

(DIS)ENGAGED

Challenges and Barriers in Sexual and Reproductive Health faced by Women Who Have Sex With Women

**Produced by Planned Parenthood Toronto
in partnership with Sherbourne Health Centre
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EXECUTIVE SUMMARY

The Women Who Have Sex with Women (WSW) consultation report is an initiative conducted in partnership between Planned Parenthood Toronto and Sherbourne Health Centre. In February 2007, the Women Who Have Sex with Women working group was established in response to the desire of both agencies to explore the sexual and reproductive health needs of WSW in their 30s, 40s and 50s. The purpose of the working group was to conduct a consultation process with community agencies and diverse WSW communities to better understand these needs and to recommend interventions in the services currently provided to WSW in the Greater Toronto Area (GTA).

This report presents key findings from this consultation. It provides insight into the experiences of WSW with the health care system and raises awareness of the specific needs and experiences of different WSW communities. This report also provides recommendations for health care and community services with a view to challenging the homophobia and other forms of discrimination that are all too common in health care delivery.

The consultation process involved: three focus groups with WSW in their 30s, 40s and 50s, representing a diversity of WSW communities; key informant interviews with service providers from Toronto-based agencies that provide sexual and reproductive health and related services to adult women; and a literature review to inform the analysis of participants' statements and concerns articulated in the report. Key informant interviews and focus groups were conducted between February and April 2007.

During the consultation WSW reported that overall, their engagement with the mainstream health care system has been negative. The question of whether to disclose their sexual identity and practices, their experience of homophobia, often coupled with other forms of discrimination, the lack of knowledgeable providers and the lack of services specifically for WSW all act as barriers to WSW accessing health care. Key informants concurred, emphasizing that racism, ableism, transphobia, classism, homelessness, poverty and language barriers exacerbate the difficulties faced by WSW from marginalized communities in accessing health services.

Consultation participants identified the sexual and reproductive health issues important to them. They were unclear about their risk of sexually transmitted infections and how to negotiate safer sex and wanted sexual pleasure to be an integral part of healthy sexuality information and services. Fertility and reproduction also raised many concerns for WSW, including access to supportive care providers, access to sperm and facing the heterosexist framework used by many fertility clinics. Key informants also spoke to these issues from their perspectives as service providers in many of these areas. The experiences of participants with all of these issues underscore the impact of homophobia and other forms of oppression on the health of WSW.

Participants also highlighted the role of relationships in their health. Intimate relationship issues included having their relationships validated, (re)defining the terms of those relationships and building healthy ways of being with each other. The importance of community also emerged as a significant part of WSW's lives. While WSW in the focus groups had differing experiences

within WSW communities, they all expressed a feeling of responsibility to change those communities to be more inclusive of all WSW. Key informants articulated the need for health promotion programs and services to have a social component to decrease isolation and further build WSW communities.

For women in the consultation, emotional health was an important part of sexual health but wasn't reduced to mental health diagnoses. Emotional health for them is about more than just healthy behaviours – it is about feeling good as WSW.

WSW are also concerned about the same issues that heterosexual women face as they age, including breast health and menopause. Both focus group participants and key informants emphasized, however, that information on these topics that acknowledges the practices of WSW and affirms their identities specifically is needed.

This report also highlights the resiliency of WSW participants. Throughout this consultation, WSW vocalized the multiple ways in which, despite a health care system that offers them so little, they manage to take care of themselves and each other.

The findings in this report provide insight into and evidence for the need for change. Reflecting the resilient spirit generated in the testimonies by the WSW focus groups, recommendations advocate fundamental, community driven changes in critical areas.

They propose that capacity building within existing community agencies, women's programs and clinical services could proceed through the establishment of a network of such organizations and partners who, basing their process on the findings of the consultation report, will develop strategies to mend gaps in programming and services to WSW.

Proposed education and training strategies address the consultation's concerns about the health care sector culture at two levels: intervention in the education of students in the health care professions with the aim of building professionals' competence in meeting the needs of culturally diverse communities; and building a knowledge base within WSW communities with regard to women's sexual and reproductive rights and health issues as well as strengthening women's capacity to navigate the health system. Recommendations urge not only a new era of research on the sexual and reproductive health needs of diverse WSW communities but argue that women's health research in general should include sexual orientation and gender variables.

A number of recommendations are aimed at improving the quality of WSW sexual health education materials and programs, including community education campaigns to demystify WSW sexualities and health issues. WSW relationship concerns and social isolation are put firmly on the table along with strategies to address these issues. Services designed to support coming out, enhancing family relationships in various cultural contexts, and spaces for WSW community dialogue, organizing and action are also strongly proposed.

It is our hope that these recommendations will encourage agencies providing services in women's sexual and reproductive health to be a part of an effort to ensure WSW benefit from universal health care that respects them as WSW and meets their unique needs.

BACKGROUND

Academics, health care practitioners and women's advocates alike have noted that when it comes to health, women get shortchanged (Davis, 2000). Whether the issue is the lack of women-centred care, the lack of health research conducted with female participants or the refusal to acknowledge the physical and social determinants of women's health, women in general face multiple barriers when trying to access the health care system and to look after their health and well-being.

Women are not, however, a homogenous group. Being female is only one factor affecting women's ability to get their health care needs met. The prevalence of homophobia and heterosexism has a profound effect on the health and wellbeing of women who have sex with women (WSW) as well as on their ability to access health care information and services. Research by the Canadian Community Health Survey (CCHS) indicates that, for some health-related measures, there are important differences between the heterosexual population and the gay, lesbian and bisexual population. Among individuals aged 18 to 59, for example, 21.8% of gay men, lesbians and bisexuals reported that they had an unmet health care need in 2003, nearly twice the proportion of heterosexuals (12.7%). In addition, gay men, lesbians and bisexuals are more likely than heterosexuals to find life stressful (Health Canada, 2003).

As individuals, lesbian, gay, bisexual, trans and queer (LGBTQ) people encounter major difficulties in accessing health care and, subsequently, in developing health-seeking behaviours (Banks, 2003; Brotman et al, 2002; Ryan et al., 2000). LGBTQ people are more likely to delay or decline seeking health care altogether to avoid having a negative experience of homophobia, biphobia or transphobia. Studies also suggest that lesbians and bisexual women are not engaging in regular or routine preventative behaviours (Wells et al., 2006). Health care providers may subject LGBTQ people to derogatory comments, voyeurism, hostility toward themselves or their partners, or undue roughness in physical examinations. Also, LGBTQ patients are rarely asked about sexual orientation during assessment or on medical history forms and this assumption of heterosexuality perpetuates LGBTQ invisibility and marginalizes their health needs. Most health care educational programs do not include discussion of LGBTQ health issues and thus most health providers are not sensitive to or knowledgeable about their particular health risks and needs. LGBTQ people do not have the same access to the quality of health care that many Canadians take for granted. Such barriers inhibit the interaction of LGBTQ people with the health care system and, as a result, impact on the possibility for increased prevention information and behaviours.

In addition, there is a dearth of health care information and research on the specific health care needs and experiences of WSW. Female sexual and reproductive health has long been narrowly defined in terms of the ability to conceive and bear a number of healthy children (Shroff & Clow, 2003). Coupled with the common assumptions that WSW either can't, don't want to or shouldn't have children, this definition means that most sexual and reproductive health messages and services aimed at women don't reach or appropriately serve WSW.

Like any social grouping of women, WSW are not homogenous but belong to diverse (racial, cultural, ability, class) communities. Consequently, WSW's experiences of the health care system are compounded not only by homophobia and heterosexism but by other systemic barriers. These WSW face a health system that doesn't address their diverse needs but rather responds to them with stigma, false assumptions, discrimination and misinformation.

This consultation process was initiated by Planned Parenthood Toronto (PPT) and Sherbourne Health Centre (SHC) in recognition of these barriers, lack of information and gaps in service.

Planned Parenthood Toronto (PPT) is a fully accredited community health centre providing primary health care services to youth 13 to 29 years as well as health promotion programming, education, training and research to improve the health and well-being of Toronto's diverse communities.

Sherbourne Health Centre (SHC), an urban primary health care centre, provides innovative health services and wellness programs to the diverse communities of southeast Toronto with a special emphasis on local residents, homeless and underhoused individuals, the lesbian, gay, bisexual, transsexual and transgender (LGBTQ) communities and new Canadians.

Supported by PPT's Strategic Plan (2006-2011) and SHC's overall mandate to serve members of LGBTQ communities, community programming staff at both organizations came together to conduct a consultation with WSW communities and service providers in Toronto. The findings and recommendations are presented in the spirit of change – changes to the delivery of health care and related services to provided WSW in their 30s, 40s and 50s with the sexual and reproductive health information and services they both need and deserve.

THE CONSULTATION PROCESS

Women Who Have Sex with Women Working Group

In the winter of 2007, PPT and SHC established a partnership to further explore the sexual and reproductive health needs of WSW communities¹. Community programming staff from both of the partner organizations established a WSW working group. The members of the working group were:

Michele Chai	Community Health Promoter, PPT
Michele Clarke	Health Promoter, SHC
Rose Gutierrez	Director of Community Programming, PPT
Amita Handa	Community Health Promoter, PPT
Anna Penner	Peer Educator, PPT
Cindy Weeds	Program Coordinator, Women's Programming, PPT

The goals for the consultation process were:

- To identify the sexual and reproductive health needs of WSW in their 30s, 40s and 50s, living in Toronto;
- To identify existing gaps and barriers in the sexual and reproductive health sector for WSW in their 30s, 40s and 50s; and
- To identify new programming possibilities for WSW in their 30s, 40s and 50s, both at PPT, Sherbourne Health Centre and other community agencies.

The consultation process included: three focus groups with women from diverse WSW communities; semi-structured interviews with 25 key informants from community agencies serving women in the areas of sexual and reproductive health; and a literature review.

Focus Groups

The working group planned five focus groups for the consultation: two groups open to all women identifying as WSW; one for WSW women of colour; one for WSW who are trans-identified women; and one for WSW who are parents of children under the age of 18. Outreach efforts made to reach diverse communities of WSW resulted in three of the five focus groups taking place: two open groups and one specifically for WSW of colour.

In total, 27 WSW in their 30s, 40s and 50s participated in the focus groups and one interview was conducted². The focus group/interview questions were designed to elicit key sexual and reproductive health related themes and issues for WSW³. Each focus group was facilitated by two members of the WSW working group.

¹ For Partnership Agreement, see Appendix A

² For Focus Group Consent Form, see Appendix B

³ For Focus Group Interview Guide, see Appendix C

Participant Profile (self identified)⁴

Gender	22 female, 2 queer femme, 1 tomboy femme, 1 male to female, 1 trans
Age	16 between 30-39 yrs, 8 between 40-49 yrs, 3 between 50-59 yrs
Race	14 white, 12 of colour, 1 Aboriginal
Country of Birth	19 Canada, 4 Caribbean, 1 Africa, 1 Asia, 1 South America, 1 USA
Immigration Status	23 Canadian Citizen, 1 Permanent Resident, 1 Refugee, 2 no answer
Religion	10 None/Atheist, 7 Christian, 6 Catholic, 1 Muslim, 1 Hindu, 1 Jehovah's Witness, 1 Pagan
Ability	10 with disabilities: 6 physical, 3 mental/learning, 1 didn't want to disclose
Relationship Status	13 single/dating, 5 partnered/in relationships, 4 common law, 3 married, 2 no answer
Education Level	18 university level education, 5 college level education, 4 high school level education
Employment Status	12 working full time, 4 working part time, 1 in school full time, 1 in school part time, 9 not currently working
Children	21 have no children, 5 have children under 18, 1 has children over 18

Key Informant Interviews

Because agencies offering programs that exclusively serve WSW are rare, the working group collectively identified partnership agencies based on their work with adult women around sexual and reproductive health that WSW are, or could be, accessing. Only one quarter of the agencies interviewed by the working group had programs and services specifically targeted to WSW and not all agencies knew if or how many WSW are accessing their services. In spite of not necessarily working extensively with WSW, key informants had much to say about the needs of diverse communities of WSW in their 30s, 40s and 50s.

Semi-structured interviews were conducted with 25 key informants from agencies concentrated in downtown Toronto. The selected agencies included AIDS service organizations, sexual health clinics, a LGBTQ community centre, midwifery organizations, a sex store and individuals who have knowledge of WSW communities. The following agencies were selected:

Sexual Health Consultant

2 Spirited People of the First Nations

519 Community Centre

AIDS Committee of Toronto (ACT)

Alliance for South Asian AIDS Prevention (ASAAP)

⁴ See Appendix D for Focus Group Participant Profile Form

Asian Community AIDS Services (ACAS)
Bay Centre for Birth Control
Black Coalition for AIDS Prevention (Black CAP)
Centre for Addiction and Mental Health – Rainbow Services (CAMH)
Good for Her
Hassle Free – Women’s Clinic
LGBT Parenting Network
Metropolitan Action Committee on Violence Against Women and Children (METRAC)
Midwife Alliance
Ontario Aboriginal AIDS Strategy
Parkdale Community Health Centre
Sages Femmes Rouge Valley Midwives
Sherbourne Health Centre
Springtide Resources
Toronto Public Health
Toronto Rape Crisis Centre/Multicultural Women Against Rape – Lesbian Caucus
Voices of Positive Women
Women’s Health in Women’s Hands

The interviews were designed to stimulate discussion around the sexual and reproductive health issues faced by WSW in their 30s, 40s and 50s⁵. Interviews were conducted by different members of the working group on site at each of the various agencies.

Limitations

The consultation process operated under a limited budget and with limited staff resources. Five focus groups were planned and three came to fruition. Despite this change, the working group successfully interviewed 25 individuals from community agencies and held three focus groups with a total of 27 women from a wide range of WSW communities.

Although particular efforts to have adequate representation from trans-identified WSW and WSW in their 50s were made, only two focus group participants were trans-identified and only three were in their 50s. This report cannot fully speak to the sexual and reproductive health needs of WSW from these communities.

Despite these limitations, the working group is confident that this process and this report provide some preliminary but meaningful insights into the experiences of WSW in their 30s, 40s and 50s in addressing their sexual and reproductive health care needs. The consultation process allowed PPT and SHC to strengthen community partnerships, increase visibility and most importantly, provide a catalyst for the development in both agencies, and potentially others, of new initiatives for WSW communities that are informed and guided by WSW themselves.

⁵ See Appendix E for the Key Informant Questions

SELECTING THE TERM *WSW*

Women Who Have Sex With Women

The working group chose the term “Women Who Have Sex with Women” (WSW) to identify the women targeted in this consultation. For the purposes of this consultation, WSW means anyone who self-identifies as a woman who engages in sexual activities with other woman-identified women. The term was selected because it includes women who engage in sexual activity with other women but don’t necessarily identify with LGBTQ communities. Women from diverse communities in Toronto may not see themselves or identify as lesbian, bisexual or queer. The working group decided that focusing on the behaviour of women having sex with other women regardless of how these women choose to name their sexual orientation would be the most inclusive. In addition to WSW, this report also uses LGBTQ and queer as umbrella terms that include WSW communities.

Key informants from community agencies were asked about the language used by their agency to describe WSW communities. In some agencies, certain terms were more common than others (ie: lesbian as opposed to queer) or sometimes it depended on the WSW staff working there and what terms they used for themselves. Other agencies used terms that are specific to the communities of WSW they serve (ie: mirchi for South Asian communities or Kwe 2 Kwe, the Ojibwe word for woman to woman). However, the majority of key informants stressed the importance of self-identity – using the terms their clients choose for themselves and working from there. No agency used the term WSW in their programs and services.

What is clear from both the focus groups and interviews with key informants is that there is no standard term that can be applied to all women who have sex with women. While the most consistent terms are lesbian, bisexual and queer, what is most important is that women themselves decide how to identify and describe themselves and their experiences.

Sexual and Reproductive Health

Focus group participants were asked what the terms “sexual health” and “reproductive health” mean to them. They responded that sexual health goes beyond the importance of adopting preventive behaviours with regard to sexually transmitted infections (STIs) and safer sex. Rather, participants broadened the concept to embrace a more holistic consciousness of what sexual health means for them that included emotional and mental components, as well as pleasure.

In defining their reproductive health, focus group participants named having children, raising a family, menstruation and menopause, cervical exams and breast health. Many participants, however, also framed their definitions around choice and autonomy. They emphasized the importance of having control over their reproductive lives, including decisions around whether or not to have children and around how to take care of their reproductive health.

INSIGHTS FROM THE CONSULTATION

This section of the report highlights the concerns of WSW articulated both in focus groups and by key informants. Together, these contributions begin to outline the parameters of a potentially creative and productive dialogue among the women's health community in the GTA.

Points stressed in focus group discussions are often substantiated by key informants and vice versa. This suggests that challenges to the health care system initiated by women from their lived experience can be carried forward at the institutional level by organizations with a strong community presence.

(Dis)engagement with the Health System

Generally speaking, focus group participants characterized their engagement with the health care system as negative. Even those who relayed positive experiences with the system shared that these better encounters tended to be the result of the following: their own advocacy; their practitioners being queer-identified; or the services they were accessing catering specifically to the needs of LGBTQ communities. One focus group participant had to repeatedly advocate for assistance for her partner who was being hospitalized before her requests were met. Another shared that she asks her new providers outright if they have a problem with the fact that she is a lesbian. Some participants had taken on the task of educating their health providers about their health issues, often over the course of several years.

Focus group participants observed that while positive experiences are possible, obtaining appropriate and quality health care is an "uphill battle". They expressed many of the same concerns that all women generally face when engaging with the health system such as long wait times, transportation issues, time constraints and difficulty finding a family doctor who is accepting new patients. However, some issues and concerns are unique to the lives of WSW when trying to access the system to meet their sexual and reproductive health needs.

Disclosure

A unique and often key consideration in obtaining adequate health care for WSW is the issue of disclosure. As focus group participants shared, the decision to "come out" or disclose their sexual orientation and same sex practices to their health care provider when seeking sexual health care complicates an already stressful encounter fraught with stigma and shame. Many participants were not out to their providers for fear of being treated badly as a result. One participant recalled a time when the health care system's response to WSW was particularly bad.

Health care professionals look at you differently once you out yourself...it wasn't too long ago we would be locked up for being out.

Focus group participant

Participants who have come out to their providers and had positive experiences expressed relief and appreciation for not being judged or made to feel uncomfortable. Indeed, evidence suggests that when lesbian and bisexual women disclose their sexual orientation to health care providers, it increases communication and can lead health providers to more actively promote preventative behaviours (Wells et al., 2006).

Regardless of their experiences, disclosure is something every WSW must make a decision about in every encounter with the health system. This puts many WSW in a bind – if they don't disclose their sexual orientation or same sex practices, they miss out on more insightful and thorough conversations about their health. If they do disclose, they run the risk of homophobia, discrimination and misinformation from their providers. It isn't surprising, then, that many WSW opt out of seeking care from the healthcare system altogether.

Homophobia / Fear of Homophobia from Health Care Providers

The most evident barrier for WSW accessing sexual and reproductive health care is the potential for homophobia from services providers (Davis, 2000). Many WSW experience health care providers as ignorant, offensive and uncaring. Focus group participants shared that once their doctor knew that they were a WSW, the way they were treated changed for the worse. Key informants concurred with this experience.

This is unique to WSW – if a WSW has a bad experience it's personalized. It becomes understood that the reason you are treated badly or will be treated badly is because of who you are – het women may go elsewhere if she has had a bad experience; it's not communicated to her that the reason she was treated badly was because she is a heterosexual woman.

Key informant

Focus group participants also described experiences where their same sex partners were not acknowledged or respected in the health care setting. Doctors discouraged participants' partners from accompanying them into appointments or made assumptions about female partners just being friends.

For WSW who are members of other marginalized communities, the experience of homophobia is compounded by other forms of oppression. Women of colour participants in particular spoke about their struggle to find a doctor who they could feel comfortable with around both their sexual orientation and their race.

You can go in and feel comfortable with someone and feel positive that they're queer-positive and then you have to go to another doctor to feel comfortable to get the fit in terms of being a woman of colour.

Focus group participant

Key informants drew attention to that added level of discrimination experienced by lower income WSW and trans WSW. For example, service providers are not informed about the impact of poverty on the wellbeing of lower income WSW. Similarly, trans WSW may be fearful of being caught or discovered as a trans woman by a health care provider who will respond in a transphobic way. Key informants strongly urged that health care providers be trained use an anti-oppression perspective.

Don't unleash physicians and health care workers onto WSW without providing them with anti-oppression training; as well, there should be no clinical teaching unless it's coming from an anti-oppression framework.

Key informant

Lack of Knowledgeable Health Care Providers & Provider Assumptions

A profound lack of knowledge amongst health care providers about the sexual and reproductive health needs of differently located WSW emerged from focus group participants and key informants. Participants reiterated their struggle to find a provider who was actually informed about their needs.

I told them I was a lesbian and I felt like they didn't know how to treat me.

Focus group participant

Many participants were discouraged from seeking out particular procedures, felt certain topics were glossed over, or were told by their providers that s/he wasn't really sure what to do. Health care providers can be unclear about what the sexual practices of WSW actually are and often make assumptions including that WSW never have been, or never will be, sexually intimate with men. Butch or masculine identified women face an added layer of assumptions about their sexual health needs, including physicians not recognizing them as women. Many WSW don't get the care they require because providers assume they are heterosexual or don't incorporate knowledge around WSW into their care of their WSW patients (Davis, 2000).

Nowhere was this lack of knowledge more pronounced than around the issue of pap smears. Studies have shown that WSW are less likely to have cervical exams than heterosexual women (Gatson Grindel et al., 2006). In one study, WSW were ten times less likely to have received timely pap tests than their non-WSW counterparts (Kerker et al., 2006). Participants reported situations where providers were totally misinformed about WSW and pap smears. Women received conflicting, confusing, and at times, outright incorrect information. WSW often had to educate their health care providers about their need for the procedure.

Well, I had to ask my doctor for a pap test because she said 'oh you don't need one, you're a lesbian' and I said 'well yeah, I do'.

I was at my doctor and the word "partner" came out and then the nurse said 'well, you don't need a pap then' and I said 'well I need to educate you, because it doesn't matter who my partners are'.

Focus group participants

Key informants had several suggestions for how to increase the knowledge of health care providers on the needs of diverse WSW. Providers could increase their awareness of, and connection to, community LGBTQ organizations that WSW know and trust, as well as organizations that address issues that affect WSW such as immigration and poverty. Key informants also identified the need for more WSW specific research that can better inform health care providers and arm them with evidence based knowledge with which to care for WSW clients.

However they get the knowledge, key informants were clear that health care providers have an obligation to educate themselves about the diverse needs of WSW.

What we've done traditionally in Canada is absolve individual care providers from caring about the diverse needs of women. Specific service agencies are overwhelmed with how do you provide care for WSW for all of the GTA – if we're looking at 10% of the population isn't that something important? For anything else, if it was 10% of the population we would expect all health care providers to know how to address their needs.

Key informant

Limited Services

When seeking out sexual and reproductive care from the health system, WSW choose between mainstream services, ethno-specific health services or LGBTQ-specific services. None of these options, however, adequately address diverse WSW's needs.

If they access mainstream services, WSW risk facing homophobia and a lack of knowledge from health care providers about their needs. Ethno-specific services meet WSW's needs on a racial and/or cultural level, but they too can be unfriendly to WSW and lacking in the knowledge to adequately serve them. In both kinds of services, there is also a lack of representation of WSW in health promotion and organizational materials.

LGBTQ-specific services can also be problematic. While they address the homophobia and heterosexism present in other services, there isn't often diversity amongst staff and services aren't culturally appropriate or competent for differently located women. WSW who access LGBTQ services may have to sacrifice one part of their identity for the other.

The way services are you have to choose between identities.

Key informant

The fact that there are so few LGBTQ services around, even less so for WSW specifically, poses additional issues. These services tend to be concentrated in the downtown Toronto area. This makes access difficult for WSW who cannot afford the travel costs. These barriers are particularly high for Aboriginal and newcomer WSW, many of whom live outside of the downtown area. In addition, while brochures, pamphlets and posters of LGBTQ services include WSW, they don't often reflect WSW in their 30s-50s, WSW in diverse relationships or trans WSW. Materials for WSW are usually written in English only and use language that may not be easy to understand.

When accessing these services, WSW's anonymity can be compromised. WSW often see community members, friends and ex-partners when they seek health care simply because there are so few places to go.

You're sitting there waiting for your pap and then someone you dated is sitting there next to you for their flu shot.

Focus group participant

Given the small size of many WSW communities such as newcomer WSW or WSW of colour communities, coupled with the shame and secrecy that often surround sexual health issues, this risk to privacy can make some WSW reluctant to seek care at the few places where they are welcome as WSW.

There is no one health care service that WSW in the GTA can go to that comprehensively meets their diverse needs. Some focus group participants and key informants felt that it would help if both mainstream and population-specific services had more providers who are themselves WSW from diverse communities to ensure services are queer-positive and culturally relevant. Others felt that it was less important that the providers be diverse, as long as they use an anti-oppressive approach and are knowledgeable about WSW. This discrepancy highlights the need for choice – to have multiple places for WSW to go to get the comprehensive care they need.

Sexual and Reproductive Health Issues

Healthy Sexuality

WSW have a very particular experience around sexually transmitted infections. Focus group participants expressed confusion over the level of risk they have as women who have sex with other women.

The info of how to protect yourself if you're having oral sex compared to whatever sex you might be having with a male...the info isn't there on how to protect yourself and why.

Focus group participant

Key informants also emphasized the lack of information for WSW about their risk of contracting STIs. They added that providers are also misinformed, particularly about the risks for trans WSW, WSW with disabilities and butch WSW. WSW are being told they don't need to worry about STIs and are discouraged from getting tested. Key informants suggested that health care providers need to be made aware of the full scope of sexual practices WSW engage in and the associated risks. In addition, key informants highlighted the need for safer sex tools such as dental dams and gloves to be as financially and physically accessible as male condoms.

Misinformation and lack of information also affects the sexual conduct of WSW. Negotiating safer sex can be difficult for everyone regardless of sexual orientation or sexual partners. For WSW, this is made worse by the lack of accurate information available that speaks directly to their sexual needs, behaviours and practices. It is difficult to negotiate what you don't know.

I went out and met a new person and I pulled out a dam and for some strange reason the person felt very insulted and left my apartment.

Focus group participant

From the viewpoint of women in the focus groups, sexual health isn't just about disease or infection prevention; as previously discussed, participants named sexual pleasure as an integral part of being sexually healthy. Participants were also well aware of the many societal myths and

assumptions regarding WSW's sexuality and sexual practices, particularly for older WSW and WSW with children. Women clearly articulated their desire to have information on, and a place to talk about, the pleasurable parts of sex.

Sexual health made sexy, sounds really good.

There's lots of stuff out there about how to keep your man satisfied but not how to keep your woman satisfied or how to be romantic with your partner.

Focus group participants

Key informants acknowledged the sense of shame women generally have about their bodies and the discomfort some women may have around their sexuality. To address this shame, service providers need to incorporate sexuality and sexual pleasure into discussions around healthy sexuality and STI/HIV prevention. While some service providers have done so, and with great success, it's not the norm. Safer spaces that have been created to talk about sex and pleasure are often downtown, physically inaccessible and lacking in cultural diversity.

Fertility and Reproduction

Several participants in the focus groups expressed a desire to get pregnant at some point in their future. While research has historically shown that lesbian and bisexual women are less likely to have children than their heterosexual counterparts (Institute of Medicine, 1999), today more and more WSW are pursuing pregnancy and having children. WSW who do make this decision face a number of obstacles (Ross et al., 2006) and this was reflected by women in the focus groups.

Many WSW delay pregnancy until their thirties (Institute of Medicine, 1999). Some participants expressed concerns about their ability to conceive given the information they have heard about fertility declining with age.

I would imagine our reproductive needs would be a little bit different than the younger group 'cuz if we want to exercise our reproductive abilities, I would imagine those abilities are getting less and less as we are escalating in age.

Focus group participant

Finding a supportive health care provider to begin the process is another barrier for WSW trying to get pregnant. Women shared experiences where doctors expressed uncertainty about whether it was even an option and the WSW themselves had to explain to the doctor how they can have children. For WSW of colour, finding services by practitioners of colour is an added challenge. An interracial couple in the group shared an experience where they felt that the health care provider's response was based in racism.

We talked about wanting to have children. And the doctor looked me closely in the face, and said 'are you sure?' She was literally up in my face asking me if I was sure.

Focus group participant

Even when women do find a supportive physician, finding other affordable WSW-positive services they need in the process is difficult. WSW face issues around sperm donation. Some participants had used a known donor in the past and for others, accessing sperm banks wasn't easy or affordable. For WSW of colour or in interracial relationships, finding sperm from donors of colour was particularly difficult.

The person who is our father, we recommended him to other people, so now he has 9 children. But he said that's it!

Focus group participant

Fertility clinics are of particular note because they best underscore the heterosexism present in reproductive care. Not only are they geared towards heterosexual couples but they are organized around the assumption that women accessing the clinic are infertile or have infertile partners. This isn't the reason most WSW are going to fertility clinics at all – WSW need assisted reproduction because they need access to sperm and insemination techniques.

It's hard because you have to find someone who is open enough to inseminate other than a queer-positive doctor. If you go to a fertility clinic, not all are supportive...it's challenging, very challenging to find where I don't have to pay X amount of dollars to have kids.

Focus group participant

Key informants also highlighted fertility as a significant issue for WSW. They stressed the importance of letting WSW define families in the way that feels right for them and the need to normalize the pregnancy and birthing process for WSW. WSW don't want to be ostracized for their decision to have children from either outside of or inside of WSW communities.

Key informants also highlighted the need for queer-positive information and services that are outside of an infertility context and cover the full span of pregnancy, from pregnancy achievement to the management of complex family relationships. They emphasized that fertility issues can be different for differently located women. For example, financial costs pose particular barriers for low income WSW and WSW without health care insurance. Trans WSW need information on the impact of transitioning on having children.

Though focus group participants talked about reproduction in terms of achieving pregnancy, key informants also indicated the need to provide information to WSW about pregnancy prevention or termination for WSW who also have sex with men.

Key informants confirmed what focus group participants already know – that more reproductive health information and services that speak to WSW specifically yet in all their diversity is needed.

General Health & Healthy Sexuality

Intimate Relationships

We've fought for so long just to be validated in relationships.

Focus group participant

Relationship issues play an instrumental role in shaping the health of focus group participants. Discussion in the group focused on (re)defining and validating relationships in a societal context where such relationships are often delegitimized.

An assumption persists that all women are heterosexual. Several participants identified their own struggles with maintaining a WSW identity in the face of the assumption that they are straight.

I've gone through the whole process of constantly having to validate my identity 'cuz I pass and everyone just assumes I'm a straight woman...does my girlfriend have to be on my shoulder all the time to confirm?

Focus group participant

When WSW are recognized as such, they face additional myths and stereotypes about their intimate relationships. There is still a great deal of confusion about what sexual practices WSW actually engage in and a belief that sex between women is somehow less meaningful or not as authentic as sex between heterosexuals.

*There's also like still a joke in the sitcoms 'so, what **do** women do in bed?'*

Focus group participant

Many participants are grappling with feeling validated in their relationships amidst stereotypes that lesbians are always jumping from relationship to relationship and that WSW couples who don't have children aren't as legitimate as those who do.

There's that question of when are you going to have children?...it's hard to take yourself out of that constant messaging. I feel like when we have a child, people will really validate it [our relationship].

Focus group participant

It is this delegitimizing of WSW relationships that leads to the lack of recognition of partner status by health care providers previously discussed. It also makes it difficult for WSW to discuss the sexual practices they engage in within relationships when health care providers don't even recognize those relationships in the first place.

It is in this context that WSW are trying to redefine their relationships. Engaging in kink, having non-monogamous relationships and opting for same sex marriage are just some of the ways in which WSW are redefining what it means to be in intimate/sexual relationships.

It's a very interesting generation space and time we're going into now, with marriage being legal – we're married now and finding our thing in a poly, kink world – marriage is the new kink.

Focus group participant

For some participants these new definitions pose additional pressures, sexual health concerns and confusion about how to navigate these untraditional relationships.

I think there's some peer pressure about what's cool in the lesbian relationship – it's cool to be poly, kinky, etc. – and it's harder to navigate through all this peer pressure.

One woman I went out with, she wanted friends with benefits and I said 'what's that?'

Focus group participants

Participants also noted that some issues are not easily discussed in WSW communities. There are few safe places for open and honest dialogue about issues such as the effects of medications on libido, lesbian sexuality in relationships over time and intimate partner violence.

There are a few things that are issues for lesbians and never get talked about but I've confronted it in all my relationships – someone who is on anti-depressants and wants to have a healthy sex life...and also this idea of lesbian bed death, that people don't remain sexually active.

There is a lack of info about same sex partner abuse and often people assume only men abuse their partners...also there's a lack of safe spaces to talk about it.

Focus group participants

WSW in the focus group identified a need for supports around negotiating healthy intimate and sexual relationships.

We need programs around communication skills, especially in relationships – help to say how you're feeling.

We need skill building to figure out how to deal with overlapping relationships – how to negotiate boundaries.

Focus group participants

Key informants also emphasized the importance of relationships but focused more on the issue of intimate partner violence in WSW relationships. They emphasized the need to dismantle the myth that women can't and don't hurt other women and develop ways to support women in negotiating healthy relationships with each other. They also suggested that more information, services and programs be available to assist women in their recovery from sexual violence, particularly childhood sexual abuse.

Key informants acknowledged other aspects of relationships, in particular some of the assumptions that can affect intimate and sexual relationships. These included the shame some WSW may feel about sleeping with men and assumptions around monogamy in relationships.

The assumption of monogamy in all relationships is a barrier. In queer relationships, monogamy as a default is much less likely.

Key informant

Key informants suggested that WSW with disabilities have unique struggles in overcoming stereotypes about their bodies, their sexuality and their desirability. It's particularly difficult for WSW with physical disabilities to connect with other WSW and find potential intimate partners. WSW with physical disabilities may be welcome to events and organizations in theory, but too

often the spaces where programs and events take place are not accessible. This means WSW with visible disabilities are not very visible in WSW communities.

The Importance of Community

Communities have a significant presence, whether positive or negative, in the lives of the WSW in the focus groups. Participants expressed a feeling of responsibility for their communities and the need to support and connect with one another. There was much talk, for example, about providing role models for young people and people newly coming out.

...role models, especially for those who haven't come to terms with their sexual orientation or sexual identity – this doesn't just apply to youth. It could be at any age you're coming out at. It's not just about educating about the facts but having role models about what the experience [coming out] is like, feeling like someone would understand you and feel safe talking about those issues.

Focus group participant

Many participants expressed a desire for social activities that could have an education-based component. They wanted fun opportunities to meet other WSW that didn't necessarily revolve around bar or club culture.

I'm not bar opposed but going there to find a long term relationship...it's almost like women go there 'cuz there's no other alternative.

Focus group participant

Key informants concurred that there is a need for events and programs that aren't necessarily about sexual health or health promotion but that are social in nature, at least to begin with.

Our events worked because it was fun. Something the community could show up to without having to be WSW. The fact that you can show up and not feel like you've come out as a dyke was part of what made it hugely successful...People could come and hang out and that's all they do – you didn't have to access sexual health info and resources.

Key informant

However, WSW communities are not always inclusive of all WSW. Women of colour participants expressed frustration and feelings of isolation in finding spaces where WSW of colour are welcomed, represented and able to connect with one another.

Part of the reason why I wasn't that involved in the community before was because everywhere I looked it was just white lesbian.

Focus group participant

Key informants added that WSW of colour are forced to contend with racism in WSW communities and stressed the need for anti-racist education in WSW communities. They also commented on the pressure within WSW communities for WSW to be out in all aspects of their lives. An assumption prevails that the wellbeing of women is diminished if they are not fully out. At the same time, newcomer women and many WSW of colour are sensitive to the fact that

being a visible part of the queer community can compromise their relationships with other communities they are, and want to remain, a part of.

Key informants also identified that trans WSW in particular face uncertainty and exclusion at many women's organizations and community events. They expressed a desire to include trans women but struggle with how to make that inclusion meaningful for trans WSW.

There are challenges around how to include trans women in a truly inclusive way. This is a challenge particularly with other non-trans participants.

Key informant

In spite of the lack of inclusion experienced by many WSW in LGBTQ communities, participants expressed a desire and willingness to enact change within those communities.

I would also like to have a group of 30, 40, 50-year olds who are aging and women of colour, where we could get together once a month to socialize...we could have discussions and maybe a movie...just so we can build some sort of community.

Well I think we have to take some responsibility too. We can attend and bring the numbers and involve ourselves. We need to take ownership because this is our community too.

Focus group participants

It is clear that for WSW, a sense of connection and community is an important part of wellbeing and feeling good as a WSW in the world.

Emotional Health and Wellbeing

Homophobia is bad for your health, bad for your mental health.

Focus group participant

Historically WSW, or more specifically lesbians, have been severely psychiatrized. Heterosexism has long stigmatized lesbian sexuality as related to mental health problems, which are also stigmatized. The misconception that LGBTQ people generally are dysfunctional and deeply troubled continues to be widespread (Brotman et al, 2002). Participants were aware of this misconception and expressed frustration about the assumption that as WSW, they must be depressed and if they are depressed, it must be because they are a lesbian.

I went to get treated for depression and they assume it's 'cuz of my lesbianism and I'm like 'it has nothing to do with this – it's this and that...'

There's this huge thing in the medical community – it seems like all lesbians are depressed or all lesbians go to psychiatry and it infuriates me 'cuz it's not all.

Focus group participants

Participants in the focus groups did acknowledge that some WSW grapple with mental health issues, depression in particular. However, they were clear that it wasn't *being* a WSW that made maintaining good mental health difficult but rather others' response to it. Adverse social attitudes, family and community rejection and homophobia are some of the additional stressors WSW must face in maintaining emotional health (Institute of Medicine, 1999).

Generally, women spoke of emotional wellbeing and self-esteem rather than particular mental health diagnoses. They made specific connections between emotional and sexual health and were critical about how often the emotional component of health is absent from health care settings.

If you're not well emotionally, it's hard to be healthy sexually.

Focus group participant

Like focus group participants, key informants emphasized WSW challenges to maintaining their emotional wellbeing in the face of homophobia.

Mental health is a huge part of sexual health. Mental health is wrapped up in relationships and feelings. If we treat sexual health as a medical problem alone then we miss a lot.

Key informant

Feelings of shame or confusion around sexuality can prevent WSW from accessing services. Trans WSW in particular may experience shame and have even fewer support services to access. Not having anyone to feel comfortable with in talking to about their sexuality can lead to feelings of isolation and stress. This gets particularly complicated when women are struggling with their sexuality and are contemplating coming out to friends and family. WSW who are not out in all areas of their lives may face or fear judgment from community members and health care providers who equate being fully out with good mental health.

Like focus group participants, key informants made the point that emotional wellbeing for WSW isn't exclusively about illness or addictions. While some WSW may grapple with addictions, depression and other mental health issues when it comes to sexual and reproductive health, key informants and focus group participants alike felt that emotional wellbeing is about feeling proud and solid as a WSW. As one key informant noted, it's not just about healthy behaviours and health information but about feeling good as queer people.

Health Issues and Aging

Although representation from WSW in their 50s in the focus groups was small, issues related to aging emerged. Participants in that age range raised concerns about the lack of information and queer-positive spaces available to WSW in their 40s and 50s around issues such as breast health and menopause. Menopause is of particular importance to WSW as they age, since there is a dearth of WSW-positive information to address this issue.

One of the things that's constantly on my mind these days is information about menopause and I would like to get that in a queer space.

Focus group participant

Women also expressed particular interest in knowing about the impact of medication, hormonal changes and chronic health conditions on their libido and ability to enjoy sex. Key informants raised similar health issues around aging. WSW face many of the same issues as heterosexual women. Practitioners and WSW themselves need to be educated about their

cervical, vaginal and breast health. What WSW also long for is sex positive information about those issues that affirms their sexual identities and is specific to their needs.

Resilience

Throughout this consultation, the resiliency of the WSW in the focus groups was clearly evident. Participants vocalized the multiple ways in which, despite a health care system that offers them so little, they manage to take of themselves and each other.

Becoming Educators and Self-Advocates

As has already been noted, WSW in the focus groups testified to experiences where they had to play the role of educator with their health care provider. Too often WSW had to inform health professionals about their sexual and reproductive health needs as a WSW and had to debunk myths and misinformation that many health care providers have about them. There were often times where WSW had to advocate for certain procedures or information when it was being withheld from them. While many of the women experienced this as frustrating, it demonstrates that many WSW can and will insist on getting the health care that they know they need and deserve.

Finding Alternatives to the Health Care System

During the focus groups, there was a lot of discussion around the use of alternative health care services. Given that the mainstream health care system can be less than satisfactory and often homophobic, many WSW turned to other sources to meet their health care needs. This included sex toy stores and the internet. Of particular note was the use of a broad scope of complementary health care providers by WSW instead of, or in addition to, their regular health care providers.

In terms of the focus on physicians, it might not capture how a lot of women are getting their health care needs met. In reality I've had more health care from my therapist, my naturopath, my fitness instructor, massage instructor, telehealth nurses, yoga instructors.

Focus group participant

For some women, the cost of complementary care providers was indeed a barrier and for others, their complementary care providers weren't necessarily any more supportive or less homophobic. However, the fact that WSW try, when and where they can, to access other avenues of health care attests to the reality that WSW are not content to put up with the compromised care they get from the mainstream health system.

Building New Kinds of Relationships and Community

As previously noted, WSW are actively redefining what intimate relationships look like and carving out new ways to be with each other that are alternatives to traditional, monogamous

partnerships. Perhaps the biggest strength demonstrated by WSW in the focus groups was around relationships, both intimate partner relationships and connection with WSW communities.

Participants are creating, challenging and/or changing WSW communities. Whether that means being active in those communities or being critical about what those communities look like and how inclusive they are or are not, focus group participants are actively imagining and engaging in ways to decrease isolation, support one another, share information and socialize.

Speaking Out

Just by coming to the focus groups, WSW participants demonstrated their unwillingness to accept the status quo and their readiness to speak out about the invisibility of WSW's sexual and reproductive health needs. Participants shared both their frustration with the lack of knowledge and services to address their needs and their excitement about making a contribution towards changing it. WSW in the focus groups clearly take advantage of, and create, opportunities both to have their voices heard and to illustrate their strength and resiliency.

It's difficult not to admire the resiliency and creativity of WSW. Despite the fact that the health care system does not serve or address their unique needs, they have managed to seek out alternatives to address their own health and well-being. While this resiliency is admirable, it is not enough. WSW should be able to access health care in the mainstream healthcare system on their own terms.

CONCLUSION

Planned Parenthood Toronto and Sherbourne Health Centre's consultation process on the sexual and reproductive health needs of women who have sex with women in their 30s, 40s, and 50s proved to be an important initiative. This report reflects the issues and barriers articulated by the 27 focus group participants and 25 key informant service providers that impact the ability of WSW to access services and make informed decisions about their sexual and reproductive health.

Our findings illustrate that while WSW face many of the same barriers that women in general face in meeting their sexual and reproductive health needs, WSW must navigate through additional barriers that are unique to their sexual orientations and practices. The question of disclosing their sexual identities and activities, their experience of homophobia, often coupled with other forms of discrimination, the lack of knowledgeable providers and the lack of services specifically for WSW are all unique barriers facing WSW when accessing health care. As a result, many WSW limit or avoid engagement with the health care system and compromised health is often the result. Education and training to ensure cultural competency in health providers so they can work appropriately, effectively and compassionately with diverse WSW would go a long way in breaking down the myriad false assumptions, misinformation and biases that many health providers hold about what WSW want and need. As key informants noted, these efforts need to be supported by more comprehensive research on the needs of WSW.

There is also a need to develop and expand health services and programming specifically for WSW in their 30s, 40s and 50s in the city of Toronto that address the broader social and political determinants that shape their health. WSW want those programs and materials to affirm their identities and provide accurate information that reflects an understanding of their sexual and reproductive needs and practices.

As with barriers to access, WSW grapple with many of the same sexual and reproductive health issues as women in general. However, their experience and needs around those issues are specific to their sexual orientations and practices. The importance of their relationships to intimate partners and their communities, the paucity of WSW specific STI/HIV information, the heterosexism of fertility services and the impact of homophobia on their emotional health and wellbeing are just some of the unique ways these sexual and reproductive health issues play out in the lives of WSW.

A critical theme in this consultation was the role of marginalization. For WSW of colour, WSW with disabilities, lower income/poor WSW, newcomer WSW and trans WSW, the impact of homophobia is confounded by other forms of oppression that complicate the issues they already experience as WSW and makes accessing services even more difficult. The lack of consensus around what exactly programs and services for WSW should look like underscores the need and desire for choice and flexibility in programs that can meet the needs of WSW from diverse communities.

Throughout this consultation, it was very clear that WSW already know what they want and need. They vocalized the multiple ways in which, despite a health care system that offers them so little, they manage to take care of themselves and each other. Recognizing WSW as the experts on their own lives and valuing their resiliency is important but it does not let the healthcare system off the hook. When any segment of the population has to seek alternatives to the health care system, not out of choice but necessity, it underlines the fact that our health care system is not equitable. As advocates of women's health care and the deliverers of community services, we must work more diligently to ensure that government and health care providers recognize their role in ensuring that WSW no longer have to create health services for themselves, but that they become the recipients of universal healthcare that meets their unique needs. It is our hope that the findings of this report will encourage agencies providing services in women's sexual and reproductive health to be a part of that effort.

RECOMMENDATIONS

Build Capacity through Community Partnerships

- Establish a network with community partners and agencies to review findings from this report and to build strategies that address the sexual health needs of WSW communities. Strategies must include:
 - Enhance existing women's programming and services in the city to ensure they meet the needs of diverse WSW communities
 - Encourage partnership opportunities among community agencies
 - Develop new initiatives to address gaps in programming and services.

Influence Training and Practice

- Advocate that curriculum be revised so that all students in health care professions receive mandatory anti-oppression and anti-homophobia training to build cultural competence to meet the needs of diverse communities, including WSW communities.
- Advocate that health care professionals, mental health professionals, support and administrative staff in the health sector receive anti-oppression and anti-homophobia training to build cultural competence to meet the needs of diverse communities, including WSW communities.
- Ensure that mental health approaches and practices do not stigmatize women who have sex with women because of sexual orientation or identity.
- Develop and implement anti-discrimination and access and equity policies in community agencies and health settings that are clearly communicated to service users.
- Develop and provide education to WSW communities on their rights within the health sector and how to navigate the health care system.

Conduct Research

- Conduct research on the specific sexual and reproductive health needs of diverse WSW communities in Canada. Research should include areas such as WSW communities and aging and the health needs of queer identified trans women.
- Ensure that research in general women's health include sexual orientation and gender identity variables.

Revise and Create Resources

- Revise existing materials and develop new educational materials and resources specifically addressing the sexual health needs of WSW communities.
- Create campaigns, tools and resources that debunk homophobic myths of WSW communities and provide positive images of WSW.

Address Sexual Health

- Provide education opportunities for WSW on their sexual health issues, needs and concerns including information on their bodies and sexual pleasure.
- Develop campaigns that challenge myths about the health needs of WSW, particularly around pap smears and STI prevention.

Address Fertility Issues

- Advocate that service providers delivering fertility services receive anti-oppression and anti-homophobia training to build cultural competence to meet the needs of diverse communities, including WSW communities.
- Strengthen partnerships with fertility clinics and sperm banks to reframe their work beyond an infertility context to be inclusive of WSW clients.
- Increase support programming for WSW who desire to become parents.

Address Relationships

- Increase programming, services and educational materials that address same sex abuse.
- Develop support services including group, individual and couples therapy on relationship issues.
- Develop and provide social opportunities for WSW to gather, connect and reduce isolation.
- Develop support programming and services that holistically addresses issues related to coming out and family relationships within various cultural contexts.

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WSW focus group participants

Key Informants

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Michele Clarke

Rose Gutierrez

Amita Handa

Hazelle Palmer

Nan Peacocke

Anna Penner

Cindy Weeds

APPENDICES

Appendix A: Partnership Agreement



**PLANNED PARENTHOOD OF TORONTO
SHERBOURNE HEALTH CENTRE
WSW Sexual and Reproductive Health Consultation
Partnership Agreement**

The Need:

Planned Parenthood of Toronto's (PPT) work in both clinical and community settings has demonstrated that there are major gaps in sexual and reproductive health programming for adult women who have sex with women (WSW) communities in Toronto. PPT in partnership with Sherbourne Health Centre (SHC) would like to address some of those gaps and explore the sexual and reproductive health needs of WSW communities. As a result, we are initiating a consultation process with service providers working with WSW communities and women from WSW communities, to identify their sexual and reproductive health needs in order to direct our programming.

Partners:

The lead partners involved in the consultation are Planned Parenthood of Toronto and Sherbourne Health Centre. Other agencies may join as collaborative partners sometime during the process.

Planned Parenthood of Toronto is a community-based, pro-choice agency that provides programs and services that focus on healthy sexuality and reproductive health, with a particular focus on youth and women.

Sherbourne Health Centre is an urban primary health care centre that provides innovative health services and wellness programs to the diverse communities of southeast Toronto with a special emphasis on local residents, homeless and underhoused individuals, the lesbian, gay, bisexual, transsexual and transgender (LGBT) communities and new Canadians.

Target Population:

This consultation is focused on adult WSW from diverse backgrounds in their 30s, 40s and 50s.

Goals:

Our goals for a consultation process with diverse WSW communities and the agencies that serve them are:

1. To identify the sexual and reproductive health needs of WSW in their 30s, 40s and 50s, living in Toronto.

2. To identify existing gaps and barriers in the sexual and reproductive health sector for WSW in their 30s, 40s and 50s.
3. To identify new programming possibilities for WSW in their 30s, 40s and 50s, both at PPT, Sherbourne Health Centre and other community agencies.

Working Group Structure:

Members of the working group will include:

Michele Clarke	Health Promoter, SHC
Cindy Weeds	Program Coordinator, Women’s Programming, PPT
Anna Penner	Peer Educator, PPT
Michele Chai	Community Health Promoter, PPT
Amita Handa	Community Health Promoter, PPT

The working group is accountable to Rose Gutierrez, Director of Community Programming and Anna Travers, Manager, LGBTTT Program

Functions:

The Working Group will conduct Key Informant Interviews and Focus Groups. The Key Informant Interviews will be conducted with various community agency workers and individuals from across the City. Focus groups will be conducted with the target population. The working group will analyze the results from the interviews and focus groups and produce a report for dissemination.

Budget:

Planned Parenthood of Toronto and Sherbourne Health Center will contribute equally to the cost of the consultation (see attached budget).

Dissemination and Next Steps:

The report will be disseminated to participants and relevant community agencies. Consultation results will also be disseminated at the Queer Health Matters health fair in April 2007 and will be organized by the working group.

Rose Gutierrez
 Director of Community Programming
 Planned Parenthood of Toronto

Anna Travers
 Manager, LGBTTT Program
 Sherbourne Health Center

Appendix B: Focus Group Consent Form

Informed Consent Form

Planned Parenthood of Toronto (PPT) is a community-based, pro-choice agency that provides programs and services that focus on healthy sexuality and reproductive health with a particular focus on youth and women.

Sherbourne Health Centre (SHC) is an urban primary health care centre that provides innovative health services and wellness programs to the diverse community of southeast Toronto with a special emphasis on local residents, homeless and underhoused individuals, the lesbian, gay, bisexual, transsexual and transgender (LBGTT) communities and new Canadians.

Our work in both clinical and community settings has demonstrated that there are major gaps in sexual and reproductive health services for adult women who have sex with women (WSW) in Toronto. Both PPT and SHC would like to address some of those gaps.

To help us do so, we are currently holding focus groups with women who have sex with women in their 30s, 40s and 50s to find out what their sexual and reproductive health needs are and what kinds of programs and services they would find useful.

As a participant, there are several things you should be aware of:

1. The groups will be run by two facilitators, who will ask questions, facilitate discussion and write your responses on a flip chart;
2. Participation is volunteer and you are free to withdraw from the process at any time;
3. You will receive \$20 cash and 2 TTC tokens at the end of the session for participating in the group discussion;
4. You are free to decide to not answer any question;
5. Our discussions in this session are confidential. Please do not share other people's personal stories in discussion with others.
6. We are documenting the groups with notes on flipcharts and notes taken by the facilitators. Documentation generated in the focus groups will be kept at PPT and SHC and may be used as the basis for written reports, research papers and publications, media articles, conference presentations and program evaluations. In all cases the names and identifying information of participants will be kept confidential, unless specific permission is requested and granted. All documentation personally identifying you will be destroyed no longer than seven (7) years from date of signing.

7. Questions about the project may be directed at any time to one of the group facilitators:

Cindy Weeds: PPT, 416-826-4560 x 223 or cweeds@ppt.on.ca

Anna Penner: PPT, 416-826-4560 x 230 or apenner@ppt.on.ca

I am fully aware of the nature of this project and have agreed to participate in it. I have read and understand this consent form.

Date

Name of participant

Signature of participant

Name of facilitator

Signature of facilitator

Appendix C: Focus Group Interview Guide

WSW FOCUS GROUP INTERVIEW GUIDE

Welcome

- Thank you for being here today, we value your opinions.
- Facilitators introduce themselves
- Housekeeping – refreshments, bathrooms, distribution/signing for tokens, childcare subsidy and honorarium at end of session, etc.

Why We are Here

Planned Parenthood of Toronto and Sherbourne Health Centre are working in partnership to talk with both service providers and women who have sex with women (WSW) communities to identify the sexual and reproductive health needs of WSW in their 30s, 40s and 50s. Our work in both clinical and community settings has demonstrated that there are major gaps in sexual and reproductive health programming that meets these needs and both PPT and SHC would like to address some of those gaps.

At this stage, we are gathering information from adult women who have sex with women and we want to know what you think about the sexual and reproductive health issues of your communities. We will use the information gathered from this process to inform the development of new programs and resources as needed and as resources permit.

Ground Rules

- There are no right or wrong answers; we want your opinion
- We want to make sure each person has a chance to talk and give us her advice
- Please be respectful of each other's answers, even if you don't agree
- We will be asking you several questions – For some questions, we would prefer to have as many people answer as possible. The discussion is free-flowing, but if we are running out of time, we may have to ask you to shorten your answer.

Questions

1. Please introduce yourself and tell us what brought you here this evening.
2. Can you describe your experiences with any general health care services that you receive?
3. What do the phrases “sexual health” and “reproductive health” mean to you?
4. What do you think are the important sexual and reproductive health needs of women who have sex women in their 30s, 40s and 50s?
5. Where do you go to get care for your sexual and reproductive health needs?
6. What do you think might stop you or other women from going to get care for sexual and reproductive health issues?
7. What kinds of sexual and reproductive health programs and services do you think we should be offering?
8. Is there anything that we should have talked about but didn't?

Appendix D: Focus Group Participant Profile

DATE: _____

WSW Focus Group Participant Profile

Thank you for agreeing to be a part of our focus group for women who have sexual relationships with women. This form is completely anonymous and voluntary. It will only be used for the purpose of informing us who participated in our consultation.

What was your sex at birth? _____

What is your current gender identity? _____

Age

30-39 40-49 50-59

Race/Ethnicity _____

In what country were you born? _____

What is your immigration status? _____
(ie: Canadian Citizen, Landed, etc.)

What is your religion? _____
(ie: Catholic, Muslim, none, etc.)

Do you have any disabilities?
 No Yes

(If yes, please note the nature of your disability)

What is your relationship status? _____
(ie: single, married, etc.)

What is your education level? _____
(ie: high school, college, etc.)

What is your employment status? _____
(ie: full-time, not working, stay home mother)

Do you have children?
 No Yes

(If yes, please note their ages)

Appendix E: Key Informant Questions

Key Informant Questions

WSW Sexual and Reproductive Health Consultation

1. Describe what sexual and reproductive health services and programs your agency provides.
2. How does your agency define “WSW”, “lesbian”, “bi-sexual”, “queer women”?
3. What services do/might women who have sex with women (WSW) access at your agency? Are any of them specifically targeted to WSW?
4. What would you identify as the sexual and reproductive health needs of WSW?
5. Can you identify any issues unique to WSW of colour, trans WSW, WSW with disabilities and newcomer WSW?
6. Can you identify any barriers for WSW accessing sexual health services in Toronto?
7. Can you identify any gaps in sexual health services for WSW in Toronto?
8. Can you describe any programming for WSW that you have been involved in and if so, what made it work/not work?
9. Are you aware of any/other sexual/reproductive health work/programs offered specifically for WSW living in Toronto? In Canada? Elsewhere?
10. If you could have any program/service for WSW in Toronto on sexual/reproductive health, what would it look like? What would be the most important elements of such a program?