

A person wearing a white lab coat stands in a field of tall, golden-brown grass. The person is positioned in the center-right of the frame, and their reflection is clearly visible in a body of water in the foreground. The background shows a clear blue sky and a distant horizon line.

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Taking Charge

A Handbook for Health Care and Social Service Providers Working with Trans People



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Much of this document was built off of the Project Max Guide.

The content of this guide was determined by a group of countless dedicated volunteers.

This resource is available to reprint and distribute, though not to sell.

The production of this document has been made possible through a financial contribution from the Public Health Agency of Canada. The views expressed herein do not necessarily represent the official views of the Public Health Agency of Canada .

March 2011

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Introduction:

A Reflection on the Creation of this Resource

We would like to extend a very warm welcome to all those who are taking the time to read through this guide! For a provider, picking up a copy of this resource is a step towards fostering trans-positive services. Because this book has a wide audience (including physicians, mental health professionals, medical specialists, social workers, staff at frontline service organizations, etc.), you will have to choose which chapters and sections are most relevant to the work you do.

Trans people in Québec experience a multitude of barriers in accessing health care and social services. These barriers include but are not limited to disrespectful and invasive primary care, a scarcity of trans-specific health care services, stringent processes for changing legal documents to accurately reflect gender identity, and policies which limit access to gender-segregated facilities. As a health care or social service provider, you can broaden your understanding of health through engaging with trans clients and their needs. This document has been created as a tool to offer providers tangible and important information about trans health as well as an understanding that the needs of trans people within the health care and social service systems are as diverse and varied as its population. Taking Charge believes that making facets of trans people's lives and realities visible is integral to providing relevant and respectful services for them.

This document was created within a harm-reduction framework and with a holistic understanding of health in mind. Taking Charge was initiated in an effort to create pertinent resources geared towards health care and social service providers, to break the isolation of allied professionals who work with trans people, and to dispel the misinformation that deters many health care and social service providers from working with trans people. The project also hopes that the information in this document will serve to develop and strengthen networks amongst frontline workers and community organizations to build a greater understanding of the needs and realities of trans people. As policies regarding access to services are often determined at the provincial level, some of the information in this guide is specific to a Québec context. A lot of

the guide's content is, however, applicable elsewhere.

This guide is an initiative of Action Santé Travesti(e)s et Transsexuel(le)s du Québec (ASTT(e)Q), a project of CACTUS-Montréal (Centre d'action communautaire auprès des toxicomanes utilisateurs de seringues), founded in 1998 by Diane Gobeil and Viviane Namaste. ASTT(e)Q was started largely in response to concerns surrounding access to services that both accommodate and are sensitive to trans people's needs; it grew out of a support group for trans women living with HIV. In the late 1990s, a needs assessment was conducted through CACTUS-Montréal to determine the shape and direction of ASTT(e)Q. The organization exists within the context of a rich history of activism, advocacy, and community organizing for improved access to health care and social services, housing, decent working conditions (in particular for sex workers), and HIV prevention. It strives, overall, to raise the quality of life of trans people in Québec.

A committee of over a dozen individuals steered the content of this guide. The committee is composed of trans people from different backgrounds and communities, as well as frontline workers, health care professionals, and social service providers who work with and advocate for trans people. This project is based on the understanding that trans people must meaningfully contribute to their own health resources, and the consultation process therefore privileged trans voices.

We hope that this resource will serve to encourage and empower those working as health care and social service providers, as well as frontline workers, to effectively advocate for trans people's needs within current systems.



Art by Irene Tsyrenski

Terms &

Definitions



People talk about their bodies and identities in many different ways. Below you will find an overview of some of the language and terms that people use within trans communities. These terms by no means constitute a definitive resource, and some of them may vary between cultural and linguistic communities. For example, a term accepted and used in one language or culture might be deemed offensive or unacceptable in another. This is especially important to keep in mind in a Québec context, as language used within anglophone, francophone, and allophone communities differs greatly.

Sex:

How we define biological differences between people's bodies. Sex is determined by what we are assigned at birth according to assumed or perceived chromosomal/genetic/anatomical/biological characteristics that are generally divided into male and female within a western medical framework.

Gender Identity:

How we identify and understand our own gender. Regardless of our physical sex, we might think of ourselves as male, female, or somewhere in between. Because they are our internal understanding of ourselves, our gender identities might not be visible to other people.

Gender Expression:

How we show and express our gender identity. For example, your gender expression might be feminine.

Sexual Orientation:

The types of people and bodies that we are sexually or romantically attracted to. For example, if you have romantic and/or sexual relationships with people who are the same gender as you, you might identify as gay, lesbian, bisexual, or queer. Like non-trans people, trans people can identify anywhere within the spectrum of sexual orientation.

Transsexual:

A person who identifies with the sex/gender different from the one they were assigned at birth. For example, a person who was assigned male at birth, but understands themselves as a woman, would be a transsexual woman. These people may decide to alter their appearance, body, name, and pronouns. Though within many circles the term “transsexual” is used only for those who choose to undergo Hormone Replacement Therapy and Sex Reassignment Surgery, this guide understands this term more broadly. We do this to acknowledge barriers to access to these services, as well as to respect people’s personal choices with regard to their bodies.

Transgender:

An umbrella term used to encompass all those whose physical sex differs from their gender identity or who experience discomfort with their gender assigned at birth. In some circles, this term is used to describe people who choose not to access Hormone Replacement Therapies and Sex Reassignment Surgeries as a part of their transition. Because this term is so vague, and used to encompass so many identities, it has been contentious, as some people feel it risks invisibilizing the varying needs between different trans communities.

Cross-dresser:

A person who presents as the opposite gender to which they were assigned at birth, either full or part time, but does not identify as transsexual, and does not wish to go through a physical transition. An example might be a man who dresses in typical female clothing, but who does not identify as a woman. This term has

replaced “transvestite” in English, though “travesti(e)” is used in many French and Spanish contexts.

Trans:

Usually short for “transgender” and/or “transsexual.” Trans means “crossing to another side.” So someone who presents, lives, and/or identifies as a gender other than the one they were assigned at birth is a trans person.

Cis:

This term is used in some trans communities to describe non-trans people. Usually it is short for “cisgender” and/or “cissexual.” Everyone is assigned a gender. Cis means “on the same side.” So someone who presents, lives, and identifies as the same gender they were assigned at birth is a cis person.

Two-Spirit:

A term used in some North American indigenous communities to describe a person who embodies both masculine and feminine qualities and attributes. This term is sometimes used to more generally describe transgender people in some Native communities.

Intersex:

A person whose body at birth is neither strictly male nor female by conventional medical standards (the medical term occasionally used is Disorders of Sex Development (DSD)). For example, a person might be born with a penis, but their body does not process the “male” hormone testosterone, and thus they might also naturally develop breasts and other “female” characteristics.

Transition:

The emotional and/or physical process of actively moving away from the gender you were assigned at birth and toward whatever makes you feel more comfortable. This looks different for every individual. This process may or may not involve a new name, new clothes, new pronouns, Hormone Replacement Therapy, surgery, etc.

Transphobia:

A prejudiced or bigoted hatred of trans people or anyone who violates gender norms, and the institutional system resulting from this bias. You don't have to be trans to experience transphobia.

WPATH:

Acronym for the World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association. It is a professional body made up of psychiatrists, endocrinologists, surgeons, and other health care professionals who work with trans people. There is also the Canadian Professional Association for Transgender Health (CPATH), the only national faction of WPATH.

Gender Identity Disorder (GID):

The official diagnosis, as outlined in the Diagnostic and Statistical Manual of Mental Disorders, to describe someone who experiences gender dysphoria. Unless the health care provider is working within a harm-reduction model, a diagnosis of GID is required to receive a prescription for hormones or to access Sex Reassignment Surgery.

Gender Dysphoria:

A term used within medical and psychiatric discourse to describe an incongruence between gender assigned at birth and gender identity. It is used to describe Gender Identity Disorder in the Diagnostic and Statistical Manual of Mental Disorders. Many trans people reject this term, as they find it pathologizing.

Passing:

Being perceived or read as the gender with which you identify.

Outing:

The act of revealing someone's trans status to other individuals. Make sure never to do this without the person's consent.

Understanding The



Bigger Picture:



A Primer on Social Determinants of Health & Harm Reduction

Now that we're starting to get familiar with some of the terms used within trans communities, it is time to start thinking about the frameworks that we use to understand health. Discussions about trans people within medical discourse, the media, and academia are too often relegated to hormones and surgeries, that is, to the "physical" aspects of a transition. Trans people's bodies and identities are therefore reduced to the status of their sexual organs, and their lives and realities are too often only understood within these terms. This kind of framework risks obscuring the ways in which institutional policies and social realities make the day-to-day lives of many trans people very difficult.

In order to approach trans health within a holistic framework, many allied professionals apply a harm-reduction approach, which recognizes the social, institutional, and economic circumstances that often result in a lack of access to basic services. Working from this approach, we can recognize that societal inequalities such as racism, poverty, ableism (discrimination against disabled people), social isolation, past trauma, and other forms of discrimination affect trans people and their access to medical and social services. These inequalities also affect the ways in which trans people are able to find accurate information regarding surgeries and hormones, as well as their ability to afford all the financial and emotional costs of transition.

Take for example the case of poverty. Trans people are disproportionately affected by poverty. With a critical eye to the barriers in place that create situations of extreme poverty, as a provider, you can learn to more effectively advocate for your patient/client.

Some of the reasons trans people and poverty are often linked are

- **Barriers in obtaining and maintaining secure employment:**

A trans person may be discriminated against because they ask to be called a name other than that which appears on their legal identification documents, or because they are not always perceived by others as their chosen gender. Showing identification, and providing transcripts, diplomas, or references are all ways in which people are inadvertently forced to reveal the fact that they are or were undergoing sex/gender reassignment. This prevents many people from applying for jobs or, if they do, minimizes their chances of being hired.

- **Loss of family and community support:** Some people lose the support of their family and friends after coming out. They can easily get kicked out of their parents' homes, disowned, or cut off from financial support or access to the financial resources upon which they once relied. This kind of extreme loss could also result in depression, which can interfere with the ability to work.

- **Standards of Care:** The WPATH Standards of Care impose strict limits on who can access hormones and surgery. In order to access surgery, a transsexual must undergo an extensive amount of therapy, often at great cost, as it is not covered by medicare. Some must pay more to access a support group or to receive a psychological evaluation. Many professionals charge exorbitant prices for their services and have no sliding scale fees based on income.

- **The high cost of surgeries and necessary procedures:** Although many trans-specific surgeries are covered in Québec, access to mental health professionals to write the letters of evaluation are a prohibitive cost for many. Furthermore, these surgeries are covered only for Québec residents with permanent immigration status, and many non-residents have to save for years to access them.

- **Other systemic barriers:** Some trans people may be working under a name that is different from their legal name. They may have difficulty cashing personal cheques made out to their chosen name or even to their legal name. This can be very stressful because of the risk of being "outed." Some trans people may not be able to access services because of their geographical location, because of the cost of transportation, or because of the cost of childcare. One way of helping with this is to be willing to see trans clients in their homes or to set up appointments in a way that maximizes the utility of their trip into your area.

While reading this guide, please try to keep in mind the various social and economic factors that limit access to essential services.

This can mean considering, for example, how immigration policies can limit access to health care and social services, how changing legal documents to more accurately reflect one's gender identity can help create the space for trans people to more safely navigate the world, and how trans people are often excluded from access to gender-segregated facilities (i.e. facilities that separate men and women), such as shelters and drug and alcohol detoxification/rehabilitation centres.

This information is far from exhaustive, but it is a starting point from which to get a glimpse into the harsh realities that some trans people face every day. As a service provider, you can advocate for your patients/clients by acknowledging the systemic barriers in place that prevent people from accessing services.

[Harm Reduction Philosophy](#)

Harm reduction is a philosophy popularized by people organizing around HIV/AIDS and other health issues related to injection drug use. It aims to reduce the harm relating to high-risk behaviors, without pathologizing or criminalizing those who engage in these activities. Harm-reduction work provides resources and options to drug users, to help make drug use a less risky activity, without trying to force users to stop this activity altogether. This includes, for example, distributing clean needles to reduce the possibility of people sharing or reusing gear. Harm reduction philosophy positions drug users as the primary agents of reducing risk in their own lives, empowers users to make their own choices, and provides non-coercive and non-judgmental services.

This framework has since been adopted by many other health care and social service providers in a wide range of contexts. Working through a harm-reduction lens in its broadest sense means learning and understanding all of the social inequalities that act as barriers in access to services, and providing non-judgmental support. A health care or social service provider applying this framework follows the lead of their patient/client by providing resources that are relevant and respectful of a person's individual needs, choices, and limitations.

Working from a harm reduction approach as a health or social service provider in a trans-specific context means

- Creating greater options for trans people to access Hormone Replacement Therapy. This can be done by using an informed consent model of care, which recognizes that your patient is best equipped to

make decisions about their own body and life;

- Acknowledging that trans people access hormones in a variety of ways, and that there are many people who find their hormones on the black market. As a health care provider, you can recognize and respect people's choices and provide resources and support on safer use of street hormones;
- Facilitating access to health care and social services to non-status trans people, and those whose immigration status is precarious;
- Dispensing all pertinent information regarding risks and side effects of Hormone Replacement Therapy and Sex Reassignment Surgery for trans clients, in order for them to make informed decisions regarding their health;
- Ensuring that people with a wide variety of gender identities and gender presentations routinely have a real voice in the creation of policies and programs designed to serve them;
- Providing clear explanations of how to safely acquire, use, and dispose of syringes and intramuscular and intravenous needles;
- Giving explanations of how to self-inject hormones safely;
- Creating and distributing resources on safer drug use;
- Consulting with peers to locate specialists who can provide services for your trans patients, including trans-positive gynecologists, endocrinologists, psychiatrists, and surgeons; and
- Respecting and recognizing that some people engage in sex work as a form of employment. This can be done by respecting people's choices, informing yourself about the distinct needs of trans sex workers, and by providing relevant resources and support.

Patient/Client Advocacy:



Frequently Asked Questions

As a provider, people from many different communities and walks of life access your services. As discussed in the previous section of this guide, trans people make up one population that is vastly medically unserved and marginalized within health care and social service systems today. It is up to you to think about ways to make your space more welcoming and respectful of trans people's needs. This chapter provides examples of respectful and appropriate responses to some of the questions health care and social service providers most frequently ask when working with trans people.

Many trans people have negative experiences accessing services, so taking the steps to create a respectful environment is critical in terms of helping your trans clients access your services with ease. A power dynamic exists in the patient/client and provider relationship, and reaching out to reduce this dynamic can create the space for your clients to feel more comfortable approaching you and being honest about their lives and needs.

This chapter will cover topics ranging from proper name and pronoun usage, to demystifying transsexual narratives and stereotypes, to respectful physical examinations.



My patient/client was assigned male at birth but is transitioning to female. At what point should I start to use female name and pronouns for this patient?

As a matter of respect and ethical service provision, you should ask every patient/client you encounter what name and pronouns they prefer. This question has no one definitive answer, and a variety of factors contribute to pronoun and name choice. Each trans person is unique; each person has a different way of expressing their gender and ways in which they want others to recognize that expression. For example, some transsexual women prefer that you use the pronouns "her" and "she" from the very beginning of their medical transition, while others might want you to wait before using these. Some trans

people use pronouns that are not gender specific. Still others may not wish to be referred to using a pronoun at all. It is always best to ask what language is considered respectful for each individual patient/client. Nothing should be assumed.

Trans people have different needs and wishes at different times during transition. Your patient is the expert on their situation and needs. Respecting changes that occur over time and the different needs associated with those times is important.

Also, aim to initiate a larger discussion specifically surrounding confidentiality and “outing.” Most trans people prefer to maintain autonomy over how and when to tell others about their transition. For example, a patient may prefer that you know and use their chosen name and pronoun in private, but may not feel comfortable with that same name and pronoun being used in the waiting room. Similarly, finding out how your patient feels about confidentiality vis-à-vis other members of your staff can be another step towards making them feel welcome. If your patient gives you permission to reveal their identity to members of your staff or other health care practitioners, this should only be done on a need-to-know basis.

Once you have had a clear discussion with your patient, consistently following their wishes shows respect, sensitivity, and support of your patient’s situation and decision to transition. If your patient wants everyone on your staff to use their chosen name and specified pronouns, you might also discuss with your patient the possibility of indicating this information on their file and medical records. The chosen name should be highlighted to indicate your patient’s preference to anyone looking at the records.



Should I write a prescription in my patient’s chosen name or in their legal name?

Laws are in place that regulate how prescriptions have to be written, and many doctors feel like they don’t have the option of prescribing medications in their patient’s chosen name. In practice, many doctors have found ways of advocating for their patients at pharmacies.

Medical care coverage is based upon the health care card number and legal name. Policy and practice regarding legal versus chosen name will vary from one pharmacy to another. Although not every pharmacy will acknowledge a prescription in a chosen name, ultimately, it should be the patient’s decision as to which name the

prescription is written in, i.e. whether or not to take this risk. Here are some other options:

If your patient would like to use their chosen name and they are worried about problems at the prescription counter, you might advise the patient to consult their pharmacist and discuss the situation before attempting to get their prescription filled. They may be able to get their pharmacist to place a note in their file stating that their chosen name is valid for their prescriptions.

Another possibility is to write the first initial of their legal name followed by their chosen name. For example, S. Jean Gagnon would be a compromise for someone legally named Sylvie Gagnon but who lives as Jean.

A third option would be to write a prescription using your patient’s chosen name and provide them with a “letter of introduction” written on your official letterhead, which explains that your patient is trans and is pursuing a course of hormonal treatment and which provides their legal and chosen names, their health care card and driver’s license information, and your signature.



Do all transgender and transsexual people need counseling to come to an understanding and acceptance of their gender identity?

Counseling is never a prerequisite for understanding or accepting gender identity. It may nonetheless be useful in some instances. However, there are many barriers to accessing appropriate therapy for trans people:


Therapy and counseling are expensive. As a group, trans people have a high poverty rate due to many factors including discrimination in employment, job loss, and loss of support networks. As a result many trans people cannot afford counseling on a regular basis.

Furthermore, it is difficult to find counselors and therapists who have an adequate understanding of trans issues, and this can be frustrating. A trans person may, for example, end up spending large portions of their counseling appointments trying to educate the counselor about trans issues.

Some therapists and counselors don’t believe that anyone can or should “change sex.” They may spend all the counseling time attempting to make the trans person feel more comfortable in their birth sex, for example. This enforced elimination of options is never beneficial in a

therapeutic setting, and is a significant barrier to trans people trying to access counseling.

Finally, for many people of all backgrounds, therapy carries a stigma. Trans people should not be required as a general rule to go through therapy in the pre-transition stages. Self-determination and bodily autonomy are important factors in the general sense of well-being. Making therapy obligatory reinforces the idea that transsexuals are unable to make healthy, educated choices. It also creates an additional financial barrier to transitioning that may put above-ground methods of doing so out of many people's reach. At the same time, it is important to try to make counseling and therapy accessible to those trans or gender-questioning people who feel they could benefit from it. Informed counselors and therapists with sliding-scale rates are valuable assets to the trans community.



What special considerations should I take concerning examinations on the genitals or breast tissue of transsexual people? What can I do to make these exams more comfortable for patients?

Physical examinations can be uncomfortable for many people. For trans people, they can be very nerve-wracking experiences. By recognizing the reasons they can be particularly difficult for trans people, you can help make their experience of physical examinations more bearable.

First of all, many people are uncomfortable being seen naked. For trans people, the vulnerability of exposure may be compounded by shame around body parts that don't match their presenting gender. Their alienation from these body parts might make acknowledging their presence difficult.


Secondly, some trans people have had negative experiences with medical professionals, for example, being treated like an oddity, or being examined for no other reason than to satisfy a doctor's curiosity or as a case example for medical students. Keep this possibility in mind, as it may be one of many reasons for trust to develop more slowly than you are accustomed to between you and your patients.

Below you will find two suggestions for ways you can make examinations more comfortable for anyone, regardless of their gender identity:

1) Acknowledge the difficulty of the situation. Vocalize that you realize that this may be difficult and explain the specific reason for this type of examination. For instance, "I know this may be difficult for you, but I will need you to lift your shirt so that I may examine your chest for lumps." Use language that is respectful of their gender identity. It can be easy to forget about appropriate gender terms when examining genitals; however, conscious respect of your client's wishes can go a long way in establishing trust. If a transsexual woman shows up and needs a routine prostate exam, do not forget to treat her as a woman throughout the process.

2) Give people privacy. Undressing can cause discomfort. For example, a transsexual man may need to unbind his chest for a breast exam, and this can be odd to do in front of someone. Be flexible to allow your patient their highest level of comfort. If they must wear a hospital gown, offer compromises like keeping certain articles of clothing on until or unless they must be removed.

These ways to make patients comfortable can be applied to all of your patients. If your patients have a positive examination experience with you they will be more likely to be honest and upfront about their health care needs and concerns.



Do all transsexual people have a history of non-stereotypical gender play from a young age?

No. This may be true for some transsexual people, but not all trans people have telltale "early signs." On the other hand, a child who does exhibit non-stereotypical gender play may never question their gender identity. At a young age, children may lack the concept of gendered play. A young boy may not be trying to communicate anything at all by trying on his mother's high-heeled shoes. Witnessing this kind of behaviour should not lead to assumptions about a child's gender and/or sexuality.

A more significant indicator of transsexuality is a person's vocalisation of the desire to or assertion that they belong to another gender than the one they were assigned at birth. However, while persistent vocalisation can be a good indicator of transsexuality, it is also not foolproof. Many transsexuals, for many reasons, never articulate their gender identity before adulthood. For others, only in middle age or as seniors are they able to express their trans identity. Age at the time of disclosure does not make anyone more or less trans.



What is the relationship between transsexuality and self-harm and self-mutilation?

People make many different changes to their bodies, genitals included. Modifications may be perceived by the individual as positive revisions, tolerable variations on previously intolerable body parts, self-mutilation, or some combination of these. Medical professionals tend to label all forms of body modification as “self-harm” or “self-mutilation,” regardless of the method used, precautions taken (sometimes otherwise recognized and valued in professional surgical settings), or relative danger of the act. The blanket use of the terms “self-harm” and “self-mutilation” ignores or dismisses the ways in which people who modify their bodies label the activity. Many people find these terms condescending or judgmental.

Some people who modify their bodies use the term “cutting” to describe the act of modification. For the purposes of this discussion, we will also use the term “cutting” to reinforce it as a viable alternative word for medical professionals.

When treating people who cut, as with anything else, mirroring how they refer to their alterations can be a way of showing respect and creating trust. Although cutting happens a lot among transsexual and transgender people, it is not a phenomenon that is linked specifically to this community. This is a population specifically categorized by discomfort in their bodies, however. Therefore, some may resort to changing their genitals in hopes to ease their pain, either through modification, or through an active desire to mutilate themselves.

Providers, when treating a trans patient who cuts, can focus on offering options for coping, or information on how to alter the body safely if that is the intention, instead of trying to stop the activity altogether. Coercive or pathologizing interventions will likely deepen any distrust of the medical establishment that already exists. People who cut will probably continue to do so in the face of such an intervention, and they will have even fewer options for medical advice, information, or assistance if their experiences with medical professionals continue to threaten their bodily autonomy.




If a transsexual person gets pleasure from their pre-operative genitals, does that mean that they are not truly transsexual?

No, true transsexuality is not determined by the pleasure a person gets or does not get from their genitals. “True transsexuality” can be

determined only by consistent self-identification as such. Some trans experiences with pre-op genitalia are described below. Please note that all of these responses are considered “normal” and part of the spectrum of transsexual experience.

- Some transsexuals are not at all comfortable with their birth genitals, do not get sexual pleasure from them, and wish to have genital surgery as soon as they possibly can.
- Some transsexuals may not feel entirely comfortable with their genitals, but may not be able to get surgery for medical, financial, or other reasons. They may come to a limited acceptance of their birth genitals, and get pleasure out of them, all the while looking forward to the day they can have genital surgery.
- Some transsexuals choose not to have their original genitals surgically altered and do get pleasure from their genitals.

Please note: Professionals should remember that talking about sexual pleasure within a professional/client relationship should be approached with sensitivity, as it is an intimate topic of conversation. If you are the person raising the issue, remember to ask yourself first if you believe your client will truly benefit from discussing the topic at this time.



My patient/client says he is transsexual but he often shows up at my office using his female birth name and looking like a girl. Is it possible that he is not really transsexual?

It is normal for a doctor who has little experience with trans people to question whether they are doing the ethical thing by providing services requested by a trans patient. One element of this questioning is to wonder whether or not the patient is “truly” trans. At times like this, a useful reminder for yourself is that a transsexual’s identity is not necessarily related to their public presentation.


Many circumstances can make it difficult for a person to present their preferred gender full time. Some examples of these circumstances are listed below:

- **Risk:** The risk of discrimination and harassment, because they may not “pass” one hundred percent, can make it unsafe for someone to exist full time in their desired gender.
- **Mental preparedness:** Some transsexuals may not be mentally ready to be completely out about their transsexuality. Becoming comfortable with their gender identity and with the concept of being a transsexual can be a long, slow process.

• **Personal circumstances:** It may be impossible for some transsexuals to present full time due to personal circumstances, for example, because they fear losing their job, or because they are a minor and their parents forbid them to present in their preferred gender.

The only person who can determine whether or not someone is transsexual is the transsexual person themself.

Health care professionals who operate on the principle of informed consent, who understand the difficulties that transsexuals face, and who respect the choices that trans people make to survive day-to-day, can rest assured that they are acting in an ethical manner.

 **My patient/client is a refugee. Which health care and social services are covered? How can I effectively advocate for a patient/client with a precarious immigration status?**

There are many trans people living in Canada who have migrated here from other countries. They live in Canada with a variety of immigration statuses. While some people arriving here apply for and are granted refugee status, there are still many trans people living here without legal status, and they access whatever services they can through underground channels. Sometimes, allied professionals will provide services to non-status people without a fee, or on a sliding scale, but for the most part, it is very difficult to access health care, social services, employment, or adequate housing without status.

While in general people arriving in Québec have to wait three months in order to be eligible to access health care, this policy does not apply to refugees. Once arriving in Québec, a refugee claimant can apply for the Interim Federal Health Program, which provides access to basic health care, but does not cover nearly as many services as the provincial medicare program. If a refugee is granted permanent residence, they may apply for full Québec Medicare coverage.

For information on access to health care and social services for refugees and others living in Canada with a precarious immigration status, check out <http://www.servicesjuridiques.org/pdf/Guide_for_community_workers.pdf>.

 **How can I make my services more financially accessible?**

Sliding scales for services can help people to access them. Adapting your “needs assessment forms,” used to determine the rate for which someone is eligible, can also be useful. For instance, if a youth wishes


to access a counseling slot reserved for people admissible under a sliding scale and the needs assessment deems that their parents should be able to pay for the full price of counseling, it can make a huge difference to understand that this person may not be receiving any financial support from their family. As well, it can be helpful to suggest alternatives to expensive products, for instance, a generic alternative aftercare product for electrolysis. Providing services free of charge (e.g. needle exchanges, assistance with hormone shots) as well as referrals to less expensive services can greatly aid in reducing the costs for trans people. Accommodating a client by suggesting a payment plan over a long term, as opposed to demanding lump payments, may be realistic as well.

 **I've noticed that many trans women do sex work. I am wondering if there is a correlation in between transsexuality and sex work?**

The reality is that many trans people (especially trans women and travesties) are sex workers. As we saw in the chapter “A Primer on Harm Reduction and Social Determinants of Health,” access to stable employment and housing is often a challenge for trans people. For some trans people, sex work is a viable job option that can provide enough money to live on. Furthermore, many trans people find supportive community as sex workers and find sex work provides a space to feel validated and desired in their chosen gender.

With that said, Canadian laws surrounding sex work often make it difficult for people in the industry to work safely. Learning about safer work conditions, and safer sex practices, as well as providing resources to sex workers on the laws about sex work in Canada are all ways of advocating for your patient/client.

To find more information on the laws surrounding sex work in Canada, visit <<http://www.chezstella.org>>.

 **I work at a women's shelter, and I'm concerned that allowing access to a pre-operative trans woman will make the other women in the shelter feel unsafe. What should I do?**


The presence of “male” genitalia is never a legitimate reason to deny access to services. People's experiences of gender must never be reduced to only their genitals. Trans women have experienced sexism, some are survivors of sexual violence, and many are systemically denied access to resources and services, just like other communities of marginalized women.

There are ways to put measures in place to support the needs of the trans women, while recognizing the needs of the non-trans women in your shelter.

Some ideas to move towards a trans-inclusive space could be:

- Developing policies at your shelter regarding gender identity. This could include expanding your anti-discrimination policy to include gender identity or implementing policies about housing people according to their gender identity.
- Promoting the visibility of trans women through popular education campaigns, hiring trans people as staff, or encouraging trans people to volunteer.
- Organizing regular trans sensitivity trainings and workshops for your staff.

Trans people are disproportionately affected by extreme poverty and homelessness, and are most often denied access to the shelter system. It is important to open dialogues about trans-inclusivity, both in your shelter, and more broadly.



My patient/client is presenting signs of a mood/personality disorder, and I'm wondering what the protocols are surrounding comorbid mental health issues? Are there any mental health issues that are contraindicative to initiating Hormone Replacement Therapy or Sex Reassignment Surgery?

Current or prior experiences of mental health issues are not absolute contraindications to the initiation of Hormone Replacement Therapy or Sex Reassignment Surgery. While it is important to follow your patient/client and support them through whatever they are struggling with, mental health issues and disability should not be a basis for refusing access to trans-specific services.

ASTT(e)Q does workshops and trainings for health care and social service providers. Consider organizing a training for the staff at your clinic or organization to facilitate the process of making your space more accessible and welcoming to your trans patients/clients. To contact ASTT(e)Q for a workshop, call 514.847.0067, extension 216.

Cross-Gender

Hormone Replacement Therapy



This section of the guide provides information on access to cross-gender Hormone Replacement Therapy (HRT) for trans people. Though not all trans people seek out HRT, for many it is an important aspect of their transition. Making HRT more accessible is integral to advocating for trans clients. This chapter will provide information to guide frontline workers and community organizations in the process of referring trans people to appropriate services and supporting them through the process of accessing hormones. It will also give an overview of different protocols and processes for prescribing hormones and outline some of the barriers that trans people face in Québec when trying to access HRT.

Initiating Cross-Gender Hormone Replacement Therapy

Many health care professionals harbour fears surrounding prescribing hormones to trans people, feeling as though they are not qualified or do not have the proper expertise or training. In fact, any doctor certified to practice medicine in Québec is able to prescribe hormones. People who get hormones by prescription (rather than through friends or the underground market) usually get them in three main ways: from a general practitioner, from a specialist, or from a gender clinic.

General Practitioner (GP): A GP (or family doctor) works with patients with a wide variety of needs and medical conditions. They may work out of a private practice or through a local CLSC. The job of a GP is to look after the overall health of their patients. Many family doctors provide HRT as part of primary care. Whether or not a GP will prescribe hormones to a trans person usually depends on both their comfort level and their knowledge base about trans health issues. If a family doctor is comfortable with providing a prescription for hormones to a trans patient, but is not knowledgeable on the subject, they might agree to do some research, and then prescribe once they are more informed.

Unfortunately, some doctors are uncomfortable providing hormone therapy to trans people under any circumstances, and a person trying to access trans-specific care might have to find a new GP. Organizations that provide services to transgender, transsexual, and/

or intersex people often maintain relationships with local doctors who are informed of the health issues surrounding HRT, so if the individual doesn't have a family doctor already, or if their family doctor is not willing to prescribe, a local organization might be a good starting point. To access information on doctors who prescribe hormones in Québec, contact a member of the Trans Health Network at santetranshealth@gmail.com.

Specialist: Other than GPs, two types of doctors who are qualified and most likely to be willing to prescribe hormones are endocrinologists and gynecologists. For the most part, these specialists require a referral from a general practitioner to book an appointment, but a person can technically self-refer. Some specialists are covered by Québec Medicare. Some specialists will initiate HRT only with a letter from a mental health professional that indicates an official diagnosis of Gender Identity Disorder. Often the waiting list to see a specialist is very long.

An *endocrinologist* is a medical specialist dealing with internal medicine. They have a special understanding of the role of hormones and other biochemical mediators in regulating bodily functions. They are also trained to treat hormone imbalances.

A *gynecologist* is a medical and surgical specialist concerned with the care of women from pregnancy until after delivery and with the diagnosis and treatment of disorders of the female reproductive tract. A gynecologist will sometimes prescribe and monitor hormones (to non-transsexuals as well as transsexuals), and will also perform hysterectomies and oophorectomies, two procedures desired by some people seeking masculinization and legally required in Québec to change one's sex designation from female to male.

Gender clinic: A gender clinic is an interdisciplinary specialty clinic usually located within a hospital. In Montréal, there is a gender clinic within the Montréal General Hospital (officially called "The Human Sexuality Unit"). While these clinics do not provide direct access to hormone therapies and surgeries on site, they have the capacity to perform assessments and treatment of concerns relating to gender identity, including counseling, psychotherapy, hormone assessment and monitoring, and documentation for approval of surgeries. Staff at gender clinics will be able to refer those accepted into the program to a GP or specialist who will write the prescription for hormones after certain requirements have been met. The estimated cost of pursuing therapy through the Montréal gender clinic is \$3375 per year. This does not include the cost of hormones, surgeries, or electrolysis; it only includes therapy. At the Montréal gender clinic, it takes one to three years to meet requirements to get access to a hormone prescription.

Although the Montréal General's Human Sexuality Unit offers services

to the trans population, it is not completely accessible nor is it realistic in its demands on its trans clients. The therapy required through this program before prescribing hormones can be years in length and cost upwards of \$200 per month. Because none of this therapy is covered by RAMQ, many trans people are left struggling to raise the money necessary to obtain the "official diagnosis" of Gender Identity Disorder that they need to access relevant trans-specific health care.

Due to the cost and duration of this channel, it is inaccessible for much of the trans population. Trans people, as a group, face discrimination in employment, education, and in housing, and as such the majority live at or below the poverty line. This makes paying \$200 a month unrealistic for many. Even in the best-case scenario, if a trans person is able to raise the money needed to complete the program, very few doctors are willing to prescribe hormones and the gender clinic does not have doctors on staff to prescribe them.

While for many years, the Human Sexuality Unit was understood to be the only option for trans and gender-variant people to access relevant services and Sex Reassignment Surgery covered by the Quebec government, there are currently many other options. Because procedure at the Human Sexuality Unit does not follow the WPATH Standards of Care or a harm reduction model, the services are often considered out-of-date. Furthermore, due to this program's prohibitive costs, stringent protocols, and lengthy waits for access to hormones and surgery, many trans people have been seeking out other options. For references to trans-positive mental health professionals, family doctors, and specialists, contact ASTT(e)Q at 514.847.0067. ext. 207.

At gender clinics in general, the common intake procedures involve the trans person answering a host of personal questions, including questions about sexual fantasies, favourite sexual positions, etc., in front of a panel of up to nine people affiliated with the clinic (e.g. doctors, student interns, and researchers).

Protocols and Standards of Care

Health care professionals use a variety of protocols when assessing readiness for HRT. Below is an outline of some of the protocols available, along with brief descriptions of the frameworks on which they are based.

The World Professional Association for Transgender Health (WPATH) Standards of Care

The WPATH Standards of Care are most commonly used among health care providers when prescribing hormones. The WPATH (formerly known as the Harry Benjamin International Gender Dysphoria Association) Standards of Care are put forward by

a professional body made up of psychiatrists, endocrinologists, surgeons, and other health care professionals. Some of the topics addressed in the Standards of Care include suggested requirements for HRT, surgery, and post-transition follow-up. WPATH released the 7th version of its Standards of Care in 2011. Many of the revisions are considered to be a vast improvement on the older versions, as the current document leaves room for health care providers to tailor the Standards of Care to their patients' individual needs.

Up until the 7th version of the Standards of Care was released, one of the suggestions for the initiation of HRT as outlined in the WPATH Standards of Care was the Real Life Experience (RLE). This prerequisite for hormone therapy initiation is based on the belief that in order to be able to make an informed choice about whether or not to transition (change sex), a transsexual person must live in their desired gender role full time. This includes seeking employment or attending school as this gender. For some professionals, only once this criteria has been met will they consider a transsexual ready for medical intervention (hormones, surgery, etc.).

A lot of debate surrounds whether or not the RLE is a necessary and/or ethical requirement for the initiation of HRT for trans people. The RLE is advocated for and practiced by many who follow older versions of the WPATH Standards of Care. According to this model of treatment, once the RLE period is over the person can decide if they would like to begin hormone treatment. The concept behind this belief is that transsexuals need to experience socialization in their chosen gender role in order to have a clearer understanding of the realities of life in that gender. Experience has shown that the RLE seldom changes a person's mind about transitioning. On the other hand, it does place transsexual people at significant risk. In many cases it is difficult or impossible for a transsexual person to pass unnoticed in the world in their desired gender without the benefit of hormones and/or surgery. Pre-transition transsexuals undertaking RLE are often easily identifiable as trans people, and thus often become targets of hate crimes and discrimination.

There is no scientific evidence that supports the belief that the RLE is beneficial or even necessary to transitioning. In fact, research done on the RLE indicates the contrary. Finally, even the WPATH board has changed opinion on the RLE several times. The 1979 version of the Standards required six months of RLE before a person was permitted to access surgery or hormones, while RLE was dropped completely in the 1981 revision. The 1988 revision reintroduced the RLE as one of the requirements to access HRT. The current edition of the Standards of Care does not suggest the RLE as a prerequisite for HRT at all.

Without scientific basis to prove its usefulness, the RLE is now sometimes used as an indicator of someone being serious about

transitioning, but is no longer considered by most professionals, and even the WPATH, to be a required step in this process. Because the RLE can actually place transsexuals at physical and emotional risk, a responsible service provider may conclude that the RLE should remain an optional experience, rather than a requirement, for cross-gender transitions.

It should be noted that the current version of the WPATH Standards of Care leaves a lot of room for a harm-reduction model. The document suggests that health care providers use the Standards of Care guidelines that can be modified depending on the individual needs and life circumstances of the patient. It states: "Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies." While ongoing therapy can be an important source of support in a person's gender transition, trans-positive and -specific mental health care is not always possible, because of financial limitations or geographical location, nor is it always desired by the patient.

Furthermore, the Standards of Care document also recommends a harm-reduction approach applied in circumstances where trans people are using black-market hormones. In outlining the requirements for HRT initiation in trans adults, this particular section indicates that it is acceptable for a doctor to forego the standard requirements "to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use."

It is important for all health care providers who are considering prescribing hormones to trans people to read through this document. The WPATH Standards of care can be found at <http://www.wpath.org/publications_standards.cfm>.

Although the WPATH Standards of Care are the protocols most widely used by health care providers, many clinics and individual doctors prefer to create their own guidelines and assess readiness for HRT using models based in harm reduction, self-determination, and informed consent. Such protocols assume that the individual is best equipped to make decisions about their own body, while providing the tools to ensure that the client has all the necessary information to make an informed decision. The relationship between these kinds of protocols and the WPATH Standards of Care changed when the 7th version of the latter was released in 2011. The new WPATH Standards of Care are more flexible, and they support the initiatives of individual clinics and doctors who alter and tailor the document to suit the needs of their clients.

Alternative Protocols

Both the Tom Waddell and Callen-Lorde Protocols are guidelines for health care providers and are based on the principles of harm reduction and informed consent. These guidelines do not determine who is eligible for treatment; they are working protocols designed to provide care to people who already self-identify as transgender and contain the assumption that people know what is best for their own bodies. These two protocols are the most commonly used by health care professionals and clinics working within a harm-reduction framework. Other protocols and standards, developed by individual doctors or clinics, are also available. A comprehensive list of these protocols can be found at <http://www.santetranshealth.org>.

Initiating hormone therapies for trans people within a harm-reduction framework is one way of advocating for trans people, who experience multiple barriers to access to adequate and respectful health care. Doing so acknowledges the ways in which the systems in place to access trans-specific health care services do not take into account many of the realities that trans people face every day. Keep in mind that the 7th version of the WPATH Standards of Care, which are internationally recognized as a document assembled based on the experience of practitioners worldwide, now supports the use of harm-reduction models of care. Trans people have pushed for harm-reduction models of care to be recognized as a legitimate practice when prescribing hormones for decades, and the importance of the inclusion of that perspective is groundbreaking.

Assessing Readiness for Hormone Replacement Therapy

An ethical approach to determining whether HRT is suitable for someone will necessarily include enhancing patient knowledge and emphasizing patient self-determination. As a health care practitioner, you will undoubtedly come into contact with trans people who want to receive hormone therapy and have differing levels of information regarding the risks and benefits of this treatment. Therefore it is essential that you can provide them with accurate information. They need to be aware of possible side effects as well as the consequences of short- and long-term hormone use. Someone who has accurate information about the effects and risks of HRT, as well as the mental capacity to make a decision, will be the best judge of whether or not they should undergo this therapy. Once your client has made the decision to begin hormone therapy, you may wish to have them sign a consent form stating that they are aware of the risks and permanent or temporary changes that might occur should they begin treatment, as well as to confirm their desire to begin treatment.

Many trans people choose not to—or are unable to—access HRT through a doctor, with a prescription. As a result, people access

hormones on the underground market, over the internet, through a dealer, or from a friend who has a prescription. Often, when trans people access hormones without a prescription, the brand or kind of hormones they are taking are inconsistent. They also might not have information on the proper dosage or how to administer the hormones.

Advocating for trans people who are taking hormones without a prescription includes the acknowledgment that people make choices in their lives that make the most sense for them. People decide not to access hormones through legal channels for a variety of reasons: many trans people access hormones through the underground market because they have had bad experiences accessing health care in the past, or because they do not have status in Canada, and therefore cannot access health care services. Please consider and be sensitive to the individual journeys of the trans patients you encounter when you are discussing HRT with them.

Liability

The use of an informed consent form, baseline tests and proper monitoring of patients on HRT are the best protection you have against liability.

Informed consent: Informed consent in the context a patient who wishes to undergo HRT involves communicating to them the risks and side effects associated with hormone therapy and making sure the patient understands these risks. A frank discussion with your patient can help determine what they already know about hormones and what information you can offer. Physicians must be able to offer accurate and complete information regarding risks and side effects of hormones to patients. Therefore, the more you as a doctor know about hormones, the better you can inform your patient and thereby reduce your liability. The more a patient knows about hormones, the better equipped they are to make good decisions about their transition and be happy with the results. The consent form must state clearly that the patient has been informed of the risks associated with HRT, and that they are willingly receiving hormone treatment. It must also state that the medical practitioner is not responsible for this decision but that they will, however, ensure the best care possible through the transitional process and follow-up.

Sample informed consent forms can be found at <http://www.santetranshealth.org>.

Baseline tests: All patients who are about to begin HRT should be given a series of baseline tests, which will be important in determining hormone dosage and useful in future monitoring. Below are the baseline tests suggested prior to commencement of HRT. It is recommended that the tests be repeated two months after starting or

increasing the dosage and every six months after establishing a stable dosage.

Baseline tests for patients planning to begin HRT:

- CBC with differential
- liver panel
- renal panel
- glucose
- hepatitis B total core ab
- hepatitis C ab
- VDRL (or RPR)
- lipid profile
- prolactin level
- urine GC
- chlamydia
- HIV
- surface antigen and antibody
- testosterone level
- estradiol

A more in-depth list of baseline tests and a detailed description of recommended guidelines for HRT in trans adults can be found at <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf>.

Monitoring: After prescribing the hormones, the doctor must be able to adequately monitor their patient. If they are uncomfortable with this type of monitoring, they can provide a referral to another health care provider, such as an endocrinologist. If you are a doctor reading this guide, please keep in mind that you already have more information and training on this subject than many other doctors. therefore, referring a trans patient somewhere else is not always the best solution. Please consider talking with colleagues about their experiences working with trans people before making referrals. ASTT(e)Q has access to a database of trans-specific and trans-positive health care and social service providers. Contact us if you are looking for a trans-positive doctor with specific skills and training.

Hormone Regimens

Trans men on HRT take testosterone. This is most commonly administered by intramuscular or subcutaneous injection, but is available in transdermal (patch or gel) or oral (pill) forms.

Trans women on HRT usually follow a regimen of taking both anti-androgens, to suppress the production of testosterone in the body, and estrogen, to induce typically female characteristics. Anti-androgens are generally administered orally (pills). Estrogen is available in oral

(pill) and transdermal (patch, gel, cream) form. While injectable estrogen is not available by prescription in Canada, it can be found on the black market. A third hormone, progesterone, is linked directly to the reproductive cycle in people assigned female at birth and is not produced in those who were assigned male at birth. It is not necessarily prescribed as part of a hormone therapy regimen for male-to-female trans people.

Permanent and Reversible Changes

Expected Effects of Testosterone

Permanent changes include:

- Lowering of voice
- Increase and development of facial and body hair
- Possibility of sterility
- Possibility of permanent hair loss
- Increase in size of the clitoris

Reversible changes include:

- Loss of menstruations
- A redistribution of body fat into a typical male pattern away from hips and to the middle
- Increase in muscle mass
- Thicker, oilier skin
- Development of acne problems
- Increase in libido
- Mood changes

* These changes should revert if HRT is stopped.

Expected Effects of Estrogen

Permanent changes include:

- Breast tissue development
- Possibility of sterility

Reversible changes include:

- Loss of erections (spontaneous and morning) as well as a difficulty to maintain a firm enough erection for penetration
- A decrease in acne
- Diminished or slowed balding
- Softer skin
- Less noticeable body hair growth
- Less prominent beard growth
- Decrease in abdomen fat and redistribution to the buttocks and thighs
- Change in libido/decreased sex drive
- Mood changes

*These changes should revert if HRT is stopped.

The amount of time it takes for certain changes to become perceptible varies from one person to another. As a general rule, people experience the majority of changes during the first two years of their hormonal transition; however, some big changes may occur after that point. The patient is unlikely to experience any growth of the musculature unless they have not yet finished puberty. Once their body has stopped growing, their bone structure will no longer change.

Many trans people initiate HRT and continue to take hormones for the rest of their lives. Some, on the other hand, choose to take hormones only until they achieve the desired changes. Everyone's decision is legitimate, and it is important to continue monitoring your patient/client's baseline levels even if they decide to stop HRT.

Referral Letters

Referral letters written by mental health professional are often necessary to initiate cross-gender HRT. As previously mentioned, protocols based in a harm reduction philosophy generally don't require a referral letter from a mental health professional. Many doctors or clinics using the WPATH Standards will request one before initiating hormones. Referral letters are also required for Sex Reassignment Surgery, and are written in the same fashion.

While it is necessary to include the person's legal name and birth sex in a referral letter, if they do not identify with either of these, then they need only be included in the letter as a matter of fact. Simply indicate legal name, the actual name, and then write the letter using the actual name and actual pronouns used by the patient (e.g. "This letter is with regards to Alice Cheng [legal name David Cheng]. She is a transsexual woman who is legally male.").

This referral should be written on official letterhead and should include your name and contact information. Therapists, counselors, sexologists, psychologists, and psychiatrists can all write referral letters if they encounter individuals wishing to access hormones or surgery. However, some surgeons or doctors may have more specific requirements for referral letters, for example, they may require a letter from a psychiatrist who specializes in gender identity. It is important to double-check the specific requirements of each doctor before sending your patient to them. According to the WPATH Standards of Care, a letter of reference to initiate HRT must be written by a mental health professional, and must include the following elements:

1. The patient's general identifying characteristics
2. Results of the client's psychosocial assessment, including any diagnoses

3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent
4. The eligibility criteria that have been met and the mental health professional's rationale for HRT or surgery
5. A statement about the fact that informed consent has been obtained from the patient
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this

Minors, Hormone Therapy, and Hormone Blockers

Under Québec law, minors younger than fourteen years old cannot consent to care on their own. When a person reaches the age of fourteen, they are then able to make many decisions about their health without requiring the consent of their parents or guardians. Minors aged fourteen years or older are generally considered capable of making decisions about their sexual health, and their confidentiality is assured in the same way as it would be for an adult except when the security or development of the teen is considered to be at risk. Minors fourteen years and older will, however, require the consent of their parents or guardian for medical treatments that pose serious risks to their health or could have grave and permanent effects.

At this time, there are no examples of court cases in Québec or the rest of Canada involving minors trying to access cross-gender Hormone Replacement therapy or hormone blockers. If such a case did come before a Québec court, the judge would need to take into account the best interests of the minor, both the minor's and their guardian's wishes, and the opinions of experts. For more information on the laws surrounding consent to care, please visit http://www.educaloi.qc.ca/en/loi/health_care_users_and_professionals.

Some doctors prefer to administer hormone blockers to trans youth, as opposed to initiating HRT at such a young age. This alternative prevents the onset of puberty, and when and if the patient wants to start hormones, that process can be initiated afterwards. There are many advantages to preventing puberty as an initial intervention in youth on the brink of developing undesired secondary-sex characteristics. It makes an eventual transition much easier and less costly. For example, a regimen of anti-androgens from pre-puberty might preclude the need for electrolysis for someone who is seeking a feminine appearance, just as the prevention of breast development might preclude the need for chest reconstruction surgery later on for someone who is seeking a masculine appearance. Another benefit is that there are fewer permanent effects. In the event that a youth changes their mind, the treatment can be stopped, and the patient will experience the normal changes of puberty for their birth sex. Most obviously and perhaps most importantly, there are the enormous psychological benefits that come from living in one's

preferred gender. Finally, it is beneficial for youth to receive support and validation from the adults in their life through their decision to transition. More information on HRT in young adults can be found at < <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-adolescent.pdf>>.

Refugees and Access to Hormone Replacement Therapy

Refugees can be covered for access to general practitioners and doctors in the public system to prescribe hormones, but do not have access to the Québec Prescription Drug Insurance Plan, which might cover some of the costs of the hormones. If the doctor is willing to advocate for their patient, hormones can be covered through the Interim Federal Health Program. The doctor following the patient would have to give an official diagnosis of Gender Identity Disorder, and explain why and how Hormone Replacement Therapy is an “essential service.” The prescribing doctor must have prior approval, by filling out the appropriate claims form, which can be found on the Medavie-Bluecross website, at <<https://www.medavie.bluecross.ca>>. For a list of providers who are registered with the Interim Federal Health Program, visit <<http://www.ifhp-pfsi.ca>>.

Depression and Hormone Replacement Therapy

Transitioning can be a difficult time for anyone, therefore it is normal that people undergo a wide variety of emotions throughout the process. The wait for HRT to begin can be a difficult and depressing time for transsexuals, as a desire or need for their bodies to reflect their inside may become incessant. This may not be a representation of their general emotional disposition. The prescription then can reduce this anxiety and offer them the feeling that they have started their transition in a concrete way. For others, their depression may be rooted in the difficulties or obstacles faced by those wanting to transition. In those cases it is necessary to gauge what kind of effect transitioning will have on their well-being. Transitioning will not be a miraculous problem solver for the rest of your patient’s life. It will however, offer them some emotional release that might allow them to better handle and tackle the other problems. It is important to remember that hormonal transition does bring some additional stresses. For some there may be problems with employment or with family. Therefore it can be good to refer the person to some other support systems in order to help them deal with the psycho- social effects of transitioning.

While there have been some reports of depression specifically due to estrogen therapy, this in itself should not be a reason to counter indicate hormones. A patient’s prior history of depression should always be taken into consideration. In some cases it may be necessary to prescribe an anti-depressant or to modify their hormone dosage.

Trans-specific Surgeries



The information in this chapter is intended to outline the surgeries available to trans people wishing to medically transition sex, and the ways in which people can access these procedures in Québec. Your relationship with trans clients will benefit from you familiarizing yourself with the steps that trans people must take in order to gain access to these procedures and why many trans people either choose not to, or are unable to, obtain access.

There are so many individual gender identities, and priorities vary so greatly from person to person, that there is no “formula” for a gender transition. Some people have many of the surgeries, some people have none, and others have one or two. Factors that play a role in determining the ways in which people transition medically include choice, ability, overall health, financial status, and immigration status.

Access to Sex Reassignment Surgery in Québec

Some of the surgeries listed in this chapter are not currently covered or available in Québec. Some of them are also accessible and covered in other provinces in Canada.

Refugees and people covered for medical services under the Interim Federal Health Program cannot access trans-specific surgeries covered by the government in Québec until they apply and are accepted for Québec residency. The policy stipulates that a person must be a Québec Resident in order to be covered for access to trans-specific surgeries.

Before September 2009, all trans people wishing to access trans-specific surgeries in Québec had to pass through the program at the Human Sexuality Unit at the Montréal General Hospital. Since then, the manner in which trans people can access Sex Reassignment Surgeries (SRS) in Québec has changed. Publicly funded surgeries are being handled by a private clinic, the Centre Métropolitain de

Chirurgie Plastique in Montréal. Following a process of psychiatric evaluation, patients can present themselves directly to the clinic.

The requirements for accessing SRS in Québec are as follows:

- Two letters of reference/evaluation from a psychiatrist, psychologist or sexologist, one of whom has seen the patient for at least six months, and the other of whom plays an evaluative role;
- One letter from a doctor (an endocrinologist or family doctor) who is prescribing hormones (this is not a requirement for a double mastectomy/chest reconstruction surgery); and
- One letter from a family doctor indicating good health of the patient.

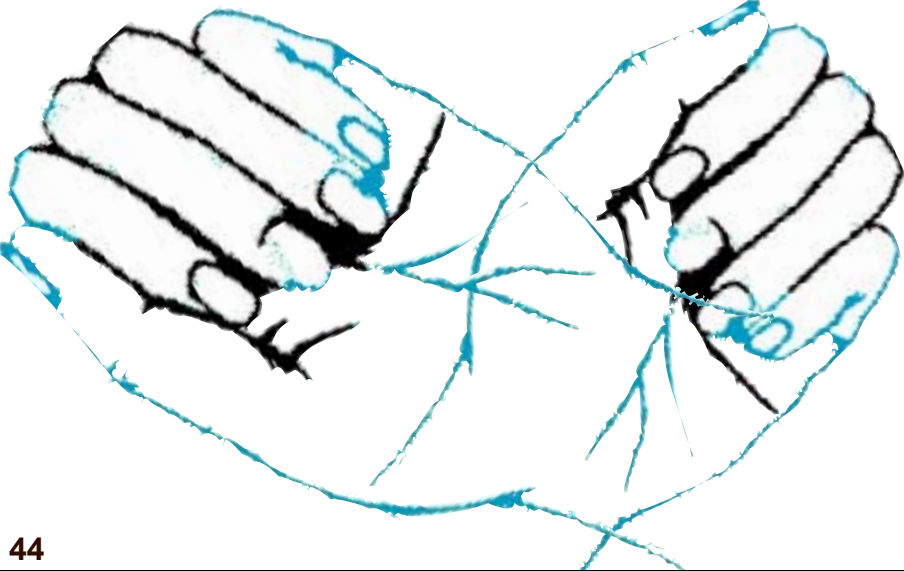
Surgeries covered by the government of Québec include phalloplasty, metoidioplasty, vaginoplasty, double mastectomy with reconstruction, and hysterectomy. With the exception of hysterectomies, all the above listed surgeries, covered by the government, are done at the Centre Métropolitain de Chirurgie Plastique. Hysterectomies are accessed by trans men through regular channels, and not through this new method.

These procedures are fully covered for Québec residents only. Residency for permanent residents and citizens of Canada can be established after living in Québec for a period of three months. As it stands now, however, one cannot be reimbursed for surgeries done before September 2009, nor for surgeries done at other clinics.

Following is a list of surgeries that trans people might access over the course of their transition, including both surgeries which are covered in Québec and surgeries only accessible through the private sector.

Surgeries accessed by female-to-male transsexuals

Surgery	Description
Double mastectomy and reconstruction	This procedure involves the removal of the breast (bilateral mastectomy) and the construction of a male-appearing chest line.
Hysterectomy	This procedure involves the removal of the uterus through one of three methods: abdominal incision, laparoscopically (by laser), or vaginally. The latter method is most commonly performed when the ovaries are not being removed at the same time.
Metoidioplasty	This procedure involves releasing the clitoris and allowing it to extend to its full length. This surgery results in a micro phallus (small penis). Some people also get their urethra extended, so that they can urinate through their penis. Testicular prostheses may also be implanted during surgery.
Oophorectomies	This entails the removal of the ovaries (and is often done in conjunction with a hysterectomy). This is one way to maintain a certain androgen level while decreasing the actual dosage of testosterone that is applied.
Phalloplasty	A procedure that involves the construction of a penis.



Surgeries accessed by male-to-female transsexuals

Surgery	Description
Bilateral orchiectomy	This involves the removal of the testes from the scrotum. Some people undergo orchiectomies in order to quit taking androgen blockers, or to place a stop to the testosterone production in their system. The scrotum is left in place, and can be used during further SRS.
Breast implants/augmentation	The surgeon inserts saline implants either over the pectoral muscles and under the glands, or under the pectoral muscle.
Cricothyroid approximation (voice box surgery)	This surgery involves the tightening of the vocal cords. This surgery does not change voice intonation, nor does it make the voice higher. It simply raises the lower range to a higher range. Many people opt to get their Adam's apple shaved (laryngeal reduction) at the same time.
Laryngeal reduction (Adam's apple shave)	This surgery can reduce the appearance of the Adam's apple. A small incision is made over the Adam's apple and the protruding thyroid cartilage is shaved and then sanded down to make it less visible.
Vaginoplasty	This procedure is the surgical construction of a vagina. A labiaplasty may be performed at the same time or at a later date. In a labiaplasty, the minor labia can be created or refined, and the neoclitoris can be hooded.
Other surgeries that some trans people may deem necessary	<ul style="list-style-type: none"> • Facial feminization surgeries (nose, jaw, forehead and/or chin recontouring and cheek implants) • Hair implants • electrolysis/laser hair removal

HIV/AIDS, Serostatus & Transitioning



Seroprevalence in Trans Populations

The HIV seroprevalence rates within trans communities, especially amongst trans women, are disproportionately high. Some research has been conducted in an effort to better understand some of the reasons behind the high seroprevalence rates, in order to create trans-specific HIV resources and prevention programs.

Some of the reasons behind the high HIV seroprevalence rates:

- Many trans people share intravenous and intramuscular needles for both drug and hormone use. While in Québec clean needles can be accessed at pharmacies and needle exchanges, many of these locations do not distribute intramuscular needles for hormone injections. Easy access to clean intramuscular needles can be a challenge especially if people are using black market hormones. As a result, many people still share their gear. A list of locations where people can access clean needles can be found at http://www.msss.gouv.qc.ca/sujets/prob_sante/itss/index.php?aid=154. Call in advance to find out if the location distributes intramuscular needles.
- Safer sex education and HIV-prevention materials and resources often fail to address the needs and realities of trans people by using language that alienates and excludes trans bodies and lives. There are very few safer sex resources that are created by and for trans people and that address their unique experiences.
- Some trans people feel as if they are not vulnerable to HIV because of a lack of visibility and open dialogue.
- Trans people often experience a lack of self-esteem and fear of rejection, especially surrounding sex and romantic relationships, which can lead people to take risks that they otherwise might not take.
- Because of a fear of being mistreated and experiencing discrimination, many trans people are reluctant to access health care services.
- Many HIV/AIDS service organizations do not actively seek to make

their resources relevant to trans realities.

- HIV/AIDS research often neglects to consider the experiences of trans people. Trans women, for example, are lumped into the men who have sex with men (MSM) category, despite the fact that they are women, and many of them do not necessarily sleep with men. This kind of research therefore obscures the realities of trans people. Some interesting information and practices on trans-inclusive research models, can be found at <<http://transhealth.ucsf.edu/pdf/data-recommendation.pdf>>. Trans Pulse is a trans health-specific research project, and is a good example of community-based research project. The Trans Pulse website can be found at <<http://www.transpulse.ca>>.

Disclosure

Patients do not generally have to disclose their HIV status to their health care provider. Moreover, many medical ethics bodies have ruled that a person should not be denied services due to HIV status or refusal to take an HIV test.

Under the Québec Charter of Human Rights and Freedoms, HIV is considered a disability. Discrimination solely because of seropositivity is therefore a violation of the Charter. Furthermore, the WPATH Standards of Care state that, “It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.” As well, the Québec code of ethics dictates that a “physician may not refuse to examine or treat a patient solely for reasons related to the nature of the patient’s deficiency or illness, or because of the race, colour, sex, pregnancy, civil status, age, religion, ethnic or national origin, or social condition of the patient, or for reasons of sexual orientation, morality, political convictions, or language; he may, however, refer the patient to another physician if he deems it to be in the patient’s medical interest.”

Finally, many practitioners follow the WPATH Standards of Care, which deal specifically with the medical care of transgendered and transsexual people, and so are ethically bound to offer services to HIV-positive clients. From this we can also conclude that HIV in itself is not a valid cause for refusal of treatment.

There may be instances where a health care provider might discourage or deny hormones or surgery because of the health issues linked to advanced HIV. Unfortunately, since anti-HIV discrimination is

often couched in these terms, sorting through medical truths versus medical discrimination remains an ongoing struggle for individuals and the people and organizations that advocate for them.

Occasionally, surgeons have refused to provide gender reassignment surgery based solely on the patient’s HIV status. This is entirely unethical and constitutes violation of Québec’s Charter of Human Rights and Freedoms. The only recourse one has in this case is to file a complaint with the human rights commission.

At the Centre Métropolitain de Chirurgie Plastique clinic in Montreal, HIV-positive trans people are deemed eligible for SRS on a case-by-case basis, depending on the overall health of the patient.

With all of that said, it is important to keep in mind that current Canadian law stipulates that HIV-positive individuals can face criminal charges for failing to disclose their HIV status when engaging in activities that pose a “significant risk” of transmission. Because of standard medical precautions, it is unlikely that this would be a cause for concern regarding disclosure with a health care provider. In most of these cases, people have faced charges related to nondisclosure with their sexual partners. As of yet, there have been no cases related to HIV-positive patients not disclosing their HIV status to their doctor.

For more information on the criminalization of HIV in Canada, visit the Canadian HIV/AIDS Legal Network website at <<http://www.aidslaw.ca>>.

Health Risks

HIV seropositivity is not a contraindication to Hormone Replacement Therapy. Risks do exist, however, and for this reason it is always best to be equipped with a wide variety of medical information and opinions. Some people have been able to do this by disclosing their serostatus to their doctor. Others do this research elsewhere, with the help of someone they trust.

There are particular risks if the person is planning on having any surgery, or if they are undergoing to planning to undergo feminizing or estrogen-based hormone therapy. There are no documented risks for masculinizing hormone therapy in HIV-positive individuals (though this could indicate a lack of research on the subject, rather than lack of risk).

Surgery and Serostatus

As previously mentioned, the WPATH Standards of Care highlight that it is unethical to refuse trans-specific health care based solely on an individual's HIV status. However, HIV can have an impact on how quickly a person recovers from surgery, and on after-surgery risk level for opportunistic infections.

Some practitioners use the following criteria to help determine eligibility for surgery.

The patient

- has no prior history of opportunistic infection
- does not have fullblown AIDS
- has a CD4 count above 200
- has viral replicas less than 600

These guidelines are suggested by A. Neal Wilson, a doctor at the Detroit Medical Center Hospitals, where at least eleven successful SRS procedures have been performed on HIV-positive patients. Sheila Kirk is another doctor who has performed successful SRS on trans patients living with HIV, and has contributed to and co-edited an anthology on the topic called Transgender and HIV: Risks, Prevention, and Care.

Hormones and Serostatus

Some HIV medications result in lower hormonal levels for feminizing or estrogen-based hormone therapy. Sometimes, these levels result in the reversal of feminizing effects, including the return of body hair, more frequent erections, and weight loss. These are among some of the observations made by Dr. Gal Mayer, an HIV specialist at the Callen-Lorde Community Health Centre in New York City.

Mayer also specifically suggests avoiding Propecia, a drug that fights hair loss. He also cautions about the contraindications for those on a regimen of ethinyl estradiol and progesterone, as drug interactions can adversely affect the level of HIV medication, and therefore increase the risks of unwanted side effects. He counsels particular vigilance with those using the protease inhibitor ritonavir in conjunction with

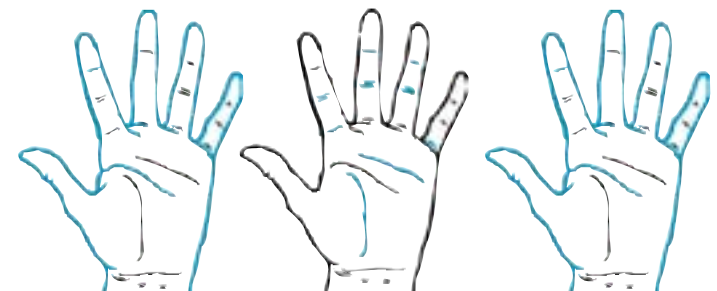
hormone therapy, as it may decrease estrogen levels.

The bottom line is that HIV itself does not make hormone therapy risky. Negative results may occur with specific HIV and hormone drug combinations. For the practitioner and patient, it is advisable to consult with doctors experienced on these matters as specific questions arise.

From a harm-reduction perspective, a fully informed patient able to provide legal consent is ultimately the most important voice when considering treatment options. Hormone therapy in an individual desiring it can be expected to have a positive impact on emotional well-being, which needless to say is a factor in overall health.

Some clinical protocols of this nature have been developed by the Tom Waddell Health Centre clinic in San Francisco, which treats many HIV-positive transsexuals. Among these protocols is the strong recommendation that health care providers for trans people enhance their own knowledge of medical issues related to HIV.

The Tom Waddell Centre protocols can be found at <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>.



Legal Name & Sex Designation



Changes in Québec

Unfortunately, the costs and legal standards for changing name and sex designation inhibit the ease with which trans people can change their legal status. Trans people cope with this difficulty in many ways. Because the criteria for changing name and sex designation is so varied from place to place, many trans people who don't meet the criteria for name change in one region may choose to move to another area in order to make the change. Other trans people have fought legal battles to win the right to change their name or sex designation in the region in which they were born or are living. Still others decide or are forced to work outside of the legal arena.

The process of legally changing one's name and sex designation is controlled by the Vital Statistics Department in each province and territory and so varies greatly. Québec in particular is different from other Canadian provinces. To figure out what information is relevant, keep the following in mind: In general, a person can change their name only in the province or territory in which they are living, and can change their sex designation ("M" to "F" or "F" to "M") in the province or territory in which they were born.

Name Change Québec

Name changes and changes of sex designation for people living in Québec are processed by the provincial Department of Civil Status (Directeur de l'État civil). The general requirements for a name change are a) Canadian citizenship, and b) at least twelve months of Québec residency.

The three main ways transsexual and gender variant people in Québec



succeed when approaching the Department of Civil Status for a name change are as follows:

The Five Year Rule

This is the path for a name change that is open to the general public. It is not specific to trans and gender-variant people. In order to access a change of name under this legislation, a person must prove that they have been using their name widely for at least five years.

Proof can include letters from an employer, school, community worker, doctor, family member, or friend. It can also include bills, receipts, ID, membership cards, or a lease in the person's chosen name. Proof of at least two documents per year over five years must be provided. The more official the documentation one provides, the more likely the name change will be accepted.

Below is a sample letter in support of a name change from a community organization or clinic:

To Whom it May Concern,

I am writing on behalf of *NAME OF ORGANIZATION*, in support of the name change request of *NAME OF PERSON*. *NAME* is a transsexual *WOMAN/MAN* who is currently undergoing various aspects of social and medical transition. *HIS/HER* use of a *MALE/FEMALE* name is essential to *HIS/HER* well-being, as it corresponds to *HIS/HER* experience of living in the world as a *WOMAN/MAN*.

Since *DATE*, *NAME* has regularly accessed our services at *NAME OF ORGANIZATION*, during which *SHE/HE* has consistently used the name *NAME*, and presented *HIMSELF/HERSELF* as a *WOMAN/MAN*. Furthermore, *SHE/HE* has been using this name with *HER/HIS* friends and for more than *LENGTH OF TIME*.

As you may very well know, the fact that *NAME*'s legal identification (driver's license, RAMQ card, etc.) does not correspond to *HER/HIS* gender/sex identity as a *WOMAN/MAN* is a source of discrimination, be it when attempting to access health care, or opening a bank account, to name a just a couple of examples. A change of name would greatly ease *HER/HIS* ability to access various services and basic needs, and would improve *HER/HIS* quality of life.

For these reasons, we urge you to accept this request for a name change. Furthermore, we also request that *NAME* be exempt from publishing *HIS/HER* name change in a local newspaper. As *SHE/HE* is subject to discrimination as a transsexual *WOMAN/MAN*, it is a serious threat to *HER/HIS* safety, security and privacy to have to publish *HER/HIS* name change in a publicly accessible source.

Thank you for your time and consideration.

Sincerely,

NAME OF PERSON WRITING ADVOCACY LETTER

Name changes using this procedure will result in the person's chosen name being added in front of their legal name on official documents. Legal/birth names will continue to appear on the birth certificate. However, forms of identification such as a health care card or driver's license can be issued with only a person's chosen name and family name appearing.

Pursuing a name change using the five year rule includes a publication requirement. The applicant must publish their request for a name change in the legal Gazette of Québec, at a cost of \$75, and in the classified section of the local paper of their choice. The publication requirement can be waived, if reason exists for the person to believe that it would put them in danger.

Transsexual-specific Method

As of 2006, the Department of Civil Status implemented criteria for name change that is specific to transsexuals. Under the new criteria, the person must provide the following proof in order to obtain a change of name:

- a letter from a psychiatrist or psychologist attesting to their transsexuality (though this is the specific requirement according to Department of Civil Status, some have succeeded by using a letter from a family doctor or a sexologist instead);
- some proof of physical change towards the gender to which they are transitioning – this could include proof of hormone therapy or surgery, though in some cases a photograph showing gender presentation has been accepted; and
- proof that they have used their chosen name for at least a year. This proof could include letters from an employer, school, community

worker, doctor, family member, or friend. It could also include bills, receipts, a lease or other documents in their chosen name.

Regarding this method, the Department of Civil Status has stated that the individual's chosen name will replace previous names on their birth certificate. However, some trans people have found that their chosen name was merely added to their other names.

The transsexual-specific method also includes a publication requirement. The applicant must publish their request for a name change in the legal Gazette of Québec, at a cost of \$75, and in the classified section of the local paper of their choice, unless the person feels as if publishing their name change would put them in danger.

Name Change with a Change of Sex Designation

If the applicant meets the requirements for a change of sex designation, they are automatically granted a name change. In order to meet the requirements in Québec, a female-to-male transsexual needs to have taken hormones and had a hysterectomy. A male-to-female transsexual has to have taken hormones and undergone a vaginoplasty.

Contrary to the “five year rule” (described above), a name changed in this manner will replace previous names. There is no publication requirement for this method.

Where to get the forms:

The first step in the name change process is to fill out the Application for preliminary analysis for a change of surname or given name and send it to the Department of Civil Status. There is no cost to submit this form. The form can be downloaded from their website at <<http://www.etatcivil.gouv.qc.ca/publications/FO-12-04-request-preliminary-analysis-modification-surname-first-name.pdf>>.

The form to access a sex-designation change on official documentation is not available online. You must either call or show up in person at the Department of Civil Status.

They can be reached directly at:

Québec: 418.643.3900

Montréal: 514.864.3900

Elsewhere in Québec: 1.800.567.3900 (toll free)

After the Department of Civil Status has received the Preliminary Analysis form, they will send the guide and application form. The total costs for this second part of the process are approximately \$300–\$400.



Gender-segregated

Facilities



Many everyday spaces are segregated by gender—public washrooms and locker rooms, for example, are spaces that for the most part are gender segregated. Spaces commonly believed to be safe, such as public washrooms, are often instead sites of violence and exclusion for trans people, who routinely experience confused looks and harassment when trying to use a washroom.

Gender-segregated social services and resources meant to support people who experience poverty, violence, and discrimination are even more complicated to navigate. The difficulties trans people face in public spaces such as public washrooms and locker rooms are relatively minor, or at least brief, compared to those they experience in many homeless shelters, drug and alcohol detoxification and rehabilitation facilities, and some crisis support centres.

Prisons are another example of a gender-segregated facility that many trans people have to navigate. Because many aspects of their realities are criminalized, trans people are overrepresented in the prison system, and as prisons are gender segregated, trans people are housed according to their sex assigned at birth. They often experience transphobic violence and discrimination at the hands of both the prison population and staff. Furthermore, trans people in prisons have difficulty accessing relevant and respectful health care.

This chapter will briefly outline what access to shelters, and drug and alcohol detoxification centres looks like in this province, as well as examine how institutional assignment and access to trans-specific services work in prisons.

Shelters

As of yet, there is no official policy in Québec with regards to how trans people are housed in gender-segregated shelters. In Toronto, for example, a city-wide policy has been written and implemented. It states that everyone must be housed according to their gender

identity, regardless of whether it is congruent with their sex assigned at birth. In Québec, no such policy exists.

Generally, admittance to shelters is determined on a case-by-case basis, and this means that many trans people are turned away. Some shelters have informal policies where they will only accept a limited number of trans people per night, or some house trans people in private rooms, as opposed to the general dorms. While some trans people appreciate the privacy of a separate room, for many others, this can be an isolating experience.

Because no trans policy exists within shelters in Québec, access is often granted based on the discretion of the staff. Advocating for a trans person accessing a shelter could mean calling the shelter in advance and offering to discuss misconceptions and fears about trans people.

Alcohol and Drug Detoxification and Rehabilitation Centres

Similarly to shelters, alcohol and drug detoxification and rehabilitation centres in Québec do not have an official policy regarding how trans people are housed, and access is usually granted on a case-by-case basis. Most often, though, people are housed according to the gender marker on their government-issued ID. Similarly to advocating for trans patients/clients accessing shelters, you can call the centre to talk about trans issues and to dispel fears and misconceptions the staff might be struggling with.

Prisons

Trans people are disproportionately targeted by police violence and brutality and are overrepresented in prisons. Due to discrimination and the legalities surrounding sex work, poverty, homelessness, and drug use, many trans people come in contact with the criminal justice system.

Institutional Assignment

As gender-segregated facilities, prisons determine institutional assignment for trans people based on the status of the person's genitals, and not on the individual's gender identity. This means, for example, that a pre- or non-operative trans woman would be housed

in a men's prison. This policy is the same for both federal prisons and provincial jails.

Hormones

The Correctional Services Canada policy on trans people in federal prison states that a trans person can continue hormones while in federal prison, if they had a valid prescription before they were incarcerated. Initiation of Hormone Replacement Therapy while in prison is possible only with permission from a "recognized expert in the area of gender identity." So, hormone initiation in federal prisons is possible in theory, but because there are so few health care professionals who work regularly with trans people, and because "expertise" in the field of trans health is rare, access is most often granted at the discretion of the individual guards, wardens, and medical staff who work in the prisons.

While this federal policy exists, in practice, trans people are most often granted access to hormones in prison based on what kind of treatment they had before being incarcerated. This means that if a trans person had been using hormones that they acquired on the black market, without a prescription, they would be denied access to hormones in prison. If they had a prescription, and had been followed by a doctor on the outside, chances are they would have an easier time accessing their hormones on the inside.

In provincial jails (for people who are serving sentences of less than two years), access to hormones is only accessible to those who had a prescription for hormones before incarceration.

Contact the nurses at the CSSS Ahuntsic for more information and advocacy related to accessing hormones in prison: 514.381.4221.

Sex Reassignment Surgery

Sex Reassignment Surgeries are not covered for people in either federal prisons or provincial jails. Up until November 2010, according to Correctional Service Canada's policy on trans prisoners, Sex Reassignment Surgeries were covered for those serving sentences in federal prisons. Similar to initiation of hormone therapy, surgeries were accessible with a recommendation from a "recognized gender identity specialist." This policy has recently been changed, as the federal government has stated that Sex Reassignment Surgery is not

an essential medical service.

The Correctional Service Canada policy on trans inmates can be found at <http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde-eng.shtml#Gender>.



A Final Thank You

Thank you for taking the time to read this guide! We want to stress how important it is for us to be working with allied health care and social service providers, in order to facilitate trans people's access to essential services.

We hope that the information in this guide proves to be helpful in increasing your understanding of all of the barriers that trans people experience in accessing relevant and respectful care.

Because the state of access to services is constantly shifting, some parts of this guide might become out-of-date. Feel free to check out our website at <http://www.santetranshealth.org> for regular updates.

Members of the Trans Health Network of Québec

ASTT(e)Q (Action santé travesti(e)s et transsexuel(le)s du Québec)

Location: 300 Ste. Catherine E., Montreal

Phone Number: 514.847.0067 ext. 207

Email: astteq@yahoo.ca

2110 Centre for Gender Advocacy

Location: 2110 Mackay, Montreal

Phone Number: 514.848.2424 ext. 7431 (general inquiries)
ext. 7880 (Peer Support)

Email: General Inquiries: info@centre2110.org

Peer Support and Advocacy: psa@centre2110.org

ATQ (Association des transsexuels et transsexuelles du Québec)

Phone number: 514.591.9038 (admin) 514.254.9038 (listening line)

Email: admin@atq1980.org (admin)

ecoute@atq1980.org (listening line)

Stella

Location: 2065 Parthenais street, Suite 404, Montreal

Phone Number: 514.285.8889

Email: stellappp@videotron.ca

Project 10

Location: 2075 rue Plessis #307, Montreal

Phone Number: 514.989.4585. (Listening Line)

514.989.0001 (Administration and Intern)

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