

'Stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health and may lead to premature death' (Wilkinson & Marmot, 2003, p.12). When this exposure to stress endures over prolonged periods, it diverts energy away from the normal functioning of the body making the individual more prone to certain illnesses (Wilkinson & Marmot, 2003).

Earlier, reference was made to 'minority stress' or stress that a minority group experiences in addition to the stress of the general community (Meyer, 2003). If this is applied to LGTB people/communities and considered for its health-harming effects, it will be significant. So far, this module and module one have identified several situations in which LGTB people experience stress every day: school, employment situations, social settings and family. The source of this stress is rooted in homophobia and heterosexism and therefore it can be deduced that stress is killing LGTB people. Despite this, there is a possibility that LGTB people reap some benefits from living in a state of constant threat. Some have been able to develop extensive coping mechanisms, some of which may have built a resiliency that sees them through other adversity. Brotman, Ryan and Cormier (2003) posit that older LG people may have developed extensive coping strategies as a result of the oppressive environment in which they grew up and that these strategies may be transferable, supporting them in other life challenges. This is really a matter of, 'life giving you lemons so you make lemonade'. Undoubtedly LGTB people would rather develop coping skills by other means than being oppressed and discriminated against.

For people who experience multiple oppressions, this type of stress is likely to be significantly compounded.

Case Example

Ken's three years of high school were the most unpleasant experience of his life. He received constant teasing and threats about being gay, something that he wasn't even certain of at the time. He dreaded going to school everyday, often experiencing nausea or headaches on the school bus. He felt that he was in a constant state of defence, ready to fend off negative comments or physical threats. Until high school Ken had always been at the top of his class, but in grade 10 his marks dropped significantly as all he could focus on was self-preservation. This meant skipping as many classes as possible, especially those where he felt most threatened. Ken scraped through high school, but viewed his academic mediocrity as a reflection of his intelligence. As a result, he opted not to pursue post secondary education.

LGTB Health Matters

Critical Thinking Questions

1. What could be done to reduce the impact of minority stress on LGTB people?

2. When considering body image of the LGTB person, how might it be different from heterosexual non-trans people and what might be some of the factors influencing it?

3. Why might health promotion for LGTB people be missing the target group? What methods might be employed to overcome this?

11. Healthy Child Development

Healthy children have a greater potential to grow into healthy adults.

The public health view of child development as a determinant of health has a particular bias toward very young children. For the purposes of this section, healthy child development will be considered from a broader perspective to include older children and the children of LGTB families.

For the most part, young children who in later life identify as LGTB share many common developmental experiences with those who will be heterosexual or non-trans. But, 'gay men and women often report 'feeling different 'as early as age 4 or 5' (Peterkin & Risdon, 2003, p. 172). For trans people '…a very small number of children experience their gender identity as being incongruent with their phenotype' (Gender Identity Research & Education society [Gires], 2004a, p. 1). Please note that this does not include the experience of intersex children. (Refer to definition of intersex in appendix A.) The pubescent child's experience will, however, be quite different from that of their heterosexual and non-trans counterparts.

Developing a sexual identity

'The process of identifying or understanding sexuality commences at about ages ten to eleven years, with investigating of sexual organs and for boys [not exclusively] it may include masturbation' (Murray & Zentner, 2001, p. 513). This can be a time that the same-sex attracted child begins to identify that their view of sex and sexuality isn't consistent with the dominant culture. This for many children is the beginning of a confusing journey often marked by denial and attempts to repress thoughts or experiences of same-sex attraction because of strict social mores attached to sex and sexual behaviour. As the child explores and possibly expresses their sexual orientation, they may become the focus of aggression, admonishment or even attempts to change their sexual orientation (i.e. reparative therapies). Depending on the child's environment, they may opt to repress or attempt to disguise their sexual orientation or they may proceed to identify as lesbian, gay or bisexual at a young age. Some people come out to friends and family at age thirteen or fourteen years. Regardless of what one person experiences, it is important to acknowledge that every individual's experience will be different.

Physical change

At about age twelve, a growth spurt often begins which results in changes to a child's appearance (Murray & Zentner, 2001, p. 513). These changes will further reinforce the physical gender image, such as the growth of breasts in girls and bulking of muscles in boys. These changes may exacerbate concerns of inconsistency

between gender identity and physical presentation. It may in fact bring about great distress for trans people as the disparity between who they are and how they appear physically becomes more apparent. In some situations, medical intervention to delay puberty might be indicated. This allows greater time for individuals to consider their options.

Responding to difference

Many queer kids fear the response to being different, particularly rejection by family and friends. This concern is well-founded as children report a range of responses from acceptance to isolation from family and friends and physical abuse. Hillier, et al. (2005) reported that in their study (n= 1749) 18% of abuse related to sexuality of same-sex attracted youth occurred in the home. The fact that almost one in five LGTB youth experiences abuse in their own home indicates a high level of intolerance by family as well as the need for greater understanding and support by those who as primary caregivers should be supporters.

Parents and families need to learn to respond to difference and the diversity that exists within their family. Families must understand that rejection, violence and insistence on treatment will not change the child's sexual orientation or gender identity, instead adding to the burden the individual will face within a homophobic society. Providing a supportive home environment for queer youth will reduce 'gay-related stressors, … associated with increasing depression, emotional distress and multi-problem behaviours…'(Ryan & Rivers, 2003, p. 113).

Case Example	Alison's mother always described her as a 'tomboy' when she was a child. She preferred to play with the boys rather than engage in traditional girl play. This didn't particularly worry Alison's mother and they developed a close mother-daughter relationship. Alison's father on the other hand had strongly held views of male/female roles and behaviours and actively dissuaded Alison from engaging in male play. He even refused to include her in sporting activities because he thought it would 'make her too masculine'. At age fifteen when Alison shaves her head and refuses to wear anything but men's clothes, her father responds with verbal abuse and tells her to 'get out because he isn't having any dyke living in his house.' Despite attempts by other family members to reconcile the rift, Alison moves from home and is staying with an aunt.

One of the participants in Hillier and Harrison's study provides an interesting lesson on how others could learn to view the sexual feelings of same-sex attracted youth, 'Boyd [name of youth] argued that his sexual feelings were normal because they *felt normal* to him '(Hillier & Harrison, 2004, p. 113). This in itself says a lot about healthy development for the queer youth. If an environment of acceptance of diversity is created, children will grow to accept their own diversity, viewing it and the diversity of others (whatever that may entail) in a positive light.

Queer families

There are a growing number of queer families who choose to have children. Previously, many children in queer households were the result of one or both partner's previous heterosexual relationships. The increase in children from queer households raises new issues for healthy childhood development based not on the sexual orientation or gender identity of the child but that of the parents. In fact, there is no correlation between the sexual orientation of parents and children. The percentage of LGB parents that have LGB children is no greater or no less than heterosexual parents, that being "7%-10%" (GALE of BC, 2000, p. 22). The real issues relate to negative social impacts such as heterosexism and LGTB-phobia. Children need to feel that they

belong because their experiences are reflected in school and social settings. The removal of heterosexist language from school lessons and the portrayal of diverse families is healthy for all children - not just those of queer families - because it reflects the reality of a pluralistic Canada. For example, families should not be defined solely as mum, dad and children with maternal and paternal grandparents. Alternatives terms could include 'family of choice,' 'gender queer', and 'same-sex.' At the same time, efforts should be made to replace parental identifiers with non-gender specific terms.

LGTB parents want to know that their children are not going to experience discrimination because of their parents' sexual orientation or gender identity. When conducting the research for this document, the author heard anecdotal evidence of parents going to great extremes to protect their children from discrimination based on their [parents'] sexual orientation. This included choosing expensive private schools over neighbourhood publicly-funded schools or even moving neighbourhoods to access more queer-friendly education and social options.

Regardless of the parent's sexual orientation or gender identity, it is important for children (including those from non-queer families) to have positive role models of LGTB families as some of these children will grow up to be LGTB themselves (GALE of BC, 2000). They all need to know that LGTB families are healthy, viable entities.

Providing environments that positively depict LGTB families is a healthy developmental exercise for all children, especially those from queer families and those youth who will later identify as LGTB.

Case Example

Gemma is 6 years old and has just started school. She lives with her Mum and Momma, but spends a lot of time with her Dad and Bill. For Gemma this is what families look like. Despite her certainty, several of the children have told her that she can't have two Mums that live together and a Dad that lives with another man. When Gemma asks the teacher (the font of all knowledge for a 6 year old) she is told that yes, a family is a Mum and Dad but they don't always live together. Gemma is very distressed by this new definition of family.

Finding an environment that is inclusive and welcoming of diversity is an important task for many queer families.

Lauren and Jennifer have a two year old daughter named Cecilia. They have been researching and looking for a daycare for Cecilia for the last four months. Lauren and Jennifer discussed the environment they desired for their daughter and they have written a list of questions that they will ask when they visit several daycare centres.

As these moms meet with several daycare directors, they are pleasantly surprised at the reception. The staff and directors are open and embracing of Lauren and Jennifer and their daughter. The Early Childhood Education philosophy in these centres includes queer and non-queer families. In some instances, the moms find there are other children from queer families attending the centres.

Critical Thinking Questions

1. How else could Lauren and Jennifer research and find positive environments for their daughter?

2. As a caregiver, how could you assist these moms with this research?

3. What factors in a child's development might influence their experience or interpretation of sexual orientation and gender identity?

12. Biology and Genetic Endowment

'The basic biology and organic make-up of the human body are a fundamental determinant of health' (PHAC, 2004, key determinant 9)

'There is some empirical evidence to support these [biological theories] propositions, but it is not conclusive' (O'Neill, 2003, p. 130). It is believed that LGTB people possess the same biological makeup as heterosexual and non-trans people. There are no missing or additional chromosomes, no extra strands of DNA, which make them LGTB. The debate over whether sexual orientation is a predetermined biological reality, a psychosocially constructed characteristic or a combination of both has raged for many years. Theories on the biological basis of same-sex attraction range from hormonal exposure to anatomical variations of the brain. Subscribing to a biological theory of sexual orientation is problematic for many queer people because of the potential for researchers to seek 'a cure'. This would have major social implications for the LGTB community, because it further reinforces the heterosexist view that homosexuality is abnormal and should be righted. It could also mean redirecting significant resources away from research and cures into biological conditions that genuinely endanger lives. If it's not broken, in other words, don't fix it. What needs to be fixed are the heterosexist and homophobic elements of society that impede LGB health, not an individual's biology.

The link between trans and the medical diagnosis of gender dysphoria means there is a closer relationship between a medical model (based on biology) and causation of certain trans identities such as transexualism, than that of same-sex attracted people. One of the biological theories of transexualism is based on prenatal development. 'Research studies indicate that a small part of the baby's brain develops in opposition to the sex of the rest of the body. This predisposes the baby to a future mismatch between gender identity and sex'(Gires, 2004b, p. 1). This in itself as a biological determinant of health is not the issue, as much as its implications for later life. This might include the need for transitioning and related biological health issues such as long-term use of hormones. The negative impact of long-term sex-hormone use on physical health is debatable. A twenty year cohort study in the Netherlands of trans-sexuals (n= >1000) treated with sex hormones found no greater incidence of death or disease that the general population (Bell, 1998)

Case Example

Gez had never felt comfortable in his body. What he looked like didn't reflect how he saw or felt about himself. He started cross dressing when he was a teenager but was overwhelmed by the guilt he experienced because of the social pressures attached. He met Sue and they married shortly after university. He thought this might 'cure him' of his desire to feminise himself but it only added to the complexity in his life. When he finally told Sue of his desire to be more 'like a woman', it marked the beginning of the end of their relationship. The loss of the relationship — along with a growing desire to go beyond cross dressing — resulted in a crisis for Gez. Contemplating suicide, he saw no option but to undergo a transition which would see him live as a woman. With this all behind her, Gez — now Gen — has a new future and feels that her body much better represents the person she is.

LGTB Health Matters

Critical Thinking Questions

1. What are the implications for LGTB communities and society in general of pursuing a biological cause-effect relationship of sexual orientation?

2. Hypothetical — A genetic researcher has just discovered that he can modify the gene that is responsible for fair skin. He argues that by developing a 'treatment' for fair-skinned people, he will be able to reduce the rate of racist violence by making everyone the same colour. Because fair-skinned people are the minority in the world population it will bring them in line with the dominant skin colours. Some of the people of Europe, North America and Australia strongly disagree with this. Conducting such research and intervention will of course mean that less money will be available to spend on diseases like TB and Polio.

▼ What does this mean for fair-skinned people?

▼ Are there other ways of dealing with the fair-skinned minority, if so what are they?

▼ What could such a decision mean for the health of the world population?

Conduct a discussion with the group to draw parallels with sexual orientation.

13. Health services

Health services impact on the health and well-being of individuals and communities because of their capacity to restore health, prevent disease and death and to promote healthy life options and environments.

The Canada Health Act states that all Canadian residents are entitled to access to health services. Despite the many issues such as lengthy waits for services, Canadians enjoy much higher standards and better access to health care than the majority of the world's population. Yet this quasi-equitable system has its gaps which put certain populations at a disadvantage, such as low income earners (who can not afford certain user pay services such as dentistry), people in remote locations and some minority cultural groups. These gaps are sometimes plugged via other systems, levels of government or employers, because they meet a clearly identified need. Where the gap has been less well-defined, access to service can be even more problematic.

The Canadian Charter of Rights and Freedoms disallows discrimination based on sexual orientation. This means that LGB people are at least guaranteed the right to service, unlike LGTB people in some countries. The gap often lies between the legislated right and the exclusionary policies & practices within health and social services. This should not be a surprise given that the health care system is part of a society that is heterosexist and in some factions overtly homophobic. While this might be fact, it does not make it any more acceptable; ultimately, it has serious implications for the LGTB client.

Exposure to homophobic and heterosexist attitudes and practices both inside and outside health systems contributes to patients'/clients' perceived need to stay hidden during interaction with their health care providers and often results in avoiding and delaying medical care and examinations(Brotman & Ryan, 2001, p. 16)

When conducting the fact-finding to prepare this document, the author had numerous conversations with LGTB community members and service providers (queer and otherwise), seeking solutions to overcome the

systemic problems of heterosexism and LGTB-phobia within health and social service systems. More often than not, people chose to speak of their experience of discrimination in these systems. These ranged from being coerced into tests that they didn't want (i.e. HIV tests for gay men), refusal of needed tests (i.e. Pap tests for lesbians) and being made to feel unwelcome. Other stories told of refusal of service or lack of acknowledgement as family members.

Case Example

Justin is assigned to a new doctor when his previous G.P. leaves his practice. They had a good doctor-patient relationship and Justin felt he could be open and honest. He has presented on this occasion with a complaint of persistent tinnitus. The new doctor commences the consultation with the usual perfunctory questions about presenting problems. At some point Justin makes a reference to his partner which includes his partner's gender. The doctor picks up on this immediately and says 'Are you a homosexual?' Uncomfortable by the blunt question, Justin replies affirmatively. The doctor questions Justin about his sexual behaviour and despite Justin's assurances that he has practiced safe sex and had been in a monogamous relationship for 5+ years, the doctor insists Justin undergo an HIV test. He complies with the demand. About to leave the office with requisition in hand, Justin sees the doctor writing 'homosexual' across the top of his chart before closing it.

M2
THE CENTRE

■ Surviving in the Health System

Years of oppression and victimisation of LGTB individuals and communities has meant that some have learned to meet their health care needs in ways that ensure their safety and when possible, dignity. Two key methods are seeking queer/queer-friendly service providers and, in other cases, censorship. The former is obviously the preferred of the two, but where queer-friendly service isn't available people have had to resort to the latter.

Queer-friendly family doctors, midwives and dentists are popular choices for LGTB people, providers to whom they can discuss the full spectrum of life experiences and emotions without fear of reproach or abuse. Queer or at least queer-friendly family doctors are particularly in demand and often difficult to access as a result.

Censorship refers to the LGTB person having to carefully guard 'their secret,' in response to an either perceived or real threat. For some this might be more problematic than others. If applied to the previous example, *Justin* might have either lied, referring to his partner as his wife or a friend or ensuring that no pronoun or other gender identifier was used. This protective mechanism could have serious health implications for future interactions or treatment. That is, if Justin presents in the future with a condition such as an STI, he may not be appropriately diagnosed if his doctor continues to think that he is heterosexual.

A system that puts the onus on an individual to seek out and secure health and social services that are safe falls short of meeting the needs of all Canadians. LGTB people should be able to expect fair, informed services and to be treated with respect no matter where they go for services. As a society would it be acceptable to apply such expectation or restrictions to ethnic or religious groups?

LGTB Health Matters

M2

THE CENTRE

Exceptions to Equality

The Government of Canada and many of the provinces can pride themselves on the equality afforded to LGTB people, but they have allowed certain discriminatory policies to be maintained in health care. A major discrepancy lies within Canadian Blood Services (CBS) and their somewhat dated view of HIV/AIDS being synonymous with gay or bisexual men. The resultant effect is the exclusion of most gay men as blood donors at a time when CBS are actively campaigning because of donor shortage. Their exclusion (longstanding deferment) of donors, states:

> All men who have had sex with another man, even once, since 1977 are indefinitely deferred. This is based on current scientific knowledge and statistical information that shows that men who have had sex with other men are at greater risk for HIV/AIDS infection than other people. (Canadian Blood Services, 2005)

Other countries have implemented systems to ensure the safety of the general public by setting less restrictive guidelines. For example, the Australian Red Cross will not accept blood from MSM if they have had sex with another man in the past 12 months (Australian Red Cross, 2005) as opposed to Canada's practice of carte blanche exclusion of MSM in the past 28 years.

Contribution to Services

Gay, lesbian and bisexual people worldwide have been great contributors to the health sector in the battle against HIV/AIDS. In the early days when AIDS was seen to be a gay disease, it was the gay and lesbian communities who advocated for and established many of the services that have developed into the existing AIDS service sector. While there is a strong affinity between the gay community and the AIDS service sector, it does not always guarantee an understanding of LGTB issues beyond this specific disease. This means that such organisations should not be assumed to be more inclusive, especially of LTB.

Health and social service providers are recognised for their many life-saving skills, but few possess the necessary skills or knowledge to provide effective services to LGTB people. To date, few health and social service professionals receive formal adequate teaching relating to LGTB people as a part of their professional education. In fact many believe a 'we treat everyone the same', approach should be adequate. This simplistic view of delivering a service to diverse communities is woefully inadequate, especially when providing an inclusive and knowledgeable service is not labour or cost intensive. There is little or no commitment to establishing competency in LGTB issues by health and social service professions.

Gaps and Opportunities

There are many shortcomings in the health and social service systems for LGTB people that need to be overcome by policy makers and service providers. There are also opportunities. Ryan (2003) suggests that Canada's use of a Population Health framework could be to the advantage of LG communities because it is how LGTB communities have been organising around health to date anyway. For example, organising LGTB health around particular communities or community needs or events. As a result, this framework may offer an opportunity to get in on the ground floor. Getting in on the ground floor of a Population Health approach to LGTB health creates an opportunity to define LGTB health outside of the traditional 'absence of illness' rhetoric. The neglect and oversight by the health sector could mean that LGTB communities have the opportunity to now define health, within a wellness framework.

Health and social service providers need to see LGTB people in broader contexts than are offered by a sexual act or disease process, such as HIV/AIDS. Gay men are working to redefine their health and health service needs beyond HIV/AIDS to include the many other facets that comprise their lives. The health needs of all LGTB people must be considered, based on ethnicity, socio-economics, politics and the many other elements that form their identities.

The largest gap in the health sector exists for lesbians and bisexual people. This ranges from research to service delivery. While lesbians have been the subject of specific research into smoking, alcohol use and body image, there has been little translation of this to health services and public health initiatives specific to this group. This could in part be explained if women-specific services are thought to provide this coverage. Unfortunately, this is not always the case and women's health services can be as heterosexist and homophobic as the rest of the mainstream health sector.

The 'T' portion of LGTB has some unique requirements and interactions with the health service sector based on diagnostic criteria, hormonal therapy or surgical reassignment. These will be discussed in more detail in module three. It is important to note that the services available to trans people vary significantly from region to region. This, along with the lack of formal protections under Human Rights Codes and the Canadian Charter of Rights and Freedoms, can easily impact on the level of knowledge and service provided by health and social service providers.

Example of variations in coverage by provincial health programs

Coverage of Sex Reassignment Surgery (SRS) Across Canada (as of January 23, 2004)

	FTM							MTF							
	Chest	Hysto/ooph	Vaginectomy	Meta	Phallo	Testicular implants	Penile prosthesis	Breast	Orchiectomy	Penectomy	Vaginoplasty	Labiaplasty	Electrolysis	Facial feminization	Vocal cord surgery
BC	✓	✓	✓	no	no	no	no	✓	✓	✓	✓	✓	no	no	no
Ontario	no	no	no	no	no	no	no	no	no	no	no	no	no	no	no
Quebec	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	no
Nova Scotia	no	no	no	no	no	no	no	no	no	no	no	no	no	no	no

Excerpt of Table. Courtesy of Transcend Transgender Support and Education Society (2004)

Case Example

Prior to meeting and marrying Jill, Ben had a couple of brief relationships with men. He was in his early 20's. He is now 39 and has been happily married for thirteen years. Jill's new workplace is the site of a mobile blood donor clinic and staff is encouraged to participate and include family members. Ben agrees to participate and arrives for the required screening interview. He is shocked when he learns that he is not eligible because of his previous relationships almost twenty years ago. He is astounded and left to explain to Jill why he is ineligible.

LGTB Health Matters

Critical Thinking Questions

1. When assessing a person you are working with, why might it be important to determine their sexual orientation or gender identity? Is this something every practitioner needs to know every time?

2. Why does a 'we treat everyone the same' approach to health care not work for LGTB people? How does this need to change?

3. How is the structure of the health and social service sectors an impediment to the health and well-being of LGTB?

14. Addictions

'Drug use is both a response to social breakdown and an important factor worsening the resulting inequalities of health' *(Wilkinson& Marmot, 2003, p. 24).*

Alcohol, illicit drugs and cigarettes are all potentially addictive substances that negatively impact the health of individuals, families and communities. They cause illness and disease and indirectly harm health through economic cost, loss of employment, family breakdown and many other social factors. Despite this, at least some of these substances have strong social approval and acceptance. Others, because of their illicit nature and labels relating to anti-social behaviour and lack of regulation, put users at greater risk of falling between the cracks of service delivery and social support.

Substance use in the LGTB communities

'*Substance use for LGTB people is often enmeshed in issues relating to sexual orientation, gender identity, and/or making connections with queer people and communities'(LGTB Health Association of B.C., 2003, p. 42).*

There are damning statistics and estimations of different types of substance use in LGTB communities, suggesting that LGB in particular may be higher consumers of these drugs. Unfortunately, there is little examination of why this situation may exist. There are additional problems with knowing what the actual usage is by all LGTB people, as most research is done on individuals who are out. This could mean the numbers are substantially skewed, as people who do not identify as LGTB are not being included in the statistics.

There seems to be little evidence specific to the trans population, so for the purposes of this document, trans people will be included with LGB. It would be fair to estimate that their experience would be similar to that of LGB.

Alcohol

'The irony is that, apart from a temporary release from reality, alcohol intensifies the factors that led to its use in the first place' (Wilkinson and Marmot, 2003, p.24).

Alcohol use versus alcoholism or misuse is an important distinction. In Canada, just over $1/2$ of the population consumed 1 or more drinks per month (GLHSS, 2003). In comparison, in 2002, 27% of British men consumed in excess of 21 units of alcohol per week and 17% of British women consumed in excess of 14 units

according to the Office of National Statistics (as cited in British Heart Foundation, 2004). This comparison is given to offer some relativity of alcohol consumption by Canadians to other similar cultures: cultures where alcohol is a more integral part of the social environment. This has been done to offer perhaps some context to the use of alcohol within the LGTB communities, suggesting that that there is possibly a cultural element which is different to that of mainstream Canadian culture.

Alcohol - in particular public consumption of alcohol - is an important social characteristic of LGTB communities. Hotels and other drinking venues have long provided meeting places for LGTB people. Prior to 'Gay Liberation,' people met at hotels known to be LGTB-friendly. These were followed by hotels that solely served the LGTB communities, although their customers were often primarily men. The venue that launched the gay rights movement, Stonewall, was a pub. Today, hotels or clubs that serve alcohol are often the identifiable if not dominant businesses in urban LGTB areas. They are significant because they are easily identifiable and serve as meeting places for community, whether for someone who is venturing into the LGTB scene for the first time, a visitor to a city or a regular. It is therefore important to understand the culture of alcohol consumption and that patterns and behaviours may be different for LGTB people than the broader community. In essence, it might be more similar to another national culture such as that of Britain, with its 'locals' or neighbourhood pubs, rather than Canadian culture.

There are conflicting views on the prevalence of alcohol misuse in the LGTB communities as research has been problematic due to sampling and other inconsistencies (GLHSS, 2001). If it is, in fact, 1.6 times higher than the general community as GLHSS suggests, there is a serious public health issue to be addressed. Intervention can not address a statistic, however, only cause and impact. People do not develop problem drinking because they are LGTB, but because of the experiences that go with being LGTB. This will be considered in more detail below under LGTB-phobia and heterosexism and substance use.

Case Example

Penny is 47 years old. She has consumed three to four glasses of wine most days for the past twenty years. Prior to that she drank only on weekends when she would go to the local pub. Penny made most of her friends there when she first came out, so it's not surprising that alcohol consumption was a big part of their socialisation. This set a pattern for most of Penny's relationships within the LGTB community. Penny manages to hold down a job and doesn't see alcohol as a problem in her life, but Penny's friends do. They have stopped inviting her to attend social functions and avoid her if they run into her when they are out.

Illicit Drug Use

It is difficult to determine the extent of illicit drug use in the general community because of its subversive nature. Therefore it is unfair to attempt to make statistical comparisons with LGTB communities. Many people make claims that there is a significant drug problem within the LGTB population. Some research would support this. GLHSS' (2003) review of 16 mostly American studies of LGB who use illicit drugs, poses 2.6 times greater use in the LGB populations. (Bear in mind this is a median figure and does not compare like populations or drug use.) These studies also include at least 6 studies focused on marijuana use. While this is technically an illegal drug, its use is ubiquitous in Canadian society and different values are associated with it

than in American society. It is therefore difficult to assess impact when including marijuana use alongside drugs such as crystal methamphetamine. Essentially, this is not a case of comparing apples with apples.

Readers should also be cautioned as to the representation of the samples of such studies, as they are usually limited to people who identify as LGTB. Whether comparative or not, illicit drug use is a part of LGTB community life. It will affect some people directly while for many others it is not part of their life or social interaction.

Certain illicit drugs have become associated with the LGTB community, particularly the 'in' gay party scene. These include drugs such as amphetamines and to a lesser degree opiates. Unlike the rave scene - which involves mostly youth - the gay-attended circuit parties may also attract an older clientele. One drug known to be currently affecting the gay community is crystal methamphetamine (aka Crystal Meth, Meth, Jib, or Tina). It is highly addictive, readily available, affordable and provides an extended period of sexual arousal, making it a very attractive substance of choice

LGTB-phobia, Heterosexism and Substance Misuse

It is important for the health and social service provider to have some understanding of the estimated magnitude of substance use for planning and policy purposes. Even more important is understanding the accepted cause/effect relationship. This equation includes LGTB-phobia and heterosexism and its resulting loss, social exclusion and other means of stigmatisation - all of which can trigger substance misuse. Hillier, et al. (2005) in their study of 1749 youth aged between 14 and 21 years reported:

> There are at least two explanations of SSAY [same-sex attracted youth] drug use. The first is that drug use is a lifestyle choice and these young people take drugs while participating in some aspects of gay recreational culture. The second is that young people take drugs to escape the isolation and pain of homophobia as it manifests itself in negative self-talk and in abuse from others in the community. (p. 58)

The second part of this quote is an important consideration and one which can be applied to people of all ages in the LGTB communities.

Both interpersonal and internalized LGTB-phobia plays a role in an individual's use of alcohol or illicit drugs. These substances can provide a powerful, if short-lived, escape from oppression. Unfortunately, this reprieve sometimes exacerbates or creates other problems such as depression and other mental health issues.

Case Example

Julio often feels on edge when he is with his friends and frequently reminded that he is different. He is in a long-term relationship with Andrea but has also been meeting other men for sex for the past 18 months. He carries considerable guilt about this and — every time it happens — swears that it won't occur again. His mates on the baseball team make a lot of homophobic comments and Julio is always censoring his behaviour and comments as he fears that others may learn his secret. The only time he feels like he can relax is when he has a few drinks on his own. He has developed a routine of having three to four drinks every night to 'unwind'. Julio knows that this doesn't change the way he feels about men, his relationship with Andrea or his friends, but at least he gets a bit of a break.

Heterosexism and LGTB-phobia impact on the causes of illicit drug and alcohol use, but there are also implications for treatment. This means having service providers in the Alcohol & Drug Treatment (A&D) sector who are knowledgeable and competent on issues relating to LGTB people. 'LGTB people are not able to bring forward the whole of their experiences when they are in environments that are non-supportive and where they experience homophobia' (LGTB Health Association of B.C., 2003, p. 42).

Case Example

Chris has finally reached a point where he knows he cannot continue to live his life the way he has been. He has been using a mix of alcohol and illicit drugs for the past three years. Chris started using around the time that he began to transition. He found it a particularly challenging time and experienced significant harassment at work and on the street. It started with a few drinks here and there, then led into using some party drugs. By now, his drug use has grown into regular use of amphetamines and cocaine. He has been seeing a counsellor at the community health centre but needs more support to withdraw and so has opted for residential treatment.

When Chris is first admitted to the treatment centre, the worker is knowledgeable and respectful of Chris' gender identity. However this changes with the next shift. The staff member consistently refers to Chris using female pronouns and seems to be avoiding him. It isn't long before Chris finds he is also being isolated by other residents. When Chris approaches staff to discuss his treatment, he is told that if he doesn't like his treatment he can leave and go to a women's treatment centre, because 'that's where you should be anyway.'

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THE CENTRE

Tobacco

Since Sir Richard Doll's findings in the 1950's linking smoking to lung cancer, there has been a growing awareness of the health impacts of tobacco use. This has resulted in smoking cessation programs, pharmacotherapy and public policy to reduce tobacco use. Canada now enjoys its lowest smoking rate ever, at 20% (Health Canada, August 2005). British Columbia's rate is lower than the national average at 16% (Health Canada, 2004). This legally-sanctioned and once socially reinforced drug use seems to have turned a corner for most Canadians. Despite these optimistic figures, the downward trend does not seem to be consistent within the LGTB community. Based on a literature review (of mostly American research) GLHSS (2003) estimates that smoking could be as high as 1.6 times greater in the GLB communities. Local research findings indicate a similar rate. McNulty Consulting and rock paper scissors, Inc. (2005) surveyed 269 LGTB people aged 19-35 years living in the City of Vancouver and found that 36% were smokers. (The authors advise that this is a small sample, one that may have been skewed by an existing smoking cessation campaign.) The researchers found similarities in reasons for smoking that were consistent with research on the broader community. They also found similarities around age-related responses. Although this is a small sample, it might suggest there are many similarities to mainstream community… but this does not explain the higher overall rates of smoking.

A number of American studies by Stall, Greenwood, Acree, &Coates (1999), Skinner & Otis (1996) and Solarz (1999) (as cited in Peterkin & Risdon, 2003), report higher rates of smoking in lesbians than in heterosexual women and gay men. Gay men in turn have higher rates than heterosexual men.

Solarz (as cited in Peterkin & Risdon, 2003), states that 'the rate of smoking in lesbians increases with age'(p. 31). If this is in fact the case, it could account for the higher rates of tobacco use in LGTB communities as there would be a broader age group under study compared to the general community where the higher rates are in the under 30 year age group (Health Canada, 2004).

Another consideration is the targeting of smoking cessation programs. Because most such campaigns and education programs are heterosexist in nature, they could potentially have missed LGTB individuals and communities. They could also be missing the age grouping if they are targeting a younger cohort when in fact it might be appropriate to target an older age grouping, particular with lesbians. Recent attempts at LGTB-targeted smoking cessation campaigns (such as 'Proud to Quit') along with associated research stand to provide significant information to health policy makers and practitioners alike about the need for unique interventions for the LGTB communities.

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Summary

Many factors influence the substance use of LGTB people. Some are the same as those experienced by the general community, such as recreational use or experimentation. Others are unique to the experience of being LGTB, and are rooted in issues such as isolation and discrimination. Efforts to overcome this misuse are affected by systems for prevention and treatment that are inadequate for LGTB people, because of their lack of applicability and recognition of the cause and effect. Rectifying this situation will require an improved knowledge base for policy makers and practitioners alike, along with better targeting of prevention and treatment services.

Critical Thinking Questions

1. What are some of the factors that might influence alcohol or illicit drug use for LGTB individuals and communities?

2. In addition to the obvious diseases related to substance misuse, what other health impacts might the LGTB communities experience related to substance use?

3. Tobacco use is alleged to be higher in at least some of the LGTB groups. What factors do you suppose might be the cause of this?

4. How could preventative strategies better target the LGTB communities?

15. Housing
Safe, affordable and appropriate housing is a key factor in ensuring the health and well-being of individuals and communities.

Decreased availability and accessibility of housing in Vancouver for a variety of reasons has resulted in an increase in homelessness which has become all too apparent. There has been a doubling of people living on the street since 2002, (City of Vancouver, 2005). There is also a less quantifiable barrier to housing access: discrimination. This often goes unrecorded.

LGTB Health Matters

Street Homelessness

The most severe and obvious form of homelessness is experienced by those who literally live and sleep on sidewalks, in doorways and parks. This group includes people of all walks of life and — like everything else — people of different sexual orientation and gender identity. LGTB youth in particular may find themselves there as a result of rejection by family and friends Rainbow BC (2000) cited:

> In a recent BC survey by the McCreary Centre Society called "Being Out", the researchers note that a "lack of acceptance can be a factor in gay and lesbian youth leaving their family homes." This lack of acceptance and support from traditional sources leads to queer youth being forced to leave their family homes and they often end up homeless and on the street. Supporting evidence for this appalling situation is shown in the "1993 Street Youth In Vancouver" survey which showed that almost half (46% of youth- 33% of male youths and 60% of female youths) living on the street in Vancouver identified themselves as not 100% heterosexual compared to the 93% of males and 92% of females attending school who identified as 100% heterosexual. (p. 9)

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THE CENTRE

Discrimination in Housing

It is against the law in Canada to discriminate against a person based on their sexual orientation, including by limiting access to housing. That of course does not mean that it doesn't happen. Anecdotal evidence suggests that discrimination does exist in accessing housing, particularly in cases of people being refused rental accommodation when it becomes obvious that they are same-sex attracted. Trans people do not have the same protection under the law as same-sex attracted people and report similar experiences of refusal to rental.

Location and Affordability

Larger cities have areas that are considered to be the gay or lesbian quarter; in Vancouver these are Davie Street and Commercial Drive. Some LGTB people will opt to live in these areas because of the neighbourhood's LGTB composition and amenities. Others will choose not to live there for the same reasons — that is, they choose not to be associated with LGTB communities. These areas, sometimes referred to as the 'gay ghetto,' can form an important part of community and a sense of place. People may also choose to live in these places because they have a perceived sense of safety, security and comfort due to larger LGTB-identified populations. These are often inner-city and have the associated price-tag. This may be the cost that people choose to bear in order to have ready access to the community to which they most identify.

Case Example

Greg has lived in Vancouver since 1988 and up until last year, always in the west end. He knew his neighbourhood and most of his friends lived within a one-kilometre radius. This meant easy access to his favourite social events and friends. Low interest rates provided him with the opportunity to buy his own place. He looked around and decided that he could get more for his money by moving just a bit further out. He purchased a place about 20 minutes away and for the first few months was content with settling in and trying to get to know his neighbourhood. He soon found that friends didn't drop in anymore and that he couldn't just pop out and pick up an Xtra West. It was a different world. Greg found that he started spending more time in his apartment watching TV. He had become far less active and much more isolated. He is starting to wonder if that extra 200 square feet actually has translated to a better quality of life for him.

Although housing isn't as clearly quantified in most instances as some of the other determinants as an issue for LGTB people, it is important that the service provider include it in the equation of LGTB health and well-being. They must consider some of the impacts and choices that people make in order to provide themselves with a domestic environment that is most conducive to their health and well-being. They must also understand that despite legal safeguards, LGTB people do face discrimination in their attempts to secure housing.

M2

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Case Example

Ellen and Jo finally make their long-planned move to the country. They have found the cutest little cottage in a town replete with 19th century architecture. Not long after they move, they start to notice things going missing and pranks being played. It is annoying, but so far nothing major had happened. Strangely, nothing seemed to be happening to the neighbour's property. Then one night when they arrive home they see graffiti scrawled across their door: 'dykes not welcome.' Despite intervention from the police, no one is apprehended.

Critical Thinking Questions

1. Besides the obvious physical security of housing, what other ways does housing affect the health and well-being of LGTB people?

2. What relationship might exist between sexual orientation or gender identity and youth homelessness?

3. What considerations do you think LGTB people might make when choosing their housing that could be different for heterosexual or non-trans people?

16. Contribution of the Social Economy

'…the term "social economy" is widely used [in Quebec] and refers to a vast array of groups (mostly non-profit organizations) including advocacy groups, voluntary organizations and other community-based organizations, including cooperatives' (PHAC, n.d., p.11)

Community and the services provided by and for it are an important factor when considering the well-being of LGTB people. Much of the services available for LGTB people have been founded by their various communities in response to specific needs.

Volunteerism is an integral part of the functioning of many LGTB community organisations. Many LGTB-specific organisations are almost entirely dependent upon the voluntary sector. Events like Pride, the Dyke March, gay and lesbian choirs, etc… are important social institutions usually run with little or no public funding. Organisations like *The Centre: A Community Centre Serving and Supporting LGTB People and their Allies* in Vancouver are dependent upon volunteers for everything from governance to cleaning the toilets. A small number of paid staff (usually through project-based funding) provides some community services. The Centre could not sustain its work without the commitment of volunteers. The work force obviously assists the community by providing a particular good or service, but the individual also receives benefits. 'Social networks help you stay healthy'(Putnam, 2000, p. 331).

Institutions such as this are important change agents for the LGTB community. They fill gaps which often exist within the community, they advocate for change and they raise awareness about important issues. Like other minority groups i.e. ethnic or faith-based groups, LGTB organisations have worked together to further

the well-being of their communities. For many of these groups, governments have followed through with the provision of services and supports to meet their needs.

Case Example

Several years ago a small group of motivated citizens banded together to organise and run a LGTB festival in their small community. Each year the festival has grown, attracting visitors from far and wide for this 2+ day event. Initially finding the event a bit of an oddity, the local population has grown accustomed to it. People aren't too shocked anymore when they see a Drag Queen in their little rural supermarket on that weekend.

The festival brings a significant cash injection to the struggling community. The success of the organising committee has also seen them turn a profit the last few years. They have made generous donations to the local hospital and childcare centre. They have achieved this success through a commitment from the local LGTB community and their businesses. There has been a gradual acknowledgment from the mainstream community that this is good for the whole community. After six years, the parade organisers have finally received permission to close the main street for the parade.

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Critical Thinking Questions

1. What functions does this type of work fulfill?

2. Think of other groups or communities that you might be familiar with (faith-based, geographical, ethnic) and how they have worked to create social institutions or services to meet their needs. What are the challenges they face and where has this led them?

3. Why might groups or organisations described above be health-enhancing for the LGTB community?

Summary

This module has encouraged the learner to consider LGTB people and communities as more than a one-dimensional group defined by their sexual orientation or gender identity. It has identified the diversity in LGTB groups and individuals spanning age, ethnicity, culture, geography and the many other features that make LGTB people and communities who they are.

By using a combination of accepted health determinants, this module has demonstrated how the experiences of LGTB people may be different to those people who are heterosexual or non-trans.

Poor health outcomes, discrimination in service delivery and exclusion have been recurring themes as a means of revealing and reinforcing the plight of LGTB health. But there have also been many examples of how health and well-being have and can continue to be achieved through positive action by and within LGTB communities.

In providing this broad and sometimes complex view of LGTB health, it is hoped that the learner will have benefited by better understanding how the many layers of an individual or community experience might impact on their health and well-being.

LGTB Health Matters

Knowledge Assessment — Pre and Post

The following statements are based on the material presented in module two. The statements are either true or false. Please read each statement and mark a T or an F beside the statement that best reflects your knowledge and understanding of the material. This tool is intended to be used before delivery of the module content and again following. It is suggested that learners take some time to compare their answers and consider how their knowledge and attitudes have changed.

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		True or False			True or False
01.	LGTB people are from all walks of life, age, shape, colour and ethnicity.		11.	Because they have protection under the law, LGTB people can safely live anywhere in Canada without experiencing discrimination or any threat of violence based on their sexual orientation or gender identity.	
02.	Now that LGTB people have more legal protection, they no longer are oppressed.		12.	LGTB people are prone to stress related to their minority status.	
03.	Gay people usually make above-average incomes.		13.	Queer families are rare and children are the result of previous heterosexual relationships.	
04.	Many LGTB people enjoy the support of their family of origin.		14.	LGB people have distinct and obvious biological features making them different to heterosexuals.	
05.	Prior to colonialism, some First Nations cultures had an understanding of sexual diversity that was far more inclusive & comprehensive than that of the European invaders.		15.	Health & social service providers have the right not to provide service to LGTB people if it makes them uncomfortable.	
06.	When providing a service, it isn't necessary to know a person's gender as long as you know what sex they are.		16.	Higher rates of alcohol, tobacco and illicit drug misuse in LGTB communities could be attributed to heterosexism and LGTB-phobia.	
07.	Health and social service providers are often not comfortable in acknowledging the sexual orientation or gender identity of people with a disability.		17.	Access to housing is no greater issue for LGTB people than anyone else.	
08.	How an LGTB youth experiences the school system isn't likely to have much impact on any decision to complete their education.		18.	Violence or threat of violence due to one's sexual orientation or gender identity is a reality for LGTB people.	
09.	Despite legal protection, LGTB people still may experience isolation and marginalisation in the workplace.		19.	Positive depictions of LGTB people in the education system offer a good means of reducing heterosexism and LGTB-phobia.	
10.	Without exception, LGTB people enjoy the same religious freedoms as their fellow citizens.		20.	All LGTB people experience discrimination in one way or another that negatively impacts on their health and well-being.	

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Module 3

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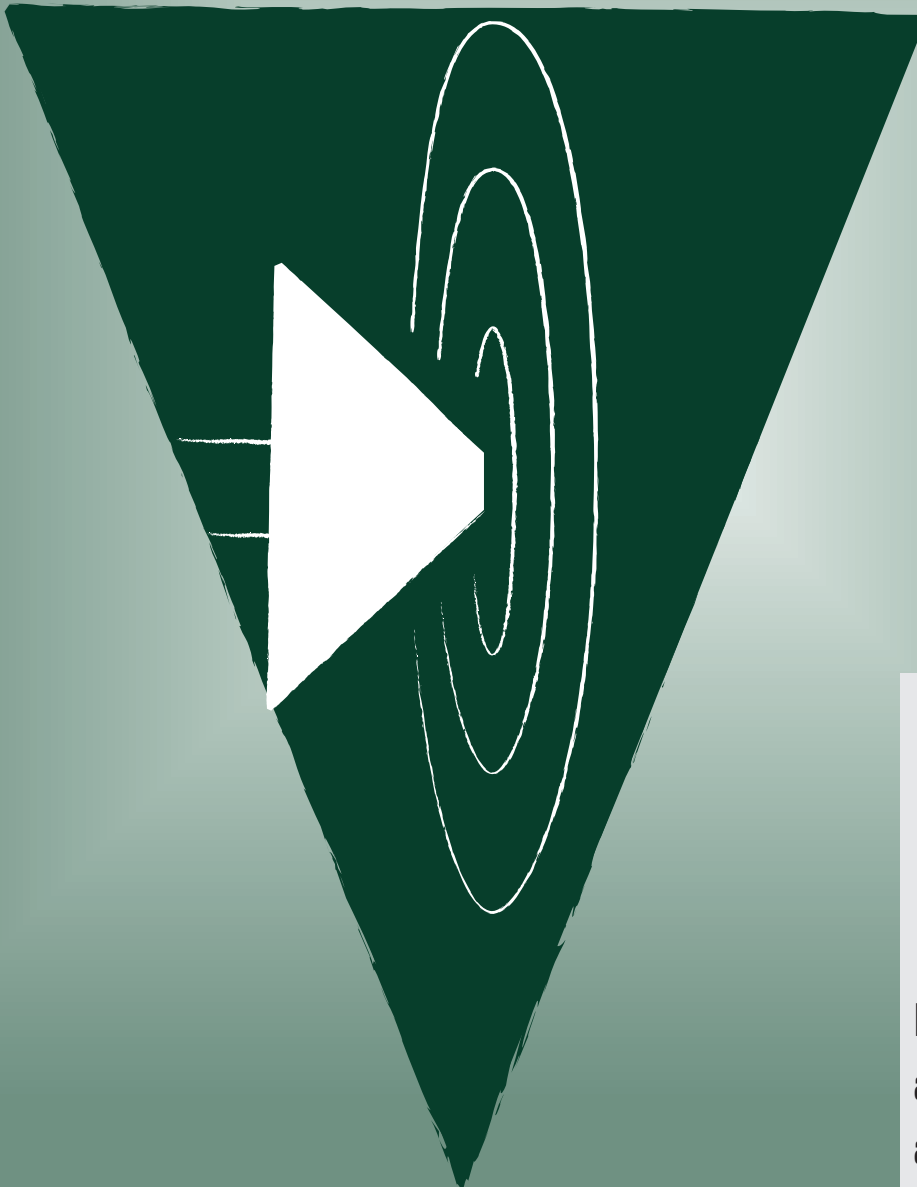
Delivering Accessible and Inclusive Health and Social Services to LGTB Individuals, Families & Communities

Introduction

This module will provide the health and social service provider with a more detailed understanding of the LGTB experience and how this might be related to LGTB health and wellness. The learner will be introduced to more detailed discussions on issues relating to LGTB community as well as specific issues affecting lesbian, gay, trans, bisexual and two-spirit health. The final section of the module will review the basis on which LGTB inclusive practice should be instituted.

As with previous modules, a combination of case examples and exercises have been employed to enable the practitioner to consider their perspective and practice in relation to the topics.

Preparation and Prerequisite

▼ Module one required
▼ Module two beneficial

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Learning Outcome

Learners will apply their knowledge and practice as health care professionals to deliver quality and equitable health care services to LGTB communities.

Learning Objectives

1.) Participants will be introduced to culturally identifying features of LGTB life such as language and roles.
2.) Participants will develop an understanding of the significance of LGTB-specific events, symbols and acknowledgements and how these might be considered in relation to service delivery.
3.) On completion of this module, participants will possess an introductory knowledge of specific health issues relating to lesbian, gay, trans, bisexual and two-spirit groups.
4.) Participants will increase their competency in working with the LGTB communities through greater awareness of the customs, practices and priorities of these groups.

Gaining an Understanding of LGTB Communities

Previous modules have reinforced the heterogeneity of LGTB groups, discussing how — like all of society — LGTB groups are a mosaic of cultures, ages and beliefs. Learners will by now understand that in addition to sexual orientation and/or gender identity, the common links between these individuals are often related to oppressive actions or policies. From these commonalities, and other bad and good experiences, LGTB communities have responded with methods to survive and thrive. This section will touch on some of the unique qualities of LGTB communities — some subtle, others not so — that will give the health and social service provider a better understanding when interacting with the LGTB communities. This section will only consider five factors but acknowledges that there are many more.

■Language

Language is a part of expressing one's identity. Within the LGTB communities there are many terms describing behaviour, characteristics and stereotypes. It is important for the health and social services provider to understand some of these terms, including their context and meaning.

There are many terms used to describe LGTB people that are derogatory and hurtful. Even those claimed by the LGTB communities as positive frequently see continued negative use by the wider community; the term 'gay,' for example, is often used in phrases such as 'that's so gay' or 'you're so gay.' Sadly, this particular term is often heard in use by children as a term of general disdain or criticism with no understanding of its link to sexual orientation.

A plethora of terms refer to LGTB people: faggot, lezzie, homo, poofter, fairy. (A number are even more offensive). Many people don't understand the relationship between these terms and the oppression from which they were born. For example, the term fag or faggot refers to a bundle of sticks, and is believed to originate in the period of witch burning in Europe. At that time, men who were believed to be having sex with men would be bundled in with the kindling sticks that were to be used for burning the alleged witches, and set alight (GALE of BC, 2000).

Terms such as homosexual have a very clinical-legal connotation and many same-sex attracted people would probably prefer alternative terms. Terms such as MSM (men who have sex with men) or WSW (women who have sex with women) were introduced to provide more generic terms to describe sexual behaviour (Young & Meyer, 2005). These terms are criticised by some as they are so behaviourist in their use that they overlook many other elements of same-sex relationships.

Gender-identifying terms may be abbreviations for the longer words such as transgendered. The term trans is frequently used and is an acceptable abbreviation. Some members of the trans community may even refer to themselves as tranny, however this is a term that a service provider would not likely use.

An important language consideration when working with the trans community is the appropriate use of pronouns. How an individual describes one's self is a significant component of their identity. This may not always be apparent or obvious for the service provider, especially in those situations where the service providers is aware that a person may have or be in the process of transition. Follow the individual's cues and language. If in doubt, ask what pronouns they prefer. Once this is established, be respectful of language and attempt to alter your behaviour to comply with the preferred pronoun or name change if applicable.

There are many terms that are being reclaimed by the LGTB communities, such as dyke, queer, fag and queen. Their use is contextual and when used in the wrong manner these words can still be offensive. Some members of the LGTB communities s do not see them as reclaimed language and are offended even when used in that manner. As a service provider, you may hear these terms used by LGTB people to describe themselves or their communities. Your use of these terms will be dependent on your degree of comfort and the relationship that you have with any given LGTB person. You might like to follow their lead or ask which terms they use or feel most comfortable with.

Language varies between generations. For example, older members of the community may find some of the reclaimed language offensive as they have had a long-time association with certain words in a solely negative connotation. One such variation would be older women who prefer the term 'gay woman' rather than lesbian or dyke.

Cultural and ethnic groups will also have different descriptions and interpretations of language for referring to queer people. In some instances, the only term that exists is quite derogatory.
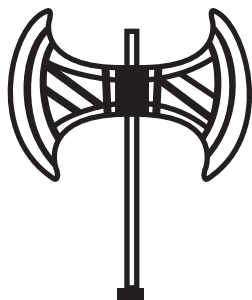
Symbols

Many symbols have become synonymous with the LGTB communities. The rainbow flag is probably the most recognised symbol of queer community. The flag was designed to represent the diversity of the LGTB community, race, faith, etc. (Shortall, 2003). It is used extensively as a symbol of LGTB pride but also commercially and as an indicator of welcome to the LGTB communities . The Rainbow Flag can be found throughout the world, wherever it can be safely exhibited. It is a sign to LGTB people that they are welcome in an area or establishment.

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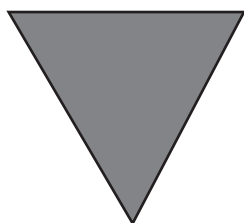
The Pink Triangle is one of the most powerful symbols of the gay community. Although many people were targeted by the Nazis during the Holocaust, one group is often excluded in the historical accounts of this period. Gay men, or those perceived as gay, were forced to wear pink inverted triangles to identify the reason for their incarceration. Homosexuals were often given the worst labour assignments, and faced attacks from both guards and inmates. They were often sterilised through castration. Later, Hitler extended punishment to death. One hundred thousand gay men were arrested by the Nazis and more than half were convicted. An estimated ten to fifteen thousand were sent to concentration camps, where approximately two-thirds died. When the war ended, most people in the concentration camps were freed, but those with pink triangles were transferred to prisons, as West German law prohibited homosexual relations until 1969 (Shortall, 2003, p. 14). 'The pink triangle was reclaimed as a powerful symbol of gay/lesbian liberation in the 1970's' (Toppings, 2004, p. 1.34)
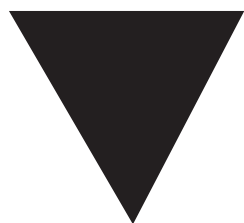
The Black Triangle was worn by anarchists in concentration camp. Among them were women who displayed anti-social behaviour, such as lesbians, prostitutes and those who refused to bear children. The black triangle has been reclaimed by lesbians and feminists as symbol of pride and solidarity. (Shortall, 2003, p. 14)

"The labrys, a double edged axe, is the oldest and most enduring of the symbols adopted by the Lesbian community. It signifies strength and self-sufficiency' (Toppings, 2004, p. 1.34)

Variations on the standard astrology symbols for male and female have been adopted to indicate gay men, lesbian, trans and bisexual.

Gay Man	Lesbian	Transgendered	Bisexual

This is one
of many symbols
indicating bisexual
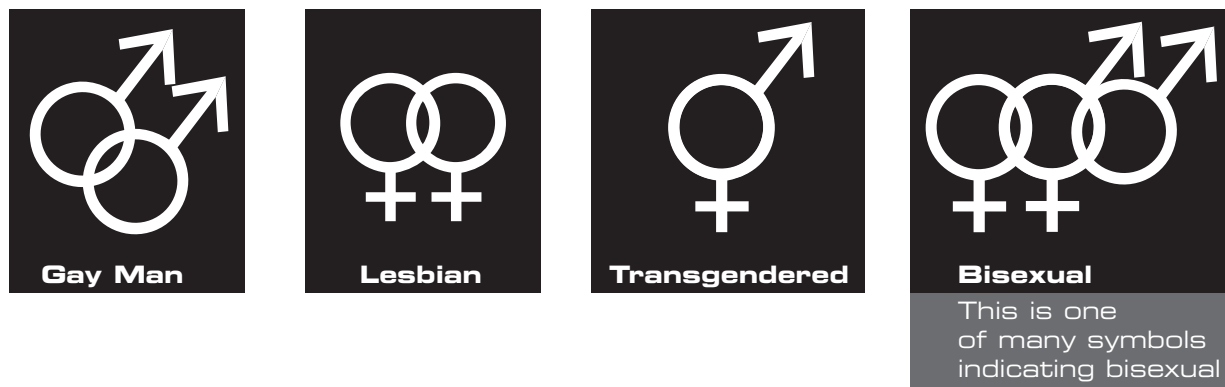
There are many other symbols within the various LGTB communities, but being familiar with the most common is a good starting point. Displaying these symbols is an effective means of communicating an organisation's commitment to and competency in providing services to the LGTB communities.

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▊ Roles

There is frequently confusion within the heterosexual and non trans communities about roles in the LGTB communities. LGTB people often don't fit into the stereotypes of gender roles prescribed by the mainstream community.

A common stereotype is the belief that in a same-sex relationship, one person will play the role of male and the other of female, mimicking heterosexual relationships. While some couples may opt for these roles, especially surrounding issues such as division of labour, most same-sex relationships are not bound by such rigid divides, providing for greater equality in the relationship. Service providers should not assume a given individual fulfills certain roles within their relationship, despite presentation. If in doubt — and if the information is necessary — find a sensitive and appropriate way to elicit it.

Sometimes stereotypes of gender roles will be played in extreme as a means of identifying or entertainment. For example *Drag Queens and Kings* (see definition in Appendix A) over-accentuate characteristics of the opposite sex by dressing and behaving in a manner stereotypical of that sex as a means of entertainment. This would not necessarily mean that person is transgendered; they are simply using sex and gender-role stereotypes as a form of entertainment or pleasure.

Unfortunately, in some instances LGTB people feel the need to fulfill a role or are forced to do so for their success or survival. In earlier modules, reference was made to how expression of gender identity and sexual orientation can inhibit a person's ability to conduct certain activities of life, ranging from where they live or how they progress up the ladder in the workplace. A common role to play in this instance is that of heterosexual or non-trans person. A person may play this role in a workplace, social setting or when they are a recipient of health and social services: whenever and wherever they do not feel safe or valued enough to express their true sexual orientation or gender identity. Playing a role in this fashion can be a highly stressful experience.

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> **Case Example**
>
> Phil is a gay man who is out to a few close friends but fiercely guards his privacy. He rarely interacts with the gay community and will often go to great lengths to avoid it. He is employed in a conservative workplace where he has achieved a position of relatively high status. Phil is fearful that if his sexual orientation was known by his employer, it might impede his opportunities within the company. To counter this, Phil not only hides his sexual orientation but plays a heterosexual role. This has forced Phil into several situations which he is uncomfortable with, such as always taking a female date to work functions. Playing such a role caused Phil a great deal of discomfort but he can see no other option.

■ Separate Space/Activities/Groups

Creating a more LGTB-inclusive society, where people can freely express their sexual orientations or gender identities, will not eliminate the need for separate places, activities or groups. Services and spaces that specifically target LGTB people have grown in response to the exclusion of LGTB individuals from mainstream options. LGTB culture has, in response, developed its own unique qualities and is not likely to be relinquished. Consider ethnic minority groups who have the freedom to move in and out of mainstream activities but maintain their own ethnic-specific options. Similarly, most people will feel more comfortable when interacting with a group with whom they share something. This may even be greater when the common denominator has led to oppression.

Exercise — individual or group activity

Think of a time when you had to attend a function when you were the only one who possessed certain characteristics. For example if you are Caucasian, a time when everyone else was of non-Caucasian origin. If you are from a non-English speaking background think of the first time you had to attend something where everyone else's first language was English. Recall what that experience felt like.
Now think about a function you attended where everyone else looked or sounded like you or at least shared important features. How did this make you feel?
Discuss as a group how this experience might resemble the LGTB experience in relation to dominant culture of heterosexuality and non-trans.

LGTB spaces may be exclusive for the provision of safety, such as in a community, work or education setting. For example, some universities and colleges have a space set aside for queer students to meet in an environment that is safe and welcoming. Other spaces may be exclusive through self-selection, meaning that the space is of most interest to people who are LGTB, for example a bathhouse. Other spaces such as 'Gay or Lesbian' villages are places where LGTB people can congregate, socialise and conduct business in an area that is predominantly LGTB-friendly. They are not exclusive and all are welcome, but visitors are expected to be respectful of the environment which they are in. These are spaces and places where LGTB people will feel comfortable expressing themselves more openly, i.e. holding hands, kissing in public. These activities are taken for granted by the heterosexual community and can be pursued almost anywhere. This is part of what is called *heterosexual privilege* (see definition in Appendix A). Davie Village in Vancouver's Davie Street is an example of such an area. Note that the symbols that exist in this part of the street include rainbow flags and rainbow stickers in the windows.

There are also many LGTB-specific groups and activities, which range from sporting groups such as tennis, ice hockey, and soccer clubs, to faith-based, advocacy and support groups. These provide the opportunity for LGTB people to participate in an environment where they can be themselves and address issues that are specific to them or their communities. While many of these examples are local and amateur-based activities, LGTB sport has advanced to a competitive international field via the Gay Games and the Out Games. Information about such activities can usually be accessed through local LGTB publications such as the *Xtra West* newspaper (which, though mostly available in Vancouver and larger centres, can provide information through its web site: www.Xtra.ca.)

Importance of Celebration

Undoubtedly the largest celebrations on the LGTB calendar are the annual Pride festivals. These are celebrated in many different manners and sites throughout the world. In some communities, even within North America and Europe, LGTB people are still fighting with local authorities for the right to publicly celebrate Pride. For many people, Pride equates to a street parade replete with colour, movement and almost every stereotype conceivable about LGTB people. Fun and celebratory, its roots are in activism and the fight for equality. What people celebrate today is the recognition of rights that others have fought for over the past four decades.

Many cities will have a Pride committee or society. These are generally committees of volunteers who orchestrate the events of Pride, which — in addition to the parade — usually include a variety of activities including recreation, arts displays and entertainment. As a service provider, it would be considerate to acknowledge events such as Pride, either as a workplace courtesy for employees or for those receiving services. This can be done in a manner similar to any other workplace acknowledgement for a cultural celebration. Hanging a rainbow flag, displaying information about Pride events or holding a special luncheon are all appropriate ways to acknowledge LGTB celebrations.

Summary

This section provided the learner with an insight into some of the significant features of the LGTB communities. It is intended to provide some context to assist the heterosexual and non-trans service provider in better understanding their LGTB clientele, noting considerations they might make in creating a more LGTB inclusive service.

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Specific LGTB Health Considerations

Earlier sections have indicated the importance of the alliance between lesbian, gay, trans and bisexual people to overcome oppression of many types. This does not imply that each group within this construct does not have unique needs and issues. The following section will provide an introduction to some of the health issues facing each of these groups as well as those of two-spirit people. It is intended to introduce the learner to some of the specific issues each group must face. Further reading and learning is strongly recommended to get a more complete picture. Recommendations for sourcing further information will be provided with each section.

Lesbian Health

Health-enhancing Capacity of Lesbians

➘ Peer support and social networks: health information-sharing within the lesbian community closes gaps left by inadequate health education.

➘ Many lesbians utilize the growing number of women's health organizations. Also, lesbians have organised women's health collectives, and participate in advising organizations around issues of lesbian inclusion.

➘ There is increasing lesbian visibility, and a growing body of research into lesbian health and wellness.

Illness and Conditions of Significance to Lesbians

➘ Coronary health conditions

➘ Cancers: Cervical, Breast, Lung

➘ Sexually Transmitted Infections

➘ Mental health

➘ Pregnancy

➘ Domestic Violence

Service Delivery Issues Specific to Lesbians

➘ Health care system and professionals' lack of proactively identifying and engaging the lesbian community.

➘ Heterosexist assumptions of health professionals, reflected in history-taking and health advice. This is particularly evident in the areas of relationships and sexual behaviour.

➘ Lack of prevention, health education and screening campaigns targeting lesbians. This lack of targeting contributes to misconceptions in the lesbian community about what risk factors and screening practices are applicable to them.

➘ Lesbians' poor utilization of health services. Research highlights numerous factors contributing to the under-use of health care services by lesbians. These reasons include, but are not limited to previous or anticipated bad experiences, expectation that the patient will have to educate practitioners, exclusion of partner, rough treatment, overhearing antigay remarks, the fear of coming out, fear of refusal of care.

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- ↳ Lack of out-queer and expressly lesbian-positive health care professionals. Imagery of same-sex couples in clinical settings, such as on pamphlets and teaching material, signifies to all patients that LGTB persons are acknowledged and supported there.

- ↳ Lack of research addressing lesbian health and wellness. Lesbians have historically been excluded or unidentified in medical research studies.

- ↳ Misconception that women are not violent and therefore lesbians do not merit screening for prevention of domestic abuse.

Public Health and Prevention Factors Specific to Lesbians

- ↳ Coronary health conditions- Research has shown that lesbians have higher rates of smoking and a higher body mass index than heterosexual women. These factors increase a lesbian's risk of developing cardiovascular disease. Lesbians should be offered heart disease and stroke prevention information, screening tests and services.

- ↳ Cancers: Cervical, Breast, Lung- Compared to other women, lesbians undergo fewer important screening services, such as cervicovaginal (Pap) smears and breast exams. This is due to multiple barriers, including medical practitioners who believe that lesbians do not require screening, and inadequate education in the lesbian community about relative risk factors and the need for screening. Lesbians have higher rates of breast cancer than heterosexual women, yet are frequently absent as targets of both research and preventive education about breast cancer. Cancer prevention for lesbians should involve the same preventive measures recommended for all women.

- ↳ Heterosexist questions and clinical forms foster the invisibility of lesbians and contribute to discomfort or fears of confiding sexual identity to practitioners. When gathering sexual history and identifying risk factors for sexually transmitted infections, health professionals tend to focus on heterosexual intercourse and birth control. If a lesbian is out to their health care practitioner, they are often not asked about pregnancy, past or present sexual experiences with men/trans/bi partners and may face the assumptions that lesbians are monogamous and in long-term relationships.

- ↳ Sexually transmitted infections, including HIV, can be transmitted through woman-to-woman contact. Lesbians are at risk of acquiring human papillomavirus, which is associated with cervical cancer; therefore lesbian patients should receive regular Pap smears. Education about disease transmission should target lesbian sexual practices, and include information on safer sex practices.

- ↳ Failure to consider the stresses of homophobic prejudice, such as low self-esteem, internalized homophobia or rejection by family, contribute to inadequate assessment and understanding of the context of a lesbian patient's mental health.

- ↳ Homosexuality was at one time pathologized as a mental illness. This legacy may continue to have residual negative effects on both patients and homophobic practitioners.

- ↳ Pregnancy: Many lesbians choose to become biological parents. Reproductive health issues apply in both familiar and unique ways to lesbians. Pre-natal care, anticipatory planning and support such as standard recommended tests, vaccinations and exams are recommended for lesbian mothers. Conception options should be discussed; alternative insemination planning often requires significant interaction with the health care system. Risks of disease transmission should be discussed if patient is using an unscreened donor.

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⬊ Studies suggest that relationship violence is experienced by a large percentage of individuals in LGTB communities. Domestic violence occurs in same-sex relationships with as much frequency and severity as it does in heterosexual partnerships. Research also indicates that as many as 25% of lesbians suffer physical abuse by family members as a result of their sexual orientation. There is a need for improved prevention services in LGTB communities, as well as lesbian-sensitive victim services organizations. LGTB domestic violence shares many similarities with the hetero-sexual community. Additionally, the dynamics of LGTB domestic violence are influenced by multiple barriers to addressing the phenomenon: the stage of coming out which the abuser and survivor are in, for example, as well as greater isolation and lack of community resources.

Gay Men's Health

■ Health-enhancing Capacity of Gay Men

⬊ Gay men initially responded positively to public health campaigns which resulted in decreased HIV infection.

⬊ Gay men organised and played an integral role in establishing and organising HIV/AIDS services across the country.

⬊ There is a growing interest and movement around a more broadly defined gay men's health that is asset-based.

■ Illness and Conditions of Significance to Gay Men

⬊ HIV/AIDS — Men who have sex with men (MSM), a group which includes gay men, are still the largest group affected by HIV/AIDS in Canada (PHAC, 2005a)

⬊ Sexual Health — As well as HIV, there are a number of other sexually transmitted diseases that affect gay men's health specifically. Lymphogranuloma Venereum (LGV) is a relatively new disease in Canada which is predominantly found in gay men. There have also been marked increases in syphilis between 1997 and 2004, with increased also in gonorrhoea and chlamydia. (Public Health Agency of Canada, 2003 & 2005b)

⬊ Hepatitis A, B and C. Some sexual behaviour can put gay men at greater risk of hepatitis. There is also a possibility that HIV+ men could be at greater risk of Hep C.

⬊ Alcohol and drug use is thought to be higher in the gay community than the general population. Certain drugs like crystal meth (methamphetamine hydrochloride) are proving to be particularly problematic in the gay community and can have immediate and long-term effects on mental health. In addition to the primary health-harming effects of these substances, they put the user at greater risk of other illnesses due to disinhibition, i.e. unsafe sex.

⬊ Anal Cancer — Higher rates of anal cancer are found in gay men than the broader community. HIV+ men seem to be at higher risk. (The Centre, 2003)

⬊ Mental Health — issues such as depression, low self esteem and altered perception of body image are all higher in gay men than in their heterosexual counterparts.

Service Delivery Issues Specific to Gay Men

- ↘ Creating an environment that is gay-positive will be encourage gay men to attend.

- ↘ Heterosexism and threat of homophobia (real or perceived) may keep gay men from including important details about their sexual orientation or behaviour which could result in misinformation and inappropriate service delivery.

- ↘ Some men will be in relationships with women but will not see their attraction to men as a gay identity. Nevertheless they will be susceptible to and experience many of the same challenges and risks of openly gay men.

- ↘ Confidentiality and the sense of trust are of great importance in the service delivery setting, possibly even more so for men who are not 'out'. This need may increase in rural or remote areas, where the small populations increases the chance of an outside social connection or relationship between the service provider and client or the service provider and the client's family.

- ↘ Gay men often experience exclusion of partners and other significant supports when accessing the health and social service system. To avoid this, determine who a man's supports are rather than making assumptions.

Public Health and Prevention Factors Specific to Gay Men

- ↘ Targeting
  - > MSM is not synonymous with gay. Gay describes an identity and for some, a cultural identity as opposed to MSM, which describes a behaviour. If targeting gay men, this can be an important distinction.
  - > Use images and language that will be appealing to gay men. Traditionally stereotyped masculine images and activities are less likely to attract the attention of gay men. For example, men's health education sessions which use team sporting heroes as a draw card may be very appealing for some heterosexual men, but have little to offer for gay men.

- ↘ Gay men's health is not limited to the single issue of HIV/AIDS. However this is often how it has been defined because of the substantial impact this disease has had on the gay community. Gay men are working to redefine their health in broader terms, including their capacity to create well-being.

- ↘ Gay men have been inundated with safe sex messages and campaigns that portray them as disease vectors. Effective health education and social marketing campaigns need to acknowledge gay men's role and responsibility in prevention, balancing this information with their right to engage in and enjoy sex.

- ↘ Other Sexually Transmitted Infections (STI) impacting on gay men can be overshadowed by HIV. With substantial growth in infection rates for chlamydia, syphilis and to a lesser extent gonorrhoea, public health priorities need to recognise and address these conditions within the gay male population.

- ↘ Despite the fact that issues of heterosexism and homophobia are known to underpin a significant amount of the illness affecting gay men, the majority of public health interventions continue to focus on men's sexual behaviour. Upstream public health interventions to address this issue need to be considered. Alternatively, efforts could be made to refocus on the health-enhancing capacity of sex, so that gay men's sexuality isn't always identified as problematic.

- ↘ Framing gay men's health in a structure of strengths versus deficits provides a more empowering role for gay men.

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Transgender Health

Health-enhancing Capacity of Trans People

- The trans community has challenged gender convention and contributed to changing views of socially acceptable gender identity and expression.

- Many trans people develop a range of coping mechanisms (some that are very healthy, and others that may be problematic) to deal with both their gender dysphoria and the significant societal oppression & exclusion they face.

- Members of the trans community have successfully developed trans-specific health services and have put trans issues on the health agenda.

Illness and Conditions of Significance to Trans People

- Unsupervised and non-prescribed hormone use. Trans people who are unable to access appropriately supervised and prescribed hormone therapy may opt for illicit sources. These may be sourced from disreputable suppliers, which can involve contaminates or results in dangerous dosages.

- Gender-specific care, even following sex reassignment surgeries. Trans people will need to be considered for conditions typical of their gender of birth. For example a trans woman (male-to-female) MTF could experience prostate problems.

- Hormone therapies impact on a variety of biological systems. Some hormone treatment results in permanent change, while other changes will revert if the trans person stops taking hormones. These changes can include changes to body hair (hair loss, growth or change to growth patterns), deepening of voice for (female-to-male) FTM trans people; growth of breast tissue for MTFs; changes to genitalia such as clitoral enlargement in FTMs; changes to fat and muscle distribution, and many others. Learners should familiarise themselves with these effects by referring to the resources identified below.

- Chest binding (to conceal breasts) if done too tightly may cause problems such as collapsed lungs or in youth — where bones are still growing — could potentially impede ribcage development.

- When FTMs take testosterone, menstruation generally ceases quickly. However, ovulation does not cease, so pregnancy is possible unless the person has had an oophorectomy or hysterectomy.

- Unlike sexual orientation, there are still diagnoses relating to gender identity in the Diagnostic and Statistical Manual of Mental Disorders fourth Edition (DSM IV), such as Gender Identity Disorder. Criteria referring to distress related to gender identity are interpreted as pathological. There are differing views on whether a psychiatric diagnosis is appropriate.

- Trans people are prone to significant discrimination in many of the socially-determined factors of health, such as employment, housing and income. Trans people are also frequently targets of violence, which ranges in scope from verbal attacks through sexualized assaults through murder. These all have the potential to seriously impact on the health and well-being of the trans individual.

Service Delivery Issues Specific to Trans People

- In many jurisdictions, trans people do not have the same legal protections as other members of society. The conscientious service provider should ensure that despite this, the trans service user must receive the same informed and respectful service that all clients should expect.

- The attitude of service providers is one of the biggest barriers for trans people when interacting with the health and social service sector.

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↘ Many of the issues that trans people will present with will not require detailed knowledge and expertise by the service provider. The service user should expect to receive the same treatment as anyone else for that specific issue, i.e. the person's gender identity should not affect treatment when someone is presenting to an emergency department with a sprained ankle.

↘ There is a lack of qualified health care providers with knowledge and skills specific to trans health issues.

↘ Ensure that adequate privacy and/or gender neutral facilities are available, such as washrooms, sleeping or changing areas, to avoid undue discomfort or embarrassment for the trans person. Inform the trans client what options are available, rather than making assumptions about what they would wish. Make arrangements for them to use the facilities that are most comfortable for them.

↘ Appropriate recognition in documentation. Provide options which enable the trans person to identify their gender in a manner that makes them comfortable: female, male, transsexual, trans-gendered, gender queer, two-spirit, FTM, MTF, other.

↘ Transsexual people may modify their bodies to varying degrees in order to fit with their gender identity. Some are unable to transition, for reasons relating to other health conditions, financial barriers, family, and a variety of other reasons. Some may use hormones only, some have or wish to have sex reassignment surgeries, and some wish to have or have had both. Service providers need to understand that this is not an 'all or nothing' process and they can not assume that the goal for all people is sex reassignment.

↘ When assessing the mental well-being of trans people, the service provider should consider the impact of oppression and trauma that is often experienced and how it relates to violence, grief and exclusion.

↘ Certain treatment options may or may not be covered by the provincial government health insurance — coverage varies from province to province. For example, Quebec covers a significant amount of surgery related to sex reassignment whereas Nova Scotia covers none. British Columbia's Medical Services Plan covers chest reconstruction for FTM but not testicular implants (Transcend Transgender Support & Education Society, 2004).

Public Health and Prevention Factors Specific to Trans People

↘ Prevention initiatives such as screening should consider the trans person's biological gender at birth. Even if a person has had one or more sex reassignment surgeries, they often retain gender-specific body parts (e.g. prostate, cervix).

↘ Public health or prevention campaigns which consider trans-specific issues may need to be target-ed separately to broader LGTB grouping. In broader campaigns, special acknowledgement should also be made, including images, statistics or specific information about trans issues and concerns.

↘ Trans people live, work and recreate in all parts of the province and country. Therefore health education needs to go beyond areas perceived to contain higher trans populations.

For further information:

> Vancouver Coastal Health operates the Transgender Health Program. Their website provides information that can be downloaded as well as helpful links to trans-specific sites. www.vch.ca/transhealth

> Transcend is a community-based organisation located in Victoria. They have education resources and links available on line www.transgender.org/transcend. Transcend has also developed guidelines for clinical competencies in partnership with the Canadian Rainbow Health Coalition. Visit www.rainbowhealth to access these.

Bisexual People' Health

▌Health-enhancing Capacity of Bisexual People

↘ There is an emerging recognition of the bisexual population as being unique and separate to lesbian and gay. Bisexual people and their allies are responding by organising around this distinction.

↘ Bisexuality challenges the dichotomous view of heterosexuality versus homosexuality, allowing for greater sexual diversity.

▌Illness and Conditions of Significance to Bisexual People

↘ There are no specific illnesses or conditions that effect only bisexual people.

↘ Bisexual men will be prone to the same conditions to gay men if they are sexually active with other men.

↘ Bisexual women will be prone to the same conditions to lesbians if their sexual activity and relationships are with women.

↘ Bisexual people as a minority may be prone to greater minority stress than lesbians and gay men. As a small and often invisible minority, bisexual people may be marginalised by both the hetero-sexual and lesbian/gay communities. This increased marginalisation and stress could lead to greater mental health issues.

▌Service Delivery Issues Specific to Bisexual People

↘ Health and social service providers need to recognise bisexuality as a legitimate sexual orientation separate from heterosexuality and lesbian/gay. For some people, sexuality may be more fluid, whereby their attraction to one sex or another may fluctuate. For others, it may be more static. A bisexual person can be in a committed relationship with a person of one sex and remain attracted to the other sex.

↘ Bisexuality can be a transitory identification for some but not all people. For example, some lesbian and gay people may identify as bisexual during the process of questioning their sexual orientation or coming out.

↘ Provide options in interviews and documentation that allows the bisexual individual to indicate their sexual orientation.

↘ Health service providers cannot make assumptions about a person's sexual orientation. Some people who have sex with a person of the same sex while being primarily attracted to people of the opposite sex do not identify as bisexual. It is up to the person to determine whether or not they identify as bisexual.

↘ There are people both within the queer and straight communities that reject the notion of bisexu-ality. This can increase confusion for the individual who is exploring or accepting their bisexuality.

↘ There is no evidence that bisexual people are any more sexually active or at greater risk of specific sexually transmitted infections. Risk of infection remains the result of behaviour, not one's sexual orientation.

↘ Heterosexism applies to bisexual people as it does to lesbians and gay men.

Public Health and Prevention Factors Specific to Bisexual People

- ↘ Bisexual populations are distinct from lesbian and gay and require separate acknowledgement: both when targeting public health interventions and when providing health education.

- ↘ Messages (education and social marketing) relating to STIs - or conditions where lesbian and gay people might be at a higher risk - are applicable to bisexual people.

- ↘ Biphobia is health-harming.

- ↘ Kinsey's 1950's research suggested that bisexuality could be as high as 25% in women and 46% in men (Bisexuality: Beyond gay or straight, n.d.). Although there is no population statistic to support these figures, they indicate a potentially substantial number of people who may be emotionally and/or physically attracted to both males and females.

Some materials sourced from The Centre's *Bisexual Health Matters* brochure.

Two-spirit People's Health

Health-enhancing Capacity of Two-spirit People

- ↘ Two-spirit people are members of a culture that, despite its oppression, has demonstrated exceptional resilience.

- ↘ There is an historical recognition and valuing of sexual diversity that remains understood and intact in some segments of the First Nations cultures.

- ↘ Two-spirit people are organising to educate the broader population as well as First Nations people about the traditions of two-spirit.

Illness and Conditions of Significance to Two-spirit People

Conditions of significance to two-spirit people include those identified as impacting on other groups of the LGTB communities, but they are also affected by those conditions of greater incidence within the First Nations communities.

- ↘ HIV/AIDS — Although Aboriginal people represent only 3.3% of the Canadian population, they comprised 5-8% of prevalent infections (persons currently living with HIV infection in Canada) and 6-12% of new HIV infections in Canada in 2002. Aboriginal people are being infected with HIV at a younger age compared to non-Aboriginal persons. (Health Canada, 2005a)

- ↘ Aboriginal people have rates of diabetes three to five times higher than the rest of the population (Health Canada, 2005b)

- ↘ Youth suicide is 5-7 times higher in First Nations youth than in the general youth population. (Health Canada, 2005)

- ↘ Poverty — urban poverty is high. In Greater Vancouver this ranges from Burnaby's 40.8% to Vancouver's 66.1% [of the Aboriginal population] (Lee, 2000, p. 83)

- ↘ In addition, there are other socially determining factors including higher rates of unemployment and inadequate housing.

Some or many of these factors may intersect with the person's identity as two-spirit, further disenfranchising individuals.

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▊ Service Delivery Issues Specific to Two-spirit People

↘ Identification as two-spirit versus LGTB
> Many contemporary gay men and lesbians are not comfortable with the denominations "gay," "lesbian," or "bisexual," and feel rather if they had been grouped into these categories by the power of the English language alone. In contrast, the terms "two-spirit" or two-spirit people" seem more acceptable for many Aboriginal people. (Ryan, Brotman and Rowe, 2000, p.117)

↘ Access to services for two-spirit people is intrinsically linked to their cultural identity. Separating out service barriers based on sexual orientation and gender identity versus cultural discrimination may not be easily achieved. Mainstream service providers must consider the intersection of racism, homophobia and heterosexism.

↘ Referring two-spirit people to Aboriginal-specific services may be problematic as they may experience discrimination within these settings, based on their gender identity or sexual orientation. The service user may not want to use culturally-specific services for reasons of confidentiality and anonymity. Check with service users if this is an issue before making referrals to such services.

↘ There are specific cultural rites and symbols associated with two-spirit people. These may vary depending on regions or beliefs of a specific nation. Service providers should become familiar with these rites and symbols, particularly if they expect their practice to bring them into frequent contact with two-spirit people.

▊ Public Health and Prevention Factors Specific to Two-spirit People

↘ Targeting — two-spirit people are a minority within minorities, i.e. LGTB and First Nations communities. Ensure that they are represented in public health and prevention projects. For example, make sure that there is imagery, acknowledgement and representation of two-spirit people in campaigns and health education materials.

↘ Engagement and participation — invite, support and include two-spirit people in the planning, implementation and evaluation of public health programs for which they will be part of the target community. Participation in a conventional bureaucratic health or even community setting may be difficult as there is a relatively small population which is frequently called upon to represent two-spirit people. Participation is often in a voluntary capacity which increases the potential for participant fatigue. You may need to negotiate with individuals to find the best way to be involved.

↘ Don't assume that all First Nations people will be familiar with or identify with the term two-spirit — refer to module two's 'culture' section for more information.

For further information:

↘ Expert resources have been developed regarding access to health and social services for two-spirit people for the Canadian Rainbow Health Coalition. These have been developed by the Two-spirit People of the First Nations organisation. Visit Canadian Rainbow Health Coalition website www.rainbowhealth.ca

↘ Two-spirit People of the First Nations website on www.2spirits.com. There are a number of good resources available on this site that will help the learner gain a better understanding of two-spirit people and the issues confronting them.

↘ Urban Native Youth have an informative document available via their website. The document *Two Spirit Youth Speak Out* can be downloaded at www.unya.bc.ca/pspubvid.htm

↘ Two Spirits Circle of Edmonton Society website on www.twospirits.ca The Two Spirits Circle may be able to provide the learner with a more distinctly western Canadian perspective.

Action you can take as a service provider to be more LGTB-inclusive

As a multicultural society, we have gained a respect for diversity and the need to provide service in a manner that is relevant to and respectful of the service user. Though far from perfect, attempts have been made to recognise and respond to different cultural needs by service providers. One example would be the provision of health education materials and health care services in languages other than the two official languages; others would include recognising dietary needs in relation to spiritual beliefs and celebrating the holidays of faiths other than Christianity. Many of these actions and considerations have become inherent in the way health and social services are delivered. Including LGTB community considerations simply adds another dimension to the way the service provider delivers their service.

Understanding what actions might be taken to achieve this inclusiveness is the focus of this section. It is intended to provide the health and social service provider with practical ideas and action to challenge heterosexism, thus reducing LGTB-phobia in the health and social service sectors.

Exercise   *Part 1 — As a group or individual exercise, brainstorm what an LGTB-inclusive workplace would include. If done as a solo activity, get feedback from the group so that everyone has access to the ideas.*

Part 2 — Ask the group to consider what actions would need to be taken to achieve an LGTB-inclusive workplace. In what order would these need to be pursued? Why?

Prompts for facilitated discussion –
   ▼ *Who needs to be on side?*
   ▼ *How might awareness be raised?*
   ▼ *What resources are required?*

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■ Creating a More LGTB-Inclusive Service Environment

Policy

   ▷ Having a written policy commitment to inclusion of LGTB people is an important starting point. It underpins the organisation's procedures and practices relating to LGTB people. The policy commitment may be a stand-alone document or part of a broader diversity commitment. A policy statement is only as good as the organisation's preparedness to act on it. The most beautifully written policy statements are not worth the paper they are written on if they are simply there to fill a space on a shelf or to meet an organisation's requirement for accreditation.

   ▷ Good LGTB-inclusion policy should include staff as well as service users.

   ▷ The policy should refer to all of the following issues.

Physical environments and signs

   ▷ Physical signs will attract people into the service and welcome them when they access it. Signs include such things as:

        > A rainbow sticker on the door or window.

        > Posters and signage that depict LGTB people, i.e. not only same-sex couples, but also images of queer families, etc.

        > During Pride week, posters or acknowledgment of the occasion

   ▷ Building environments should include at least one washroom that is non-gender specific and provide privacy, to meet the needs of trans clientele.

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Staff knowledge and skills

▷ LGTB awareness on the part of the staff is the basis from which all employees should work, from the reception personnel through to senior clinicians and management. The first point of contact is as important as the service that is to be delivered. Clients need to feel comfortable and welcome on arrival. A rainbow sticker on the door needs to be supported by knowledgeable and approachable staff. All staff should undergo some type of awareness training.

▷ Staff should understand the legal and 'professional rights' of LGTB people so that they ensure their practice respects these rights.

▷ Practitioners need to understand the issues impacting on the health and well-being of LGTB clients and communities. To achieve this, they must have some understanding of the impacts of heterosexism and LGTB-phobia.

▷ Practitioners should develop methods of working with clients that are not based on heterosexist assumptions, i.e. gender of partner, marital status etc.

▷ Make information available to staff re LGTB training and conferences and encourage and support attendance.

Education materials and publications

▷ Ensure that education materials, including brochures and fliers, do not use offensive or heterosexist language.

▷ Including symbols (as described above) will increase interest from people of the LGTB community.

▷ Include pictures and examples that reflect LGTB people as well as other groups

Information collection

▷ Forms and documentation should include opportunities for gender identities other than male/female, while identifying relationships in an equally open way, allowing the service user to define the status and name of other person(s) — partners, friends, family, or family of choice — important to them in regard to health and social service

▷ Information about a person's sexual orientation or gender identity is important but not always necessary. Collect and document this information when required.

▷ Have a method for documenting this information that is consistent and respects the persons' privacy. Writing 'homosexual' in large letters across the top of a clinical file is not appropriate documentation of this information.

▷ Develop skills and techniques for eliciting this information that are sensitive and allow the practitioner to gather the information with ease and comfort. This will in turn put the client at ease.

■ What is your professional responsibility to deliver services to LGTB people?

There are several levels of guidelines which indicate the need for health and social service providers to practice in a manner which is inclusive of all people. Federally, the Charter of Rights and Freedoms and the Canada Health Act make reference to freedom of discrimination and access to services without barriers.

▷ The Canadian Charter of Rights and Freedoms makes it illegal to discriminate based on sexual orientation.
'The courts have also recognized other grounds of discrimination that are not specifically set out

in the *Charter* such as sexual orientation and marital status. This section came into effect in 1985'(Dept of Justice Canada, 2003, Equality Rights Sec.15).

▷ The Canada Health Act states '…the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or **other barriers**'(Dept of Justice Canada, 2004, Canadian Health Care Policy).

Professional bodies or provincial colleges may also make reference to discrimination based on sexual orientation. It is best to visit the *code of ethics* and or *standards of practice* for the applicable profession. Below is an example from the Registered Social Workers in BC Standards of Practice.

'3.4 Social workers do not discriminate against anyone based on race, ethnicity, language, religion, marital status, **gender, sexual orientation**, age, ability, economic status, political affiliation or national origin' (Board of Registered Social Workers in BC, 2004, p.4, Standards of Practice 3.4)

Employers will also usually have their own references to discrimination and or inclusion based on sexual orientation. At this juncture, it is less common to see reference to gender identity, but hopefully this exclusion will soon be overcome. It is recommended that practitioners familiarise themselves with their employer's position on discrimination or — even better — their commitment to diversity. Being familiar with these policies also enables the practitioner to become an advocate for greater inclusion. If the employer hasn't included sexual orientation and gender identity, find out why not and explore how this can be rectified.

These few examples serve to demonstrate that there are legal and binding grounds to deliver an LGTB inclusive service. The fact that they have frequently been thwarted in the past does not mean that they should not be adhered to in the present.

Case Exercise

You are in a supervisory role and are responsible for the allocation of clients to a group of practitioners in your service. You have allocated a young Lesbian to a practitioner who you think is best able to provide the service. The practitioner returns the file to you with a note that says 'I don't work with those people.' You learn that the practitioner's refusal to work with this client is based on their discriminatory beliefs about LGTB people.
What steps might be taken to address this issue?

▼ *Who needs to be on side?*
▼ *Review all applicable legislation and practice guidelines*
▼ *Identify the barriers for practitioner*
▼ *Provide educational opportunities*

Ethical question for discussion — Is it okay to allow the practitioner to refuse to work with this client? Would there be any exemptions?

Summary

Upon completing this module, the learner will have been introduced to a number of aspects of LGTB community life which should be considered when planning or delivering service. Symbols, celebrations and language are all factors that have the potential to impact on health and well-being, whether as a sign of inclusion or declaration of self-empowerment. Health and social service sectors will improve their service by understanding what these are and their significance to community.

The LGTB combination has many inter-related, if not synonymous needs and issues. They also have many differences which must be taken into account when planning and delivering services. The challenges, strengths and even illnesses which can be specific to each of the communities have to be seen individually. What works for gay men, lesbians and bisexual people isn't necessarily going to work for trans or two-spirit people and vice versa. The synopses provided for lesbian, gay, trans, bisexual and two-spirit health were intended as an introduction and to encourage further exploration of the unique qualities and needs of each component of the LGTB group. Each of these areas has the need and potential to be examined in much more detail. Specific modules or other more detailed course material on these is required but beyond the scope of this document.

The need to be more LGTB-inclusive in the health and social service sectors starts with change in policy and practice. The final segment of the module begins to introduce the learner to practical considerations that can be made toward greater LGTB-inclusion, through these steps. In doing so, it provides a prologue to module four, where these factors will be considered in relation to the power and responsibility of health and social services to act as agents of change for greater LGTB-inclusion.

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LGTB Health Matters

Knowledge Assessment Pre and Post

The following statements are based on the material presented in module three. The statements are either true or false. Please read each statement and mark a T or an F beside the statement that best reflects your knowledge and understanding of the material. This tool is intended to be used before delivery of the module content and again following. It is suggested that learners take some time to compare their answers and consider how their knowledge and attitudes have changed.

		True or False			True or False
01.	Terms like queer, fag and dyke are always offensive.		11.	There are no specific considerations necessary when providing a service to bisexual people.	
02.	The rainbow flag is a symbol that LGTB people are welcome.		12.	Bisexual men could account for as much as 46% of the male population and bisexual women for 25% of the female population.	
03.	Having separate spaces and activities for LGTB people only marginalises them further and therefore cannot be good.		13.	Heterosexism doesn't apply to bisexual people because they are attracted to people of the opposite-sex.	
04.	Today's Pride celebrations have their roots in activism and the fight for equal rights for lesbians and gay men.		14.	Once a transsexual person has had sex reassignment surgery, they no longer have to worry about conditions affecting their birth sex.	
05.	Public health interventions usually target lesbians as a separate population.		15.	People who experience gender transition always have sex reassignment surgery.	
06.	Lesbians have been found to have higher rates of smoking and a higher body mass index than heterosexual women.		16.	When Canada was colonised, First Nations people and Europeans shared the same understanding of sexual orientation and gender identity.	
07.	There is rarely or never violence in a lesbian relationship.		17.	Two-spirit people are dually marginalised because of their aboriginality as well as their sexual/gender status.	
08.	The only thing different about gay men's health from heterosexual men is STIs & HIV/AIDS.		18.	The practice of using a rainbow sticker to indicate that LGTB people are welcome needs to be accompanied by knowledgeable staff and an LGTB-positive environment.	
09.	The term 'gay men' is synonymous with the term MSM (Men who have Sex with Men).		19.	If I don't feel comfortable around LGTB people, I am not legally required to provide a service to them.	
10.	Certain sexual behaviours can put gay men at higher risks of hepatitis A & B.		20.	The Charter of Rights and Freedoms protects people from discrimination based on sex, which is read to include sexual orientation.	

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Module 4

The Health and Social Service Provider as an Advocate for LGTB Inclusion

LGTB Health Matters

Introduction

This module is designed to assist health and social service providers in examining their role in either perpetuating or mitigating and eradicating practices that exclude LGTB people in their sectors. It considers their role of power and that of their sector, offering practical examples as to how these power imbalances might be overcome. There is a focus on systemic change, highlighting the need for strong policy commitment, education, and advocacy, behavioural and attitudinal change. Each strategy, although significant in its own right, depends on the others to achieve real and lasting change. The health and social service provider must understand this relationship and how they can impact on it, whatever their status or position within their sector. Whether they have the power or position to lead on major policy shifts or simply the capacity to act locally to create more LGTB-inclusive service settings, each individual or organisation has a role to play.

Module four also discusses issues relating to community engagement and the participation of LGTB populations in the health and social service sectors. LGTB communities have successfully self-advocated for all of their rights and therefore play an integral role in change within the health and social service sectors. The service sectors need to recognise this potential and work with these communities to develop services which better reflect the needs and experiences of LGTB people.

The need for appropriate local research and steps that might be taken to overcome this lack form the closing discussion for this module. This section highlights some of the challenges with existing research, followed by practical recommendations on how people with an interest in LGTB health and wellness might initiate or advocate for research.

Health and social service providers are important change agents who possess substantial power and resources. If they are heterosexual or non-trans they have even greater privilege to bring to their role of ally. When these resources are marshalled and directed, they have the capacity to make a difference in the health outcomes of LGTB people and communities.

Preparation and Prerequisite
▼ Module one & three required
▼ Module two beneficial

Learning Outcome
Learners will critically evaluate access to LGTB health resources in order to support self-directed learning and advocacy for system change

Learning Objectives
1.) Participants will develop an understanding of their role and responsibility in making health and social services more LGTB-accessible, by combating the effects of heterosexism and LGTB-phobia and advocating for systemic change.
2.) Participants will gain practical skills and knowledge of how they can influence change to create greater LGTB inclusion in their work and service delivery places.
3.) Participants will possess knowledge about the relationship between systems and LGTB individuals and communities.

Power, Health and Social Service Services and the LGTB Community

Health and social services are an integral part of Canadian society and for some Canadians even contribute in defining the national identity. They are significant entities which consume a considerable percentage of the Gross Domestic Product (GDP). Health spending alone accounts for approximately 10% of the GDP (Canadian Institute for Health Information, June 9, 2004). The extensive social service sector is indicative of Canada's past commitments to a welfare state and its values of greater equality. As both significant social indicators and substantial economic commitments, health and social services play an important role in Canadian life. They have the capacity to affect the health of the population through income, housing allocation, preventative and treatment services, making these sectors powerful entities within our society as a whole.

In modules one and two, the impacts of heterosexism and LGTB-phobia in health and social services were identified and discussed. The impacts referred to the establishment and delivery of services based on the assumption that all people are heterosexual or non-trans. This assumption creates a power imbalance for populations who do not neatly fit into heterosexual or non-trans groups. The combination of large and powerful service systems in conjunction with the minority status of LGTB people has the potential to put them at a greater disadvantage when seeking services. For this reason, the service provider must be cognisant of their role in either perpetuating or mediating the unequal power relationship between the service sector and LGTB person.

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Addressing the Power Imbalance

There are lessons to be learned from multiculturalism. 'Because, like racism and sexism, homophobia is learned, it can be unlearned' (Tate & Longo, 2004, p. 31). So too can many of the practices that are resultant of these attitudes. In addition to 'unlearning,' there is a need to develop new approaches and practices to serve all populations better. As the health and social service sectors have learned, within the dominant culture service system there are ways of meeting the needs of minority ethnic groups. Use of language interpreters, acknowledgement of special holidays, dietary needs and birthing rites are just a few of these practices. These actions all reduce the power imbalance between the service user and the provider or dominant system. The application may not seem as obvious for the LGTB client, but there are still many actions that will assist. Below are some points to consider:

Creating a Respectful and Welcoming Environment

➘ From the time an individual enters a service delivery site, there are means in which they can be made to feel a valued partner in the service interaction. Previously, the importance of symbols, posters and information specific to LGTB people has been identified. Providing this type of environment sends the message that LGTB people can expect to be treated with dignity and respect.

➘ Offering verbal cues to open dialogue and disclosure indicates a safe and respectful environment.

➘ In other service delivery sites — such as an individual's home — the power relationship might be reduced by having the visiting service provider positively acknowledge indicators of a person's sexual orientation or gender identity. (For example, positively acknowledging images, queer memorabilia or photos that the person may display in their home.)

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↘ For LGTB service providers, power imbalances in the workplace can be addressed through equal treatment and valuing of an individual's personal life, such as acknowledgement and inclusion of the individual's life partner and family at work functions. Once again, ensuring that language is appropriate and respectful is critical. This will be discussed in more detail below under *behaviour*.

◼ Documentation

↘ The manner in which documentation is constructed serves to disadvantage LGTB people. Lack of opportunities to describe their life circumstances adequately can be marginalising and disempowering.

↘ Providing options to reflect a range of gender identities other than male and female as well as different types of relationships can be an important starting point. By not requiring the person to alter options or write in alternatives, the service provider sends a message to the service user that they are a part of a community served by that provider, rather than an anomaly.

Case Example

Jenni and Margot have just become Moms and now need to register the baby's birth. They have heard about different options in the Registration of Live Birth form — one refers to 'mother and father' while the other refers to 'parents.' Jenni and Margot obviously want to complete the form referring to parents, but fear they will have to challenge the system to utilise this option. It seems like just one more hurdle they will have to overcome. However, when the nurse approaches them to complete this form, the couple is pleasantly surprised - they are asked which form is appropriate for their situation. They are then presented with the necessary and appropriate Registration of Live Birth form.

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Acknowledgement of sexual orientation and gender identity

↘ Positively acknowledgement of a person's sexual orientation or gender identity by their service provider is a significant step in establishing a relationship. Lack of acknowledgement or the discrediting of an individual's sexual orientation or gender identity (for example, giving less respect or acknowledgement to a same-sex relationship than a heterosexual one) can form powerful components of heterosexism and LGTB-phobia.

↘ 'We treat everyone the same here.' This is not necessarily an endorsement of good and inclusive service. Instead, this phrase can often imply there is no need to acknowledge individual difference or uniqueness. Ensure that the service user is aware that they can expect to be treated fairly and without discrimination, but also their sexual orientation or gender identity will be considered where appropriate within the context of service delivery. Including and displaying statements of inclusive practice or a service charter highlighting this policy is an option.

↘ Including same-sex partners or families of choice in service delivery communicates greater equality with the dominant group.

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Rachael is attending her first appointment for a pap smear in a long time. She has always found the health system very intimidating and has been the recipient of homophobic treatment and as a result she avoids it. Her girlfriend has encouraged her to try the community health centre as she had heard that it was 'quite queer-friendly'. Rachael arrives with some trepidation. The first thing she notices is a rainbow flag sticker on the door followed by information in the waiting room about a support group for same-sex parenting. She finds this reassuring but remains pessimistic that things will be different when she meets the nurse.

Prior to the procedure the nurse asks Rachel questions about her overall health, including sexual health. Unlike other visits there is no assumption made that Rachael's sexual partner is a man, nor any insistence that she should be using contraception. On completion of the examination, Rachael is provided with sexual health education materials for lesbians.

Prior to departure Rachael makes an appointment to see a doctor about some other health issues that she has been avoiding.

Critical Thinking Questions

1. Health and social service providers are in a position of power because

_____ .

2. How might the power imbalance between health and social service practitioners and LGTB people be exacerbated by the   a) individual practitioner,   b) service setting?

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▌Summary

The service provider must be aware that they are a part of a system that is inherently disempowering due to its structures and size. This is further compounded when working with a minority group which does not enjoy social approval or endorsement. Understanding the role that the service provider plays in the power imbalance will assist in mitigating these disadvantages and delivering a more equitable service.

Systemic Change

There are many strategies and undoubtedly innumerable methods that might be employed to induce systemic change, creating more LGTB-inclusive health and social services. This section will consider four main strategies, while posing questions and offering practical methods to assist the learner in better understanding the need for systemic change and tactics for achieving this change.

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■ **Policy**

Does your organisation or the system within which you work have a policy that explicitly refers to LGTB inclusion in service delivery? This is an important starting point and the foundation of quality service delivery. It is a component that currently is absent in most health and social service agencies.

A policy stating the organisation's commitment to LGTB-inclusive services provides the necessary under-pinning to introduce change via other strategies and methods. The policy must be more than a few 'warm and fuzzy' lines about valuing and inclusion of LGTB individuals. If there is no plan to implement the policy, it will lack the capacity to bring about the necessary change. The policy needs to reflect your governing body's belief and commitment to fairness and inclusion of LGTB people, while reaching the varying levels of decision-makers from governance through to management.

So, what might a good policy on LGTB inclusion in health and social service include? The following are some ideas to consider when reviewing or developing LGTB policy in the health or social service sectors.

Rationale

�’ What is your organisational commitment to LGTB-inclusion based upon?

�’ Does it make reference to important legislation and charters? Examples might include the Charter of Rights and Freedoms or other legislation referring to hate crimes or discrimination.

�’ Is there acknowledgement of LGTB as a population group, including demographic and health data? Statements like 'We are committed to providing services to a diverse community including people with disabilities, aboriginal people, people of other cultures, LGTB, etc.' do not indicate any specific commitment to any of these groups.

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Stakeholder and stakeholder participation

�’ Stakeholders should be identified, i.e. lesbian, gay, transgender, bisexual, two-spirit, questioning, etc. If there are specific groups or community interests, identify them as well.

�’ A strong policy will describe the organisation's intention to engage and work with the LGTB communities. Approaches might include formal consultation, representation on committees (advisory or decision-making) or ongoing liaison with existing LGTB serving groups or organisations.

Policy commitments

�’ Policy should reflect all stages of the service interaction, from the point of entry to departure. Therefore LGTB-inclusive policy should reflect the organisation or sector commitment to everything from providing a welcoming environment to the assessment and consultation process. For preventative services, it may include identifying and working with the LGTB communities or components of those communities for targeted issues such as smoking cessation.

➢ The policy needs to articulate the main strategies being employed to address necessary organisational change, i.e. education and ongoing training.

➢ Although specific actions and resources to implement policy may not be identified in the policy document, they should exist in one of the organisation's operational plans, i.e. corporate, strategic and budget.

➢ Some organisations' human resources policy may make reference to LGTB employees or employees of diverse backgrounds. If this reference does not exist, the policy document may provide the opportunity for some reference to LGTB employees and visitors.

These few points are intended to provide the learner with a basis to critically appraise or develop an initial policy on LGTB inclusion in health and social services. It is expected that many other factors will emerge once a policy development process is undertaken.

Education

Education is a powerful agent of change and an important precursor to action. In previous modules, the lack of education on LGTB issues for health and social service providers was identified. Attempts to introduce LGTB content to undergraduate education form part of the solution in overcoming this knowledge deficit, however the vast majority of service providers in these sectors are already practicing. This means a commitment to continuing education from both employers and practitioners.

An LGTB education strategy for health and social service providers should not attempt to create 'specialists,' instead aiming to create a level of knowledge and awareness that enables all service providers to provide LGTB individuals with sensitive, relevant factual services.

An effective education strategy should:

- Be a mandatory requirement.
- Include all staff, from reception and telephonists to service providers, including management and governance.
- Ensure that all staff possess a level of knowledge and competence on such issues as human rights, language, importance of confidentiality, etc. in relation to LGTB clientele.
- Promote inclusion within the employee group as well as for service recipients.

The onus to possess adequate skills and knowledge rests with the practitioner, their educator and employer — not with LGTB individuals. Many people will be open to sharing their experiences or knowledge, but it is not the service user's responsibility to teach health and social service provider's general awareness and or understanding of LGTB issues. People are often vulnerable or compromised when interacting with these systems. Having to explain the difference between gender identity and sexual orientation should not have to be part of their experience.

Behaviour and Attitudinal Change

As important as the policy and education strategies are, the ultimate goal is for positive behavioural change. To differentiate behaviour as a strategy rather than an outcome, this section will consider a number of practical methods.

Language as a reflection of attitudinal shifts

Appropriate and respectful language is a major part of positive behaviour change. This has been witnessed with other minority groups. Discarding the language of oppression and terms with negative connotations helps an oppressed group develop more positive self-descriptions. For example, we no longer refer to people with an intellectual disability as being an imbecile, idiot or retarded. These previously used diagnostic terms had taken on negative social inference.

The use of language as an element of change in health and social service settings should include:

- Prohibition of negative or questionable terms referring to LGTB people in the practice setting.

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➘ Inclusion of reclaimed language on the list so that people learn to use it appropriately.

➘ Reconsideration of the use of clinical descriptions which depersonalise the individual. For example, using terms gay or lesbian rather than the more clinical 'homosexual.'

There was a more detailed discussion of language in module three, describing terms and some of their impacts.

Zero tolerance

Health and social service settings need to develop workplace norms which disapprove and ultimately negate homophobic behaviour and attitudes to reflect policy commitments. As discussed below, personal responsibility, peer disapproval, real and actual consequences are all part of intolerance of LGTB-phobic behaviour.

➘ The personal responsibility of practitioners to not act in an offensive or LGTB-phobic manner is the crucial first step. All practitioners must know that this is first and foremost their responsibility. This point can be reinforced by including this responsibility in staff charters or agreements.

➘ The role of peer disapproval can be a powerful change tactic. Staff members who correct or admonish their peers' inappropriate behaviour help create an environment whereby LGTB-phobic behaviour, including language, will not be tolerated. Conversely, silence may give tacit approval.

➘ Service providers need to know that LGTB-phobic attitudes and behaviours are not tolerated and that there are consequences for displaying such attitudes and behaviours. Consequences need to be known and executed as an indication of commitment to LGTB-inclusion. Few health and social service settings would now tolerate blatant use of racist language or exhibitions of racist behaviour because it is known that there are consequences. The same considerations must be made for LGTB populations.

➘ These practices and sanctions need to exist for the protection of staff as well as service users.

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Advocacy

Health and social service providers have the potential to be strong allies and advocates for greater inclusion of LGTB people, ranging from practice to policy change. Advocacy may take on many different styles, from individual through to systemic, and the advocate's role may vary from supportive to lobbyist. In some cases it may be a support worker advocating for the rights of an individual with whom they work; in others, it may be a group or professional organisation lobbying for equal treatment.

What stops you from being an advocate?

As an advocate, the individual service provider may need to assess their own position on LGTB issues prior to attempting to change the system within which they work. How far are you prepared to push for greater inclusion? What implications might this have for you?

What can be done in an individual service setting?

Below are some actions that the individual practitioner or service setting might consider as forms of advocacy for greater LGTB-inclusion.

➘ Determine your organisation or sector position on LGTB-inclusion. Is there a policy or other commitment? If not, start asking questions as to why not and propose solutions. A good advocate must be prepared to be as much a part of the solution as a critic of the problem.

⬊ Establish a group of like-minded practitioners to work together on change.

⬊ Identify LGTB-phobic or heterosexist policies or practices and suggest strategies for overcoming them.

⬊ Suggest environmental changes that reflect diversity, including LGTB diversity.

⬊ Support affirmative measures and actions to include LGTB members of community, i.e. representation on advisory committees.

⬊ Participate in political action to support LGTB rights. This can range from minor actions such as wearing a rainbow sticker on your name tag or signing petitions through to participating in an organised rally.

⬊ Use the size, position or influence of your organisation or sector. Health and social service organisations and professional bodies have immense capacity to institute change when motivated. The individual practitioner or small group may first have to initiate the interest of a larger group/body in order to take action.

⬊ Join in with other advocacy groups. For example in BC, the Hospital Employees Union has a Lesbian and Gay Standing Committee, advocating for greater equality for LGTB employees as well as improved access to health services for LGTB community.

Case Example

Gillian has an interest in lesbian and bisexual women's health issues but notes that there seems to be very little interest or action on this topic within her profession. She has observed the growing interest in gay men's health, which includes articles in her professional organisation's magazine. She decides to take action and approaches her professional body, making a request to establish a lesbian and bisexual women's health interest group. She receives support and advertises through the next monthly newsletter asking for interest. Gillian's call results in seven other women expressing interest. They have organised themselves and set about establishing methods to get greater recognition within their professional body and the local health authority.

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Critical Thinking Questions

1. How is the success of these strategies (policy, education, advocacy & behaviour change) interdependent? Why is each important?

2. If we are treating everyone 'nicely', why do we need to worry about all of this?

3. Why isn't it enough to give everyone some sensitivity training?

Community Capacity

LGTB people are not hapless victims, no matter what their health outcomes are or their need of allies and advocates. Therefore the service provider should not underestimate their capacity and success in negotiating rights. In fact, most of the human rights — if not all — that LGTB people have achieved have been the result of successful self-advocacy. These have often been legal fights involving the highest courts in the land. Some of these have been for health-determining rights, such as access to pensions, i.e. Egan and Nesbit versus Canada (refer to Appendix B, history 1995). In previous modules, reference has been made to the role of lesbian and gay people as advocates for services during the early days of the HIV/AIDS crisis, resulting in the development of an entire sub-sector of health services. This history means that there are skills and networks that can be utilised within the LGTB communities to create more inclusive health and social services.

There are several ways in which health and social service providers can engage and draw on the capacity of the LGTB communities to build greater inclusion.

LGTB community engagement

Below are some considerations and suggestions the health and social service provider might make when attempting to engage with LGTB people and communities.

↘ Are there readily identified agencies or community leaders with whom to work? These might be business people, organisations or known community groups. Approaching organisations like the *Vancouver Pride Society, The Centre or Gay and Lesbian Business Association (GLBA)* as a starting point will lead to many other connections. In Vancouver the GLBA also compiles an annual directory of business and community organisations operating within the LGTB communities. Engagement at this level may be helpful to make deeper connections within the LGTB communities or form a relationship with broader implications such as community consultation.

↘ Many larger centres have LGTB-specific media. Whether a formal newspaper or a newsletter, these can be used as a source of engagement. As a health or social service provider, you might like to review some of these publications to get a sense of what is happening in community and what the needs are before approaching. Media also serves a valuable role in reaching community members, either through articles or advertising. In Vancouver the main publication is *Xtra West*.

↘ Relationships with individuals rather than organisations offer another means to engage. Seeking the advice or assistance of an LGTB friend or colleague may provide you with contacts within the LGTB communities. There is also the potential to develop a champion who can lead on your cause.

↘ Doing the groundwork: if your organisation or sector is serious about engaging the LGTB communities, you will need to do some preliminary research before you call upon them to deliver or participate. Examples include: having your organisation represented in the Pride parade, having a stall at LGTB festivals or events or providing sponsorship (even partial) for an event. Vancouver City Savings Credit Union (Vancity) has been an excellent example of using these methods of engagement.

↘ There is a need to articulate purpose, to say how and why your sector wishes to engage with LGTB people. The traditional lack of acknowledgment and discrimination against LGTB people within the health and social service sectors might make people question your motivations and interest. Some sections of the LGTB communities may also feel that they have been over-researched with little outcome for them. They may see your attempt to engage as another fruitless exercise from which there will be no gain for them. Attempt to be clear on what your service wants, how it will benefit individuals and community and when results might be seen.

⤵ 'Engaging with the LGTB community', although a convenient heading for discussing methods of engagement, is really a misnomer because it implies that there is only one type of community or point of entry. Like the broader community, it is necessary to use multiple methods of engagement as many people will not identify with the more formalised view of LGTB community. As important as it is to engage people through LGTB-specific entities, it is equally necessary to engage via broader methods. For example, if advertising a consultation on the health of a given geographic community, state that the interests of all groups will be considered — and specify interest in LGTB communities along with other groups or symbolic representation.

Participation in health and social services

Recognition of LGTB people or communities in the health and social service sector has been limited, therefore it is not surprising that the opportunity to participate in decision-making has been equally limited for these groups. Recognising LGTB as distinct populations provides an opportunity for health and social services to engage with LGTB people as they do with other targeted populations, i.e. people with a disability, ethnic communities or First Nations.

⤵ Many public bodies use systems such as advisory or other representative groups. If this is the preferred method of your organisation, creating an LGTB advisory group is an option. Alternatively if there are no such population-specific groups but instead issue groups (for example, an 'access to health care' group) have an LGTB portfolio or rep included.

⤵ Networking and liaison. Invite LGTB-specific groups or organisations to be a part of service delivery networks. Although they may not have a specific health service mandate, organisations like community groups significantly impact on other determinants of health. Having them involved in your networks may aid your work and improve LGTB health access.

⤵ Partnerships and coalitions. Beyond networking and liaison lies the opportunity to establish formal relationships such as partnerships or coalitions. This type of participation has the potential to open doors for the health and social service sector as well as LGTB community organisations to different funding resources and methods of operating. For example, a funding submission between a health authority and LGTB community agency could be written as an application for resources only available to community sector or health sector.

⤵ Consultations. If your organisation employs a system of consulting with specific populations, ensure that LGTB communities are included, especially in areas with high representation.

⤵ As with education, it is not the responsibility of the queer individual to be the voice of LGTB health. Expecting a queer employee or other representative to advocate for LGTB health when it is not specifically a part of their role does not make for good representation. Nor is it fair to the individual.

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Case Example

Pam is a member of a multicultural advisory group that was established for your organisation. You are aware that she is an 'out' lesbian and involved in the local LGTB Pride celebration. It has been suggested that because she is in this group that she will likely comment on LGTB issues. At the first meeting, you ask for clarity about what viewpoints the participants are representing and advocate for an LGTB representative.

LGTB Health Matters

Role of Health and Social Service Provider as an Agent of Change

The role of service providers and the actions that they can take to create greater LGTB inclusion has been identified throughout these modules. Earlier in this module, the power of the health and social service sectors was referred to in the context of the inequity that it creates. As part of this system, service providers have the opportunity to use their positions of power to bring about change through leadership while improving the environment in which services are delivered and work is conducted. Service providers and decision-makers who are also heterosexual or non-trans have further capacity to be advocates for change because of their sexual majority status.

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Leaders

➘ Individuals and organisations alike can be leaders on greater inclusion of LGTB people.

➘ As a practitioner, leadership for LGTB-inclusive practice could include the way in which you conduct an interview, collect a history or present a case. For example, a practitioner might include issues relating to how a person's sexual orientation or gender identity might be impacting on the reason they are seeking service. Practitioners have the potential to influence the team in which they work by using appropriate language and correcting other's misuse.

➘ Managers have the capacity to influence the practice and behaviours of their subordinates through education, policy and role modelling. They also can create change within their peer groups through similar techniques. They have access to other levels of management and governance and the opportunity to work upwards.

➘ Governance holds the right and capacity to set policy and steer the organisation. Using documents like corporate plans or their equivalent, governance bodies often have the option to direct resources to support change. Through their own practices, they can demonstrate inclusive practices that shape the ethos of an organisation.

➘ As well as individuals or groups within the health and social service sectors, the organisation itself has the ability to be a change agent. Through demonstrating inclusive practice and policy, an organisation has the potential to bring about change for greater LGTB-inclusion within its sector or even geographical community. For example, in many small communities, health, social service and education are often the largest single employers or services. By adopting strong policies around discrimination and greater LGTB inclusion, these organisations send a clear message to the community and create a positive role model.

▐ Creating Welcoming and Safe Work and Service Environments

Throughout this document, reference has been made to the importance of environment and symbols (how symbols might be inviting and so on) but what hasn't been discussed is whose responsibility this is. It has already been established that it is not the sole responsibility of LGTB staff to create an LGTB-inclusive service/work environment, so therefore it should be the job of all service providers. Below are a few points to consider on how this might be done:

↘ That all people within the service/work environment take responsibility to challenge and correct inappropriate use of language by peers and service recipients.

↘ Ensuring that symbols of LGTB communities and pride are accessible and respected. Defamation or removal of materials sends a message of exclusion and disrespect.

↘ Ensuring that people are greeted and treated with the same respect provided to all other service recipients.

Exercise

Lead a group in a brainstorming exercise about what actions could be taken by individuals or their organisations to lead on greater LGTB-inclusion.

▐ Summary

The role of a change agent in creating a more inclusive health and social service sector requires many qualities. This section highlighted two areas: one demonstrating the cultural aspect via leadership and the other the environmental or physical change. There are no doubt many other ways in which an individual or organisation can act to create greater LGTB-inclusion. This section has outlined a few as a starting point.

▐ Research

Throughout the development of this resource, the limitations of research have been obvious in many areas, from availability of research to the LGTB communities's perceptions of being over-researched with no outcome.

What is apparent is the paucity of good Canadian research. This is not a criticism in content of what does exist as much as acknowledgement of the lack of material available. What does exist has provided rich and detailed information that has been most beneficial in preparing this material. However, much of the empirical evidence that has been drawn upon is American, European or Australian. Some generalisations are appropriate but there are major cultural and legal differences in LGTB rights and the systems of health and social services, particularly in the largely private health sector of the U.S.A..

▐ Reach

In contrast to the absence of substantial evidence-based research, there is a perception by some communities that they have been over-researched with little or no outcome. In fact, many groups within the LGTB rubric have been the focus of multiple studies. Despite this there is often little useful available data to support the need for better access to health services.

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Research into LGTB communities and issues can be fraught with sampling bias due to the definitions of LGTB. Many people who either do not identify as LGTB or associate with LGTB communities will be overlooked in research. For this reason most research refers to people who are in some way accessible to researchers via LGTB community sources. This results in an over-representation of these groups or issues because of convenience sampling. One example would be studies on alcohol consumption which have taken their samples through gay or lesbian drinking venues.

Disease and behaviour-specific

Research for some groups such as gay men has frequently focused on HIV/AIDS or sexual behaviour with little recognition of the other aspects of the gay men's health. Such a narrow focal point comes at the cost of understanding what is at the root of the cause. For example, this approach does not examine how heterosexism or LGTB-phobia might impact on diseases or behaviours that lead to certain diseases.

Gaps

There is a disparity in available research between the different components of LGTB. Although gay and trans issues are not adequately or comprehensively researched, there seems to be a greater representation of these interests than there is of lesbian or bisexual health, with the latter being severely underrepresented.

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What can be done?

In order to advocate for greater inclusion and better health outcomes for the LGTB populations, there needs to be a strong and respected evidence-base. Although there is substantial anecdotal evidence within LGTB communities about health-harming circumstances or health-enhancing potential, researchers have been less motivated or able to capture this data and translate it into material that will influence decision-makers or the health outcomes of LGTB people.

There are actions that health and social service providers can take to overcome the lack of applicable research.

- ⬂ Publishing what is being done: whether it is community or organisational research, it needs to be accessible.
- ⬂ Valuing the research that can be done with a smaller local population. Because of the size of smaller populations, the quantitative data might not be as statistically significant as large samples from countries like the US. However, local material can support statistically stronger research that lacks the local content. For example GLHSS (2001, p. 30) estimated that the '…mean GLB smoking rate was 39%' - a very helpful statistic, but its author was forced to use American research. McNulty and rock, paper, scissors (2005) surveyed 269 LGTB people aged 19-35 years living in the City of Vancouver and found that 36% were smokers. This local research can support the American findings and suggest that there is a similar smoking pattern locally. The combination of studies gives more relevance to both pieces of research because of its statistical significance and local nature.
- ⬂ Micro vs. macro: research does not all need to be conducted at a macro level by academics. Practitioners who conduct local research can impact locally and further up the chain of decision-making, changing local practice and policy and eventually creating systemic change. Remember to share what you learn!
- ⬂ Creating an interest for LGTB research. Because of the relatively small and marginalised nature of LGTB communities, there is a potential for research to be devolved and remote. This can

result in research being isolated by sector or geography. Making research ideas and findings more centrally accessible creates a critical mass. It also helps to create interest by more clearly identifying gaps in the knowledge base.

↘ Advocating for research. Research often occurs because people ask for it. Health and social service providers need to request/demand the data to create a need for this research to be conducted.

Critical Thinking Questions

1. In what ways might health and social service providers bring about change through leadership, research and the environment in which they work?

2. What are some of the pitfalls in applying international research findings directly to the Canadian LGTB experience? What is different about how services are organised in Canada, and how might these differences influence research outcomes?

3. Health and social service providers are a part of powerful and respected social institutions. How might this aid or hinder their capacity to be agents of change?

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Summary

Health and social service providers across the spectrum — from direct service to policy and decision-makers — have the potential to play a significant role in creating greater LGTB-inclusion within their sectors. All service providers are in positions of power and have some capacity to shift systems either incrementally or monumentally. Research, policy development, advocacy, education, behaviour change and community capacity building are all skills or strategies available to and utilised by the health and social service sectors. By employing them for the purpose of greater LGTB-inclusion, service providers can bring about the major changes required by these systems.

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Knowledge Assessment Pre and Post

The following statements are based on the material presented in module four. The statements are either true or false. Please read each statement and mark a T or an F beside the statement that best reflects your knowledge and understanding of the material. This tool is intended to be used before delivery of the module content and again following. It is suggested that learners take some time to compare their answers and consider how their knowledge and attitudes have changed.

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		True or False			True or False
01.	The structure of health and social services isn't anymore disempowering to the LGTB community than anyone else.		11.	It might be difficult to engage LGTB communities because they are not a homogenous group.	
02.	Positively acknowledging a person's sexual orientation or gender identity can send a powerful message of equality and inclusion.		12.	If there is an LGTB person of some description involved in my work, they will likely raise all of the necessary issues and ask all of the right questions.	
03.	LGTB-specific health policy shouldn't be necessary if you are nice and treat LGTB service users like 'everyone else'.		13.	Health and social service providers are well-positioned to be agents of change for greater LGTB-inclusion.	
04.	A strong policy is the foundation of effective LGTB-inclusion.		14.	There is really nothing service providers need to do to their physical environment to communicate welcoming and inclusive practices.	
05.	It is up to LGTB people to ensure that health and social service providers know about LGTB issues.		15.	It isn't necessary to do separate research on LGTB populations because they aren't biologically proven to be different from heterosexuals.	
06.	Proper and respectful use of language is a key factor in behaviour change toward greater LGTB-inclusion.		16.	LGTB research is only valid when done by large institutions and highly qualified academics.	
07.	It is okay to occasionally make LGTB-phobic jokes at work as long as you know your co-workers well enough.		17.	There is a shortage of LGTB-specific research available that has been conducted in the Canadian context.	
08.	It's everyone's responsibility to challenge LGTB-phobia. Silence may be interpreted as tacit approval.		18.	Establishing partnerships or coalitions with LGTB organisations or groups is a good means of community engagement.	
09.	There is very little you as an individual can do to create greater LGTB-inclusion.		19.	LGTB-awareness education strategies need to be supported by other strategies like policy and advocacy in order for real and sustainable LGTB-inclusion.	
10.	LGTB people and communities have been strong and effective self-advocates in achieving the rights they now enjoy.		20.	The power and structure of the health service sector is only ever a liability to greater LGTB-inclusion.	

Resources

There are many Canadian and local LGTB organisations which can be accessed via the Internet. This section will provide a number of these resources as a source for further information. Some are specifically health-related where as others may consider broader elements of health including legal rights. The resources listed below form a good reference point when attempting to locate specific services, groups or information including LGTB-specific documents.

The Centre A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and their Allies	**www.lgtbcentrevancouver.com**
Canadian Rainbow Health Coalition	**www.rainbowhealth.ca**
Gay & Lesbian Association of Kamloops GALA	**www.gaykamloops.ca**
Queer Kootenays	**www.queerkootenays.com**
North Okanagan Gay and Lesbian Organization NOGLO	**www.noglo.com**
Gay and Lesbian Saltspring Island (GLOSSI)	**www.saltspring.com/glossi**
EGALE Canada	**www.egale.ca**
Lesbian & Gay Standing Committee Health Employees' Union	**www.pridepages.org**
Positive Space at UBC	**www.positivespace.ubc.ca**
Gay and Lesbian Business Association of Greater Vancouver (GLBA)	**www.glba.org**
Gayway	**www.gayway.ca**
PFLAG	**www.pflagvancouver.com**
Trans Health Program (Vancouver Coastal Health)	**www.vch.ca/transhealth**
Transcend Transgender Support and Education Society	**www.islandnet.com/transcend**
Intersex Society of North America	**www.isna.org**
2-Spirited People of the 1st Nations	**www.2spirits.com**

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Gay and Lesbian Health Services of Saskatoon. (2001). *The cost of homophobia: Literature review of the economic impact of homophobia on Canada.* Saskatoon, SK: Banks.

McNulty Consulting and rock paper scissors, Inc. (2005). *WCGMH tobacco reduction mass media campaign prevalence survey results.* Vancouver, BC: McNulty & Ragan

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Glossary
of terms

Appendix A

Ableism — the cultural, institutional and individual set of practices and beliefs that assign inferior values to people who have developmental, emotional, physical and/or psychiatric disabilities. Discrimination in favour of the (temporarily) able-bodied.

Ageism — a stereotypic and negative perception of ageing and older adults in society. It can include any attitude, action, or institutional structure that subordinates an individual or group on the basis of age.

Ally (heterosexual) — a heterosexual person who supports and celebrates LGTB identities, interrupts and challenges LGTB-phobic and heterosexist remarks and actions of others, and willingly explores these biases within her/himself.

Bashing — physical (or verbal) assault against people who are or perceived to be gay, lesbian, bisexual, or transgender. *Gay bashing also used.*

Bears — a subculture within the gay men's community. "Bears" are men who typically have facial hair, and who are often hairy and/or big (chubby, portly, heavyset). There are many social groups specifically for bears and their friends/admirers.

Biphobia — the fear and dislike of bisexuality. Biphobia exerts a powerful, negative force on the lives of bisexual people. It can include dismissing bisexuality as an inferior or irrelevant expression of sexuality. It can also take the form of disparaging jokes, verbal abuse and acts of violence. Bisexual women and men often face biphobia and discrimination in mainstream society, as well as struggling for visibility and understanding from gay and lesbian communities.

Bisexual — an individual who is attracted to, and may form sexual and romantic relationships with both women and men. A bisexual may feel equally attracted to each gender, or may experience stronger attractions to one gender while still having feelings for the other. Degree of attraction may vary over time. Bisexuality, like homosexuality and heterosexuality, may be either a transitional step in the process of self-discovery, or a stable, long-term identity.

Butch/femme — are terms used by some lesbians to describe their unique expression of gender. Contrary to popular myth, it is rarely about emulating heterosexual gender roles. It is more about a woman's comfort with a particular gender expression.

Classism — a system of beliefs which ranks people according to economic status, "breeding", job and level of education. It is the oppression of poor people and people who work for wages by those control the resources by which other people make their living.

Closeted — being "closeted" or "in the closet" refers to not disclosing one's sexual orientation or gender identity; it is a metaphor usually associated with not being able to tell others that one is lesbian, gay, bisexual, or transgender.

Coming Out — "coming out" or "coming out of the closet" is the process of becoming aware of one's homosexual or bisexual orientation, or one's transgender identity, accepting it and telling others about it. This is an ongoing process that may not include everybody in all aspects of one's life. "Coming out" usually occurs in stages and is a non-linear process. An individual may be "out" in only some situations or to certain family members or associates and not others. Some may never ''come out'' to anyone beside themselves.

Co-parent refers to same-sex partners raising a child together. Sometimes refers to the non-biological or non-adoptive parent raising a child.

Crossdressers refers to people who wear clothing traditionally associated with the opposite gender. Some prefer to crossdress privately, while others crossdress publicly all or part of the time. Crossdressers may or may not have a gender identity related to the clothing they are wearing. Crossdresser has generally replaced the term 'transvestite."

Discrimination dealing with people based on prejudicial attitudes and beliefs rather than on the basis of individual characteristics and merits. While prejudice is a state of mind, discrimination refers to specific actions.

Drag Queens/Drag Kings refers to people who cross dress in a showy or flamboyant way, often for entertainment purposes. "Drag" is a term that is often associated with gay/lesbian communities; some people who perform professionally outside gay/lesbian communities prefer the term "male/female impersonator."

Dyke a lesbian. It can be used as an insult or reclaimed as a positive term.

Fag, faggot a gay man. It can be used as an insult or reclaimed as a positive term.

Family of Choice people forming an individual's social support network and often fulfilling the functions of blood relations. Many LGTB people are rejected when their families learn of their sexual orientation/gender identity, or they may remain "closeted" to their biological relatives. In such cases, it is their partner/significant other and close friends who form their social/support system and who will be called upon in times of crisis.

Family of Origin the biological family or the family in which one was raised. These individuals may or may not be part of a person's support system.

FTM female-to-male. Generally used to refer to anyone assigned female at birth, but who identifies or expresses their gender as a man all or part of the time.

Gay a person who forms sexual and affectionate relationships with those of the same gender; often used to refer to men only.

Gender Dysphoria a term used to describe the feelings of anguish and anxiety that arise from the mismatch between a trans person's physical sex and their gender identity; and from parental and societal pressure to conform to gender norms.

Gender Identity one's internal and psychological sense of oneself as male or female, both or neither (regardless of sexual orientation); people who question their gender identity may feel unsure of their gender or believe they are not of the same gender as their physical body. Third gender is the term sometimes used to describe people who feel other than male or female, and bi-gender refers to people who feel they are both male and female. Often bi-gender people will spend some time presenting in one gender and some time in the other. Some people choose to present androgynously in a conscious attempt to challenge and expand traditional gender roles, even though they do not question their gender identity.

Gender Roles the socially constructed and culturally specific behaviours and expectations imposed on women (femininity) and men (masculinity). Society uses gender roles to differentiate females from males.

Heterosexism the assumption that everyone is, or should be, heterosexual and that heterosexuality is inherently superior to and preferable to homosexuality or bisexuality; heterosexism also refers to organizational discrimination against non-heterosexuals or behaviours not stereotypically heterosexual.

Heterosexual an individual (female or male) who forms sexual and romantic relationships with members of the other gender; also referred to as "straight"; a term people apply to themselves because they feel it represents their basic sexual orientation, even though they may occasionally experience attraction to people of their own gender.

Heterosexual privilege refers to the benefits that heterosexual people automatically have and are denied to lesbians, gay men, transgender and bisexual people in a heterosexist culture.

HIV a virus that attacks the body's defense system, making it susceptible to infection and disease. Can develop into AIDS. Body fluids that can carry high amounts of HIV are blood, semen, vaginal fluids and breast milk. Can be transmitted by needle sharing or unprotected sex (vaginal or anal.)

Homophobia the irrational fear or hatred of, aversion to, and discrimination against, homosexuals or homosexual behaviour. There are many levels and forms of homophobia, including cultural/institutional homophobia, interpersonal homophobia, and internalized homophobia. Many of the problems faced by lesbian, gay, bisexual and transgender people stem from homophobia and heterosexism.
See also biphobia and transphobia.

Homosexual a person who has emotional, romantic and sexual attractions predominantly to the same gender; because this term is associated historically with a medical model of homosexuality, most homosexuals prefer the terms lesbian, gay or queer.

Inclusive Language the use of gender non-specific language (i.e. "partner" instead of "husband") to avoid limiting assumptions and to enhance the accessibility of information and services. Educational, social service, and health professionals are especially encouraged to use inclusive language.

Internalized Homophobia the experience of shame, guilt, or self-hatred in reaction to one's own feelings of sexual attraction for a person of the same gender.

Interpersonal Homophobia the fear, dislike or hatred of people who are or believed to be lesbian, gay, bisexual, or transgender. This may be expressed by name-calling, ostracism, verbal and physical harassment and individual acts of discrimination.

Intersex intersex people (or intersexuals) are individuals who may have external genitalia which do not closely resemble typical male or female genitalia, the appearance of both male and female genitalia, individuals who have the genitalia of one sex and the secondary sex characteristics of the other sex or have a chromosomal make-up that is neither XX or XY but may be a combination of both. Intersex people have

generally rejected the term 'hermaphrodite' as out-dated. An intersex person may or may not identify as part of the transgender community.

LGTB
abbreviated term used to refer to lesbian, gay, transgender and bisexual people. Also interchangeable with GLBT, LGTB, etc.

LGTB-phobia
an inclusive term used to include all forms of homophobia, biphobia and transphobia.

Leather Community
a subculture of people who enjoy the look, feel and smell of wearing leather. In some circles, leather community is synonymous with the 'BDSM community' where bondage/domination and sadomaschistic (BDSM) sexuality is practiced within a context of ethics and consensuality. The leather community is like other subcultures in having (in a limited way) its own dialect, social organizations, and having a set of members who gather together, form friendships, attend community events, etc. Some people use the word 'kink' interchangeably with leather or BDSM while others use 'kink' to denote a broader mix of individuals (heterosexual, bi, gay/lesbian, trans) who engage in a wide range of activities including fetishes, cross dressing, etc.

Lesbian
a woman who forms sexual and romantic relationships with other women; the term originates from the Greek island of Lesbos which was home to Sappho, a poet, a teacher and a woman who loved other women. Although not as commonly used, some women who have intimate relationships with other women may prefer the term 'gay woman' instead of lesbian.

MTF
male-to-female. Generally used to refer to anyone assigned male at birth, but who identifies or expresses their gender as a woman all or part of the time.

Out
to be open about one's sexual orientation or transgender identity.

Outing someone
publicly revealing another person's sexual orientation or transgender identity without their permission.

Pan-Gendered
people who identify and/or express the many shades of gender. Multi-gendered is another way to describe this.

Partner
primary domestic partner in a spousal relationship; may be referred to as "girl-friend/boyfriend," "lover," "life partner," or "significant other."

Passing
a term used sometimes within LGTB communities to refer to people who are not visibly recognizable as LGTB. People who 'pass' may experience less LGTB-phobia and discrimination. Some LGTB people make considerable efforts to 'pass' while others choose to make a political statement through their appearance.

Prejudice
the pre-judgement of a person or group in the absence of valid information about them.

Privilege
refers to the positions of power and authority that people from the dominant cultures hold over minority cultures as a result of being white, male, upper middle-class, heterosexual, etc.

Queer
broad term rapidly becoming more wide-spread in use by LGTB communities. One reason it has gained in popularity is because of its inclusiveness. "Queer" usually refers to the complete range of non-heterosexual people and provides a convenient shorthand for "lesbian, gay, transgender, bisexual." — *see also ''reclaimed language.''*

Questioning
an apt term or self-label sometimes used by those exploring personal and political issues of sexual orientation and gender identity, and choosing not to identify with any other label.

Rainbow Flag/Colours
a symbol of LGTB presence and pride. Represents diversity within the LGTB communities.

Racism
the belief in the inherent superiority of one race over all others. The term refers not only to social attitudes towards the non-dominant ethnic and racial groups but also to social structures and actions which oppress, exclude, limit and discriminate against such individuals and groups.

Reclaimed Language
many LGTB people have chosen to positively use and hence reclaim terms that were previously used by others in only derogatory ways. Some examples are dyke, fag, faggot, queen, and queer. Although these terms are used positively by those reclaiming them, it is still offensive to hear them used by others whose intent is to hurt. Although many LGTB people have reclaimed these terms, there are still other LGTB people who consider any usage of these terms offensive.

Sero-discordant
a somewhat clinical term used to describe a couple in which one partner is HIV-negative and the other partner is HIV-positive.

Sexual behaviour
refers to what a person does sexually; this term refers specifically to actions. A person's sexual behaviour can be different from his or her sexual orientation. For example, some lesbians and gay men may have sex with members of the opposite gender due to desire, outside pressure to conform to heterosexuality, economic need (sex workers) or for the purpose of procreation.

Sexual orientation
refers to a person's deep-seated feelings of sexual attraction. It includes who an individual desires sexually, with whom they want to become intimate, and with whom they want to form some of their strongest emotional relationships. The inclination or capacity to develop these intimate sexual and emotional bonds may be with people of the same gender (lesbian, gay), the other gender (heterosexual) or either gender (bisexual). Many people become aware of these feelings during adolescence or even earlier. Some do not realize or acknowledge their attractions (especially same-sex attractions) until much later in life. Orientation is not the same as behaviour since not everyone acts on his or her attractions. It is also important to note that one's gender identity is totally independent of one's sexual orientation.

Sexual preference
refers to whom one prefers to have sexual and romantic relationships with (homo-sexual, bisexual, heterosexual). It is sometimes used interchangeably with "sexual orientation", but *considered by many to be inaccurate (or even insulting)* because the word "preference" implies choice, whereas the term "orientation" implies that a person is born heterosexual, homosexual or bisexual.

Stereotype   a fixed image that attributes certain characteristics or habits to a specific group distinguished from others based on race, ethnicity, language, gender, country of origin, sexual orientation, abilities, or age.

Stonewall   during a routine police raid of Stonewall Inn, a gay bar in New York, gay men and lesbians fought back for the first time in June 1969, touching off three days of riots and gaining national media attention. This event is considered by many to be the birth of the modern gay/lesbian liberation movement.

Transgender (TG) (trans)   a transgender or trans person is someone whose gender identity or expression differs from conventional expectations of masculinity or femininity; transgender is also a broad term used to describe the continuum of individuals whose gender identity and expression, to varying degrees, does not correspond with their genetic or physical gender, or does not conform to society's assigned gender roles and expectations. Many researchers now believe that transgenderism is rooted in complex biological factors that are fixed at birth.

Transition   the period during which transsexual and transgender persons begin changing their appearances and bodies to match their internal gender identity. Transition may involve a change in physical appearance (hairstyle, clothing), behaviour (mannerisms, voice) and identification (name, pronoun). It is often accompanied by the use of hormones to change secondary sex characteristics (e.g. breasts, facial hair)

Transphobia   the fear and dislike of transgender people. Transphobia can take the form of disparaging jokes, name-calling and violence such as sexual assaults and bashings. Rejection by family and friends, denial of services and job loss are ways in which transphobia exerts a toll on the health and well-being of transgender people.

Transsexual (TS)   an individual who has a gender identity that is not in keeping with their physical body. Transsexual individuals typically experience discomfort with this disparity and seek to modify their body through hormones and/or surgical procedures in order to bring their body closer to their gender identity.

Two-spirit   a term used by some North American aboriginal societies to describe what western societies now call gay, lesbian, bisexual and transgender. Many Aboriginal communities had two-spirit people who were visionaries, were considered to be blessed, and were regarded as spiritual advisors. Often, two-spirit people were mediators within the community/band because it was believed they understood both sides of the disagreement between women and men. Unfortunately, due to colonisation and its devastating effects, many aboriginal people have lost this part of their cultural history and two-spirit people may experience discrimination and violence within their own communities.

Contains definitions adapted from Challenging Homophobia in Schools, GALE, Gay and Lesbian Educators of BC, 2000 and Transforming Community, Resources for transgendered people, intersexed people, and their families, Transcend Transgender Support & Education Society, 2001.

Critical Moments in the History of Lesbian, Gay, Transgender, & Bisexual (LGTB) Persons

Appendix B

What follows are some critical moments in the history of oppression and liberation of LGTB people.
It concludes with legal advances LGTB people have fought for and won in Canada and British Columbia.

1400 BC – 1AD	Greek and Roman era. No conception of sexual orientation as an identity. Sexual relationships between men were accepted as part of culture.
615 – 565 BC	Sappho, living in the isle of Lesbos, celebrates love between women in poems and songs.
1 – 700 AD	Rise of Christianity in Western Europe. Extremely repressive period in which all sexuality except for procreation in marriage is condemned.
1260 – 1600	Rise of intolerance. Inquisition, witch hunts. Heresy equated with same-sex acts. Women punished for violating gender order. First English civil law to call for death penalty for same-sex acts between men (Buggery Law).
1600 – 1800	China and Japan: sex between men tolerated into mid 1700s. Emperors, Buddhists, samurai have younger male lovers. First law punishing male same-sex acts in China.
1600 – 1800	Colonial America: colonists bring prejudices about sexuality with them from Europe. They are scandalized by Native American beliefs about sexuality and nudity. Cross-dressing women and men in some Native American cultures are revered as healers and shamans. Sex between men or between women referred to 'buggery", "the unspeakable sin against God", "sodomy", and "wickedness not to be named among Christians."
1800 – 1860	Liberalizing of attitudes about sodomy in United States and Western Europe. Sodomy is still a crime but not punishable by death. Thomas Jefferson recommends that in Virginia sex between men be punishable by castration and sex between women be punished by having a hole 1+ in diameter bored into the nose cartilage of the offending women. Hungarian doctor Karoly Benkert coins "homosexuality" to describe same-sex acts.
1870 – 1910	Western Europe and United States: rise of the medical profession's influence. Sodomy becomes homosexuality, a topic suitable for scientific study. Doctors develop a typology for a "Homosexual Personality", also called "inverts" and "the third sex", and "men trapped in women's bodies." Medical experts call for the decriminalisation of homosexuality because they are sick, not criminals.
1885	On August 6th, the British Parliament votes to make homosexual acts a criminal offence.

1890s	"Heterosexual" is first used in medical texts to refer to people inclined towards sex with both men and women. By mid 1890s, heterosexual is used exclusively to refer to people who are inclined towards sex with the opposite sex.
1900 – 1930	Rich urban subcultures for homosexual men and women flourish in Germany and the United States. African-American lesbians, gay men and bisexuals form a prominent part of the Harlem Renaissance. "Gay" becomes a code word in the homosexual subculture in the U.S. The "New Woman" (feminists and suffragists) are stigmatized as "lesbians". Doctors "treat" the "symptoms" of homosexuality with a variety of "cures": castration, electric shock, cliterodectomy, hormone injections, lobotomy, untested drugs, commitment to insane asylums.
1910	Magnus Hirschfeld coins the term "transvestite."
1919	Magnus Hirschfeld founds the Institute for Sexology in Berlin, Germany, which becomes the first clinic to serve transgendered people on a regular basis.
1920	Jonathan Gilbert publishes "Homosexuality and Its Treatment" including the story of "H", Dr. Alan Hart's 1917 FTM transition.
1923	Magnus Hirschfeld coins the term "transsexual".
1930 – 1946	Pro-Nazi Forces in Germany target homosexuals as 'un-German". State sanctioned harassment and violence against homosexuals begins under Paragraph 175 of the German Penal Code.
1931	"Genital Reassignment of Two Male Transvestites", is published by Felix Abraham, MD.
1932	Harry Benjamin arranges a speaking tour for Magnus Hirschfield in the U.S.A..
1932	Man Into Woman, the story of Lili Elbe's MTF transition and sex reassignment surgery is published.
1933	The Institute for Sexology is raided, shut down, and its records destroyed by the Nazis. Physicians and researchers involved in the clinic flee Germany. Some, unable to escape, commit suicide in the coming years. Magnus Hirschfeld dies in 1935, an exile in Paris.
1933 – 1944	Hitler becomes Chancellor of Germany and all homosexual organizations are banned. Thousands of homosexual men are sent to concentration camps; few survive. Gay men are identified with pink triangles and lesbians are identified with black triangles.
1938	Di-Ethyl Stilbesterol (DES) is introduced into chicken feed as a means of increasing meat production. Later the drug is marketed to pregnant women to

prevent miscarriage, a claim that is never substantiated. The drug causes serious heath problems in the children whose mothers took the drug while pregnant: endometriosis, cancer, infertility, intersex and possibly transsexuality. (The drug is still available but no longer recommended for pregnant women.)

1941

Premarin®, conjugated estrogens collected from pregnant mares, is first marketed in Canada. Two years later it is marketed in the United States. Premarin is a female hormone replacement, prescribed for menopausal symptoms. Also used for MTF transitions.

1946 – 1960

The post-war period marks return to traditional family values. Cold War begins.

1948

Kinsey study reveals that homosexual behaviour among men is far more wide-spread than previously thought. Research highlights "bisexuality."

1949

Harry Benjamin begins to treat transsexuals in San Francisco and New York with hormones.

1952

Christine Jorgensen is "outed" in the American press. She begins a life-long effort to educate the public about transsexual people.

1960 – 1968

Time of social change with minority voices speaking out in various forms: black civil rights movement, anti-war protests, feminist acvitism.

1961

Illinois repeals its sodomy laws, making it the first state in the U.S.A. to decriminalize homosexuality between consenting adults in private.

1961

U.S.A. Motion Picture Code rules that homosexuality, previously banned from the screen, can be depicted "with discretion, care and restraint."
Everett Klippert acknowledges to police that he is gay, has had sex with men over a twenty-four-year period, and is unlikely to change. In 1967, Klippert is sent to prison indefinitely as a "dangerous sex offender," a sentence which was backed up by the Supreme Court of Canada that same year.

1966

Harry Benjamin publishes The Transsexual Phenomena.

1967

On July 27th, England and Wales decriminalize private homosexual acts between consenting adult men over the age of 21, except for those in the military and police. Scotland and Northern Ireland follow suit in 1980 and 1982.
On December 22nd, Justice Minister Pierre Trudeau proposes amendments to the Criminal Code which, among other things, would relax the laws against homosexuality. Discussing the amendments Trudeau says, "It's certainly the most extensive revision of the Criminal Code since the 1950s the subject matter it deals with, I feel that it has knocked down a lot of totems and over-ridden a lot of taboos and I feel that in that sense it's new. It's bringing the laws of the land up to contemporary society I think. Take this thing on homosexuality. I think the

view we take here is that there's no place for the state in the bedrooms of the nation. I think that what's done in private between adults doesn't concern the Criminal Code. When it becomes public this is a different matter, or when it relates to minors this is a different matter."

1968   Olympic Committee begins chromosome testing of female athletes, effectively banning transsexuals and some intersexed individuals (some of whom were fertile as female, with children) from competition.

1968   Universities begin opening clinics for treating transsexuals; first surgeries performed on non-intersexed transsexuals.

1969   Trudeau's amendments pass into the Criminal Code, decriminalizing homosexuality in Canada, hence homosexuality is no longer a crime under the Criminal Code of Canada.
On June 27th, Stonewall Riots, New York City. During a routine police raid of a gay bar in Greenwich Village, gay men, lesbians, and transgender people fight back for the first time, touching off three days of riots and gaining national media attention. This is marked as the birth of the modern gay/lesbian civil rights movement in the U.S.A.

1970   April Corbet's (neé Ashley) marriage is annulled and Corbet is declared to be legally still a man in spite of a legal sex reassignment, leaving United Kingdom post-operative transsexuals in legal limbo, unable to marry as either sex.

1971   On July 20th, Everett Klippert is released.

1972   George Weinberg coins "homophobia" to describe an irrational fear of homosexuality.

1973   Beth Elliott, aka: "Mustang Sally," becomes vice-president of the Daughters of Bilitis. Soon after, she is 'outed' as transsexual and hounded out of the organization by transphobic lesbian separatists.

1973   New York Trans activist Silvia Rivera is followed at a Gay Pride Rally by Jean O'Leary who denounces transgendered people as female impersonators profiting from derision and oppression of women.

1973   Amercian Psychiatric Association removes homosexuality from its list of mental disorders.

1974   Jan Morris publishes Conundrum.

1976   Renee Richards is 'outed' and barred from competition when she attempts to enter a women's tennis tournament. Her subsequent legal battle establishes that transsexuals are fully, legally, recognized in their new identity after sex reassignment in the United States.

1976

Jonathan Ned Katz publishes the connection between Gilbert's "H" and Alan Hart. He also incorrectly characterizes Dr. Hart as a "lesbian," effectively stealing transgender history.

1977

Sandy Stone is 'outed' while working for Olivia Records as a recording engineer. Lesbian separatists threaten a boycott of Olivia products and concerts, forcing the record company to ask for Stone's resignation. Angela Douglas writes a satirical letter to Sister as a protest of the transphobia in the lesbian community in general and the virulent attacks on Sandy Stone in particular.

1977

On December 16th, Quebec includes sexual orientation in its Human Rights Code, making it the first province in Canada to pass a gay civil rights law. The law makes it illegal to discriminate against gays in housing, public accommodation and employment. By 2001, all provinces and territories take this step except Alberta, Prince Edward Island, and the Northwest Territories.

1978

On January 5th, The Pink Triangle Press (now publisher of Xtra magazine) is charged with "possession of obscene material for the purpose of distribution" and "the use of mails for the purpose of transmitting anything that is obscene, indecent or scurrilous" for publishing an article titled "Men Loving Boys Loving Men" in the Dec. 1977/Jan. 1978 issue of The Body Politic. After almost six years in the courts, including two trials, the case is finally resolved when on Oct. 15, 1983 the deadline passes for the Crown to appeal the second court acquittal. (In the first trial, The Pink Triangle Press had also won an acquittal but upon appeal the Crown won a retrial.) The case results in an important precedent. On June 15, 1982, Judge Thomas Mercer, the judge for the second trial, rules that the article "does, in fact, advocate pedophilia," but says, "It is perfectly legal to advocate what in itself would be unacceptable to most Canadians."

1978

Canada gets a new Immigration Act. Under the act, homosexuals are removed from the list of inadmissible classes.

1979

Janice Raymond publishes The Transsexual Empire, a semi-scholarly transphobic attack. In the book she cites Douglas' Sister letter out of context as an example of transsexual misogyny and casts Sandy Stone's involvement in Olivia Records as "divisive" and "patriarchal."

1979

The Canadian Human Rights Commission recommends in its Annual Report that "sexual orientation" be added to the Canadian Human Rights Act.

1980

On May 2nd, Bill C-242, an act to prohibit discrimination on grounds of sexual orientation, gets its first reading in the House of Commons by MP Pat Carney. The bill, which would have inserted "sexual orientation" into the Canadian Human Rights Act, doesn't pass. MP Svend Robinson introduces similar bills in 1983, 1985 1986, 1989, and 1991. In 1991, Robinson tries to get the definition of "spouse" in the Income Tax Act and Canada Pension Plan Act to include "or of

the same-sex." In 1992 he tries to get the "opposite sex" definition of "spouse" removed from Bill C-55 which would add the definition to survivor benefits provisions of federal pension legislation. All the proposed bills are defeated.

1980   Joanna Clark organises the ACLU Transexual Rights Committee.

1980   Paul Walker organises the Harry Benjamin International Gender Dysphoria Association to promote standards of care of transsexual and transgendered clients.

1981   On February 5th, more than 300 men are arrested following police raids at four gay bath houses in Toronto, the largest mass arrest in Canada since the War Measures Act was invoked during the October Crisis. The next night, about 3,000 people march in downtown Toronto to protest the arrests.

1981   First cases of AIDS begin to appear.

1982   On February 25th, Wisconsin becomes the first state in the U.S. to pass a gay civil rights law. Massachusetts, Connecticut, Minnesota and Rhode Island follow, with Massachusetts passing a law forbidding the placement of children for adoption or foster care with gay people.
On July 27th, The U.S. Centers for Disease Control and Prevention replaces the acronym GRIDS (Gay Related Immune Deficiency Syndrome) with AIDS (Acquired Immune Deficiency Syndrome).

1982   The first Gay (Olympics) Games with 1500 participants is held in San Francisco. USOC sues organisers and prohibit the use of the word "Olympics" in association with the Gay Games.

1985   In October, the Parliamentary Committee on Equality Rights releases a report titled "Equality for All." The committee writes that it is shocked by the high level of discriminatory treatment of homosexuals in Canada. The report discusses the harassment, violence, physical abuse, psychological oppression and hate propaganda that homosexuals live with. The committee recommends that the Canadian Human Rights Act be changed to make it illegal to discriminate based on sexual orientation. In March 1986, the government responds to the report in a paper titled "Toward Equality" in which it writes "the government will take whatever measures are necessary to ensure that sexual orientation is a prohibited ground of discrimination in relation to all areas of federal jurisdiction."

1988   On December 1st, The first World AIDS Day is held by the World Health Organization in Switzerland.

1988   Svend Robinson, MP of the New Democratic Party, goes public about being gay, becoming the first Member of Parliament to do so. Robinson was first elected to the House of Commons in 1979. In 2000, the B.C. riding of Burnaby-Douglas (though its borders have changed) elected Robinson for the eighth time.

1988	U.S. Department of Justice releases a report on hate crimes. Lesbians and gay men are cited as most frequent targets.
1989	On October 1st, Denmark becomes the first country to legally recognize same-sex partnerships, essentially sanctioning gay marriages. The Danish Registered Partnership Act states "Two persons of the same sex may have their partnership registered" and "the registration of a partnership shall have the same legal effects as the contracting of marriage." By 2001, Norway, Sweden, Iceland, the Netherlands and France recognize registered partnerships and Italy, Spain and Israel are considering adopting similar legislation.
1989	Billy Tipton, a minor but well respected jazz musician, dies and is discovered to be female... after presenting as a man since 1933.
1991	Delwin Vriend, a lab instructor at King's University College in Edmonton, Alberta, is fired from his job because he is gay. The Alberta Human Rights Commission refuses to investigate the case because the Alberta Individual Rights Protection Act does not cover discrimination based on sexual orientation. Vriend takes the government of Alberta to court and, in 1994, the court rules that sexual orientation must be added to the act. The government wins on appeal in 1996 and the decision is overturned. In November 1997, the case goes to the Supreme Court of Canada and on April 2, 1998 the high court unanimously rules that the exclusion of homosexuals from Alberta's Individual Rights Protection Act is a violation of the Charter of Rights and Freedoms. The Supreme Court says that the act would be interpreted to include homosexuals even if the province doesn't change it. The Alberta government does not use the notwithstanding clause despite pressure from conservative and religious groups.
1992	In August, the Ontario Court of Appeal rules in Haig and Birch v. Canada, that the failure to include sexual orientation in the Canadian Human Rights Act is discriminatory. Federal Justice Minister Kim Campbell responds to the decision by announcing the government would take the necessary steps to include sexual orientation in the Canadian Human Rights Act.
1992	In November, the Canadian federal court lifts the country's ban on homosexuals in the military, allowing gays and lesbians to serve in the armed forces.
1992	On December 9th, as promised, Justice Minister Kim Campbell introduces Bill C-108 which would add "sexual orientation" to the Canadian Human Rights Act. The act, which would also restrict the definition of "marital status" to opposite-sex couples, doesn't pass first reading. On June 3, 1993, the Senate passes Bill S-15, another attempt at adding "sexual orientation" to the Canadian Human Rights Act, but the bill doesn't make it to the House of Commons because Parliament is dissolved for the 1993 federal election.

1992	British Columbia amends its Human Rights Code to include sexual orientation as a prohibitive ground of discrimination.
1992	Jean Burkholter is ejected from the Michigan Womyn's Music Festival by transphobic festival organisers.
1993	On February 23rd, in the Mossop case, the Supreme Court of Canada rules that the denial of bereavement leave to a gay partner is not discrimination based on family status defined in the Canadian Human Rights Act. The case isn't a complete loss to homosexuals. Two of the judges find the term "family status" is broad enough to include same-sex couples living together in a long-term relationship. The Supreme Court also notes that if Section 15 of the Charter of Rights and Freedoms had been argued, the ruling might have been different.
1993	Immigration policy allows lesbians and gays to sponsor same-sex partners in certain circumstances.
1993	Cheryl Chase founds Intersex Society of North America (ISNA).
1993	"March On Washington" organisers include bisexuals but refuse to include transgender in the name of the march, angering trans activists who worked for months to get inclusion.
1993	"Camp Trans" is pitched outside of the entrance gate to the Michigan Womyn's Music Festival to protest the Festival's newly publicized "Womyn-Born-Womyn-Only" anti-transsexual policy. "Camp Trans" is pitched for three years running.
1993	Trans activists working for many years with gay and lesbian activists successfully pass an anti-discrimination law in the State of Minnesota protecting transsexual and transgender people along with gays and lesbians.
1994	Trangender activists protest exclusion from Stonewall 25 celebrations and the Gay Games in New York City. The Gay Games rescinds rules that require "documented completion of sex change" before allowing transgender individuals to compete.
1994	Several cities on the west coast of the U.S. pass anti-discrimination statutes protecting transsexual and transgender people.
1995	In May, the Supreme Court of Canada confirms that discrimination on the basis of sexual orientation violates the Canadian Charter of Rights and Freedoms. Parliament amends the Canada Criminal Code to provide increased penalties for crimes motivated by hatred on certain grounds, including sexual orientation.
1995	The Supreme Court rules on the case involving Jim Egan and Jack Nesbit, two gay men who sued Ottawa for the right to claim a spousal pension under the Old

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Age Security Act. The Court rules against Egan and Nesbit. However, all nine judges agree that sexual orientation is a protected ground and that protection extends to partnerships of lesbians and gay men.

1995

In May, an Ontario Court judge finds that the Child and Family Services Act of Ontario infringes Section 15 of the Charter by not allowing same-sex couples to bring a joint application for adoption. He rules that four lesbians have the right to adopt their partners' children. Ontario becomes the first province to make it legal for same-sex couples to adopt. British Columbia, Alberta and Nova Scotia follow suit, also allowing adoption by same-sex couples. Other provinces are looking into the issue.

1995

Transsexual activists protest the stealing of TS/TG history by the gay and lesbian community. Efforts by the Ad Hoc Committee to recognize Alan Hart success-fully pressure Oregon's Right to Privacy (RTP, now known as "Right to Pride") political action committee to cease using Alan Hart's old name for an award given out to gay and lesbian rights activists.

1996

The federal government passes Bill C-33 which adds "sexual orientation" to the Canadian Human Rights Act.

1996

Parliament amends the Canadian Human Rights Act to include sexual orientation as a prohibitive ground of discrimination.

1996

JoAnna McNamara of It's Time Oregon successfully convinces Oregon's Bureau of Labour and Industry (BOLI) that transsexuals are protected under existing Oregon labour law dealing with discrimination of people with disabilities and medical conditions. This makes Oregon the third state to extend employment protection to transgender people, following Minnesota and Nebraska.

1997

The BC Family Relations Act is amended to include same-sex partners under the definition of "spouse".

1998

Trans activists protest exclusion from the Gay Games in Amsterdam. The Gay Games reinstates rules that require "documented completion of sex change or two years of hormones" before allowing transgender individuals to compete. Loren Cameron, an FTM athlete expected to compete, drops out of competition in protest. However, European singer and transsexual, Dana International, performs at the Games' festivities.

1998

Japan allows first legal sex reassignment surgery to be performed on an FTM.

1999

"Camp Trans" is revived to protest at the Michigan Womyn's Music Festival. Post-op MTF transsexuals are allowed to attend the festival, but confrontations with transphobic lesbian separatists occur.

1999

In a Texas court, in Littleton vs. Prang, Christine Littleton, a post-op MTF transsexual, loses her case against the doctor who she contended negligently allowed her husband to die. The doctors' defence lawyers argue that she was never married to her late husband since her Texas birth certificate, though now amended to read female, originally read male, and thus she could not be the widow as the law does not allow "same-sex marriage." Her appeal to a higher court fell on bigoted ears: Littleton was declared to be still male in spite of having taken all of the proper medical and legal steps. Thus, transsexual citizens of the United States joined those of the United Kingdom in finding their legal status in legal limbo.

1999

In May, the Supreme Court of Canada rules same-sex couples should have the same benefits and obligations as opposite-sex common-law couples and equal access to benefits from social programs to which they contribute. The ruling centres on the "M v. H" case which involves two Toronto women who had lived together for more than a decade. When the couple broke up in 1992, "M" sued "H" for spousal support under Ontario's Family Law Act. The problem was that the act defined "spouse" as either a married couple or "a man and woman" who are unmarried and have lived together for no less than three years. The judge rules that this definition violates the Charter of Rights and Freedoms and declares that the words "a man and woman" should be replaced with "two persons." "H" appeals the decision. The Court of Appeal upholds the decision but gives Ontario one year to amend its Family Law Act. Although neither "M" nor "H" chooses to take the case any further, Ontario's attorney general is granted leave to appeal the decision of the Court of Appeal which brings the case to the Supreme Court of Canada. The Supreme Court rules that he Ontario Family Law Act's definition of "spouse" as a person of the opposite sex is unconstitutional as is any provincial law that denies equal benefits to same-sex couples. Ontario is given six months to amend the act.

1999

On June 8th, although many laws will have to be revised to comply with the Supreme Court's ruling in May, the federal government votes 216 to 55 in favour of preserving the definition of "marriage" as the union of a man and a woman. Justice Minister Anne McLellan says the definition of marriage is already clear in law and the federal government has "no intention of changing the definition of marriage or legislating same-sex marriage."

1999

On October 25th, Attorney General Jim Flaherty introduces Bill 5 in the Ontario Legislature, an act to amend certain statutes because of the Supreme Court of Canada decision in the M. v. H. case. Instead of changing Ontario's definition of spouse, which the Supreme Court essentially struck down, the government creates a new same-sex category, changing the province's Family Law Act to read "spouse or same-sex partner" wherever it had read "spouse" before. Bill 5 also amends more than 60 other provincial laws, making the rights and responsibilities of same-sex couples mirror those of common — law couples.

1999	Parliament redefines common-law relationships to include same-sex couples. Aspects of "common-law partnerships" under federal jurisdiction include income tax, Canada pension and Old Age Security benefits, and immigration.
2000	On February 11th, Prime Minister Jean Chrétien's Liberals introduce Bill C-23, the Modernization of Benefits and Obligations Act, in response to the Supreme Court's May 1999 ruling. The act gives same-sex couples who have lived together for more than a year the same benefits and obligations as common-law couples. In March, Justice Minister Anne McLellan announces the bill will include a definition of marriage as "the lawful union of one man and one woman to the exclusion of all others." On April 11, 2000, Parliament passes Bill C-23, with a vote of 174 to 72. The legislation gives same-sex couples the same social and tax benefits as heterosexuals in common-law relationships. In total, the bill affects 68 federal statutes relating to a wide range of issues such as pension benefits, old age security, income tax deductions, bankruptcy protection and the Criminal Code. The definitions of "marriage" and "spouse" are left untouched but the definition of "common-law relationship" is expanded to include same-sex couples.
2000	On March 16th, Alberta passes Bill 202 which says that the province will use the notwithstanding clause if a court redefines marriage to include anything other than a man and a woman.
2000	On July1st, the Netherlands jumps to the forefront when its lower house of parliament enacts the world's most comprehensive legal recognition of gay rights. The Dutch law allows same-sex couples to marry and gives them the same rights as heterosexuals when it comes to adopting. The only restrictions to the new law are that same-sex couples can only adopt Dutch children, and foreign same-sex couples can't come to the Netherlands to marry unless one of them lives there. The law tops Denmark's law, which allows gays and lesbians to adopt their partners' children but not children outside the marriage. Pope John Paul II criticises the new law, saying no adult relationship other than that of a man and a woman should be recognized as marriage.
2000	On July 21st, British Columbia's Attorney General Andrew Petter announces the Province will ask the courts for guidance on whether Canada's ban on same-sex marriages is constitutional, making his province the first to do so. Toronto was the first Canadian city to ask for clarification on the issue in May 2000.
2000	On December 10th, Rev. Brent Hawkes of the Metropolitan Community Church in Toronto reads the first "banns" – an old Christian tradition of publishing or giving public notice of people's intent to marry – for two same-sex couples. Hawkes says that if the banns are read on three Sundays before the wedding, he can legally marry the couples. The reading of banns is meant to be an opportunity for anyone who might oppose a wedding to come forward with objections before the ceremony. No one comes forward on the first Sunday but the next week two people stand up to object, including Rev. Ken Campbell who calls the procedure "lawless and Godless."

Hawkes dismisses the objections and reads the banns for the third time the following Sunday. Consumer Minister Bob Runciman says Ontario will not recognize same-sex marriages. He says no matter what Hawkes' church does, the federal law is clear. "It won't qualify to be registered because of the federal legislation which clearly defines marriage as a union between a man and a woman to the exclusion of all others." The two same-sex couples are married on Jan. 14, 2001. The following day, Runciman reiterates the government's position, saying the marriages will not be legally recognized.

2002

On May 10th, Ontario Superior Court Justice Robert McKinnon rules that a gay student has the right to take his boyfriend to his high school prom. Earlier, the Durham Catholic District School Board said student Marc Hall couldn't bring his 21-year-old boyfriend to the dance at Monsignor John Pereyma Catholic high school in Oshawa. Officials acknowledge that Hall has the right to be gay, but said permitting the date would send a message that the Church supports his "homosexual lifestyle." Hall attends the prom.

2002

On July 12th for the first time, a Canadian court rules in favour of recognizing same-sex marriages under the law. The Ontario Superior Court rules that prohibiting gay couples from marrying is unconstitutional and violates the Charter of Rights and Freedoms. The court gives Ontario two years to extend marriage rights to same-sex couples. As a result of the Ontario ruling, the Alberta government passes a bill banning same-sex marriages and defines marriage as exclusively between a man and a woman. The province says it will use the notwithstanding clause to avoid recognizing same-sex marriages if Ottawa amends the Marriage Act. Also, a ruling against gay marriages is expected to be heard in B.C. by the province's Court of Appeal in early 2003, and a judge in Montreal is to rule on a similar case.

2002

On July 16th, Ontario decides not to appeal the court ruling, saying only the federal government can decide who can marry.

2002

On July 29, the federal government announces it will seek leave to appeal the Ontario court ruling "to seek further clarity on these issues." Federal Justice Minister Martin Cauchon says in a news release: "At present, there is no consensus, either from the courts or among Canadians, on whether or how the laws require change."

2002

On August 1st, Toronto City Council passes a resolution calling the common-law definition restricting marriage to opposite sex couples discriminatory.

2002

On November 10th, an Ekos poll commissioned by CBC finds that 45 per cent of Canadians would vote Yes in a referendum to change the definition of marriage from a union of man and woman to one that could include a same-sex couple.

2003

On February 13th , New Democrat MP Svend Robinson unveils a private member's bill that would allow same-sex marriages. The federal government has already changed several laws to give same-sex couples the same benefits and obligations as heterosexual common-law couples.

2003

On June 7th, an openly gay Anglican priest announces he will not accept an appointment as bishop of Reading after bitter arguments within the Church of England. Canon Jeffrey John acknowledges that he is in a long-term relationship with a man, but says he has been celibate since the 1990s. Traditionalist groups within the Church insist the Bible forbids homosexuality.

2003

On June 10th, The Ontario Court of Appeal upholds a lower court ruling to legally allow same-sex marriages. "The existing common law definition of marriage violates the couple's equality rights on the basis of sexual orientation under (the charter)," reads the decision. The judgment follows the Ontario Divisional Court ruling on July 12, 2002. Hours after the ruling, Michael Leshner and Michael Stark are married in a ceremony in Toronto. Both men played a key role in the court case.

2003

On June 11th, Ontario attorney general Norm Sterling announces that the province will obey the law and register same-sex marriages. Nearly two dozen homosexual couples applied for marriage licences in Ontario on June 10.

2003

On June 17th, Prime Minister Jean Chrétien announces legislation to make same-sex marriages legal, while at the same time permitting churches and other religious groups to "sanctify marriage as they see it." It means Ottawa will not appeal two provincial court rulings allowing same-sex unions. "There is an evolution in society," Chrétien said.

2003

On July 8th, British Columbia becomes the second province to legalise same-sex marriages. The British Columbia Court of Appeal lifts its ban on same-sex marriages, giving couples in the province the right to marry immediately. The decision alters a ruling that would have made same-sex marriages legal, but not until July 2004. The court has already agreed that the definition of marriage should be the union of "two persons" rather than of "one man and one woman." Ontario was the first province to recognize same-sex marriages as legal.

2003

On July 17th, Ottawa reveals the exact wording of historic legislation that will allow gay couples to marry. The Act Respecting Certain Aspects of Legal Capacity for Marriage is sent to the Supreme Court of Canada for review. According to the draft bill, "marriage for civil purposes is the lawful union of two persons to the exclusion of all others. The Supreme Court is being asked: whether or not Parliament has the exclusive legal authority to define marriage; if the proposed act is compatible with the Charter of Rights and Freedoms and whether or not the Constitution protects religious leaders who refuse to sanctify same-sex marriages. If the country's top justices decide that the draft legislation is constitutional, it will be put to a free vote in the House of Commons — meaning members of Parliament will not have to vote according to party lines.

2003

On July 31st, The Vatican issues a 12-page set of guidelines, approved by Pope John Paul, warning Catholic politicians that it is immoral to support same-sex unions. "There are absolutely no grounds for considering homosexual unions to be in any way similar or even remotely analogous to God's plan for marriage and family," it says. "Marriage is holy, while homosexual acts go against the natural moral law."

2003

On August 5th, Episcopalian Church leaders in the United States vote to accept the election of the American Anglican church's first openly gay bishop. The vote is 62-to-45 to confirm Rev. Gene Robinson as the new bishop of New Hampshire. Robinson, 56, is a divorced father of two. He has been living with his partner for thirteen years. Conservative church members warn that Robinson's installation could trigger a split in the church.

2003

On August 13th, Prime Minister Jean Chrétien vows not to let religious objections alter his stand on same-sex marriage. He says members of Parliament will be allowed to vote freely on the bill when it's introduced in the House of Commons after his retirement in 2004. A significant number of Liberal MPs say they do not support same-sex unions and will vote against the legislation.

2003

On August 14th, after extensive and emotional debate, the United Church of Canada votes overwhelmingly to endorse same-sex marriages. The majority of delegates at the church's general council meeting in Wolfville, N.S., vote to ask Ottawa to recognize same-sex marriage in the same way as heterosexual ones.

2003

On August 18th, the Archbishop of St. John's defends his censure of a local parish priest, saying Father Paul Lundrigan's comments were unacceptable within the Catholic Church. In a sermon one week earlier, Lundrigan challenged the Catholic Church's campaign against legalizing same-sex marriage. Lundrigan called the church hypocritical, criticizing it for fighting same-sex marriages while it remained silent about sexual abuse by clergy members

2003

On September 9th, a gay and lesbian group goes to trial against the federal government in an attempt to force Ottawa to extend survivor benefits to excluded gays and lesbians. Gay and lesbian partners pursuing Canadian Pension Plan benefits from their deceased partners say the federal government is discriminating against them and file a $400-million class-action suit.

2003

On November 3rd, Rev. Gene Robinson becomes the first openly gay Anglican bishop. Before the consecration, two Episcopal clerics read letters of protest denouncing Robinson's appointment as Bishop of New Hampshire.

2003

On November 27th, Alliance Leader Stephen Harper Thursday fires MP Larry Spencer as family issues critic after Spencer said homosexuality should be outlawed. Spencer told the Vancouver Sun that homosexuality is part of a "well orchestrated" conspiracy that should be outlawed, a Canadian Alliance MP says.

2003

On December 19th, an Ontario court rules that Ottawa has discriminated against same-sex couples by denying benefits to those whose partners died before 1998. The court rules that benefits will be retroactive to April 17, 1985, when equality rights in the Charter of Rights and Freedoms came into effect.

LGTB Health Matters

2003	Same-sex couples in British Columbia and Ontario (and pending a Court of Appeal decision in Quebec) gain the legal right to marry. Parliament is expected to introduce legislation in 2004 to redefine marriage as the union of 'two people' to the exclusion of all others.
2004	On January 28th, Justice Minister Irwin Cotler announces the government has asked the Supreme Court of Canada to determine whether limiting common-law marriages to opposite-sex couples only is constitutional. This adds to the three original questions sent to the top court in 2003.
2004	On February 12th, city officials in San Francisco marry a lesbian couple in a closed ceremony at City Hall, defying a state ballot measure defining marriage as a union between a man and a woman. In the following days, more than 3,200 same-sex couples are married.
2004	On February 24th, President George W. Bush calls on Congress to prepare a constitutional amendment that would ban same-sex marriage in the U.S.A. and "define and protect marriage as the union of a man and woman as husband and wife."
2004	On March 3rd, New York's attorney general, Eliot Spitzer, says gay marriage is illegal in his state. The mayor of New Paltz, a village outside of New York City, faces nineteen criminal charges for marrying twenty-five same-sex couples.
2004	On March 11th, the California Supreme Court orders San Francisco to stop same-sex marriages, nearly one month after the city issued its first same-sex marriage licence to a lesbian couple. In that time, more than 3,700 same-sex couples have been wed, including comedian Rosie O'Donnell and her partner Kelli Carpenter.
2004	On March 19th, the Quebec Court of Appeal rules that homosexuals have the right to marry, and that the traditional definition of marriage is discriminatory and unjustified. The ruling upholds a lower-court decision and follows similar decisions in Ontario and B.C.
2004	On April 13th, in Zanzibar, the parliament of this semi-autonomous and mainly Muslim island unanimously passes a bill outlawing homosexuality. The penalty for being in a homosexual relationship is a prison term of twenty-five years for men and seven years for women.
2004	On May 17th, city clerks across the state of Massachusetts hand out marriage licence applications to gay couples, making it the first state to legalise same-sex marriages.
2004	On May 24th, Australian Prime Minister John Howard asks Parliament to define marriage as a union between a man and a woman. The government also takes steps to block gays from adopting children from overseas. However, homosexuals are to be allowed to name their partners as beneficiaries for pension and death benefits.

2004   On June 10th, Ottawa goes to the Ontario Court of Appeal to try to reverse the December 2000 decision of Ontario's Superior Court of Justice that would grant retroactive pension payments to same-sex partners back to April 17, 1985. The government argues that it needs to be able to make laws and set its own payment dates.

2004   In June, a lesbian couple files the first same-sex divorce petition in Canada. Lawyers for the couple are asking the Ontario Superior Court of Justice to grant the divorce and declare the definition of "spouse" under the Divorce Act unconstitutional. A judge grants the divorce in September 2004.

2004   On July 14th, the U.S. Senate rejects a bid to amend the constitution to ban gay marriage. Before the vote, Republicans say a setback in the Senate will not deter their efforts to get the amendment passed. Six Republicans vote with the Democrats against the measure.

2004   On August 3rd, about 72 per cent of Missouri voters support an amendment to the state constitution banning gay marriage, making Missouri the first state to do so. Missouri already has laws defining marriage as only between a man and a woman, but some opposed to gay marriages say an amendment is the only way to prevent courts from legalizing it, as they did in Massachusetts.

2004   On August 12th, the Supreme Court of California voids more than 4,000 same-sex marriages performed in San Francisco between Feb. 12 and March 11, 2004. The justices rule that the city's mayor overstepped his authority by issuing marriage licences to gay couples.

2004   On September 16th, a Manitoba judge ruling in the Court of Queen's Bench declares the current definition of marriage "no longer constitutionally valid in view of the provisions of the Charter of Rights and Freedoms. Neither federal nor provincial lawyers attempted to oppose the lawsuit launched by three Manitoba couples. Officials in the province begin issuing marriage licences to same-sex couples shortly thereafter.

2004   On September 24th, Nova Scotia Supreme Court Justice Heather Robertson rules that banning same-sex marriages is unconstitutional, effectively changing the definition of marriage in the province to "the lawful union of two persons to the exclusion of all others."

2004   On October 18th, the Anglican Church in the UK criticises the U.S. Episcopal Church for consecrating Gene Robinson, who is openly gay, as bishop of New Hampshire. The report also suggests that the 38 national churches that make up the Anglican Communion should sign an agreement to support the church's current teachings, which also prohibit same-sex marriages.

2004	On November 2nd, in the U.S. national election, voters in eleven states — Arkansas, Georgia, Kentucky, Michigan, Mississippi, Montana, Oklahoma, Ohio, North Dakota, Oregon and Utah — pass amendments to state constitutions banning same-sex marriage.
2004	On November 26th, the Ontario Court of Appeal rules that gays and lesbians in the province are entitled to survivors' benefits under the Canada Pension Plan dating back to 1985. The class-action lawsuit was filed for gays and lesbians whose partners died before Jan. 1, 1998, the cut-off date for retroactive benefits set by the government in 2000.
2004	On November 29th, the United States Supreme Court rejects a challenge to the ruling of the Massachusetts Supreme Court allowing same-sex couples to get married. The challenge was launched by conservative religious groups and eleven state lawmakers.
2004	On November 30th in South Africa, the Supreme Court of Appeal rules in favour of a lesbian couple seeking to have the common-law definition of marriage changed to a "union between two persons." The government will later announce plans to appeal the decision to the Constitutional Court, the country's highest.
2004	On December 9th, the Supreme Court of Canada rules that the federal government can change the definition of marriage to include same-sex couples, but does not answer whether such a change is required by the Charter. It also reaffirms that religious leaders can not be compelled to perform same-sex marriages.
2004	On December 9th, New Zealand passes the Civil Union Bill to recognize unions between homosexual couples and unmarried heterosexuals, giving them the same rights as married couples in child custody, taxes and welfare.
2004	On December 21st, Newfoundland and Labrador is the seventh province to legalise same-sex marriage after a Supreme Court judge approves the licences for two lesbian couples.
2005	In January, the U.S.A. Indiana Court of Appeals supports a state law prohibiting recognition of same-sex marriages, including those that take place in states where they are legal. Louisiana's Supreme Court reinstates a state constitutional amendment prohibiting gay marriage. A judge in Florida throws out a lawsuit filed by two women who want their Massachusetts marriage recognized there.
2005	On February 1st, the Canadian federal government introduces its same-sex marriage bill in the House of Commons. The bill, if passed, would give married same-sex partners the same legal recognition as other married couples, but protects religious freedoms. "No church, no temple, no synagogue, no mosque, no religious official will be asked or forced to perform a marriage that is contrary to their beliefs," says Prime Minister Paul Martin.

2005	On March 15th, a judge in San Francisco Superior Court rules that California's ban on gay marriage is unconstitutional and has "no rational purpose," comparing it to laws requiring racial segregation.
2005	On April 14th, the Oregon Supreme Court throws out nearly 3,000 marriage licences issued to same-sex couples by Multnomah County. It says laws governing marriage are a state matter and the county does not have the authority to issue the licences.
2005	On April 25th, four gay couples in New Brunswick file papers with the province's Court of Appeal asking it to redefine marriage to include same-sex unions. New Brunswick, the Northwest Territories, Nunavut, Alberta and Prince Edward Island are the only jurisdictions in Canada that don't recognize same-sex marriages.
2005	On May 3rd, two men - a Canadian Forces sergeant and a warrant officer — are married in the chapel at CFB Greenwood, N.S., in the military's first gay wedding.
2005	On May 9th, the governing body of the Anglican Church of Canada puts off its decision on same-sex marriage until 2007, saying, "We are in the midst of a conversation."
2005	On May 20th, Jason Perrino and Colin Snow, a same-sex couple from Yellowknife, sue the government of the Northwest Territories over the right to be married.
2005	On June 16th, Bill C-38, the same-sex marriage bill, continues to be delayed in Parliament. The Liberals want the budget bill passed first, but it is being delayed by the Conservatives.
2005	On June 23rd, MPs vote to extend the sitting of the House of Commons, giving the government more time to push through the same-sex marriage bill. This follows a written promise made by the Liberals to the Bloc Québécois that the legislation will be voted on before the end of the parliamentary session.
2005	On June 23rd, New Brunswick's Court of Queen's Bench finds the province's current definition of civil marriage violates the rights of gay people. The ruling makes New Brunswick the eighth province where a court has opened the door to legal same-sex unions.
2005	On June 24th, New Brunswick Minister of Justice Brad Green says his government will comply with the court's ruling. He also orders a review of adoption laws to see if they are compatible with same-sex couples having the same rights as other married couples.
2005	On June 27th, in a late evening session, MPs vote to pass a motion limiting the debate to eight hours. This decision sets the stage for a final vote on June28th.

2005	On June 28th, the Liberals' controversial Bill C-38, titled Law on Civil Marriage, passes a final reading in the House of Commons, sailing through in a 158-133 vote. Supported by most members of the Liberal party, the Bloc Québécois and the NDP, the vote makes Canada the fourth country in the world, after the Netherlands, Belgium, and Spain to officially recognize same-sex marriage. The vote comes at a price for Paul Martin's minority government. Joe Comuzzi, the minister responsible for Northern Ontario, resigns from the cabinet so he can vote against the bill – an open rebuke of the government legislation. Conservative Leader Stephen Harper says if his party forms the next government, the law will be revisited.
2005	On July 20th, Canada becomes the fourth country in the world to sanction same-sex marriage. The Canadian Senate passes Bill C-38 with Senators voting 47-21to approve same-sex bill.

Adapted from: (1) Breaking Barriers: Anti-homophobia workshop development and facilitation training manual, Rainbow Resource Centre, 2001; (2) Indepth: Same Sex; and (3) Online transhistory.org (1910-1999).

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LGTB Health Matters

Appendix C

Suggested Answers for Knowledge Assessments Pre and Post

▮Module one

True > 1 , 4 , 8 , 10, 12, 13, 14, 19, 20

False > 2, 3, 5, 6, 7, 9, 11, 15, 16, 17, 18

▮Module two

True > 1 , 4 , 5 , 7 , 9 , 12, 16, 18, 19, 20

False > 2 , 3 , 6 , 8 , 10, 11, 13, 14, 15, 17

▮Module three

True > 2 , 4 , 6 , 10, 12, 17, 18, 20

False > 1 , 3 , 5 , 7 , 8 , 9 , 11, 13, 14, 15, 16, 19

▮Module four

True > 2 , 4 , 6 , 8 , 10, 11, 13, 17, 18, 19

False > 1 , 3 , 5 , 7 , 9 , 12, 14, 15, 16 , 20