

**“Invisible” but not Invulnerable:  
A Case Study Examining Accessibility for Gay Men at  
Three Bridges Community Health Centre**

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## ABSTRACT

**Background:** The purpose of this research was to examine how the Three Bridges Community Health Centre conceptualizes and addresses the issue of accessibility for gay men. This research explored the intersection and disjuncture of how accessibility for gay men is understood and practiced from multiple perspectives (staff and clients). It revealed perceived and real barriers and opportunities for gay men in accessing health services, and provides insight into the mechanisms Three Bridges Community Health Centre employs to provide comprehensive health care to a local population that is not easily identifiable.

**Methods:** Case study is the central defining methodological feature of this research. This study applies both inductive and deductive approaches. The data are qualitative, derived from 14 semi-structured interviews, document analysis (25 documents with a total of 398 pages) and participant observation (approximately 33 hours). Analysis and interpretation of the data were accomplished through the various procedures and techniques associated with qualitative data analysis, including the use of a qualitative software package – NUD\*IST 4.0.

**Results:** The study revealed twelve main factors that facilitate (and obstruct) accessibility for gay men. They were developing a mission of accessibility for vulnerable populations; assessing gay men's health issues, barriers and needs; utilization of the clinic; delivery of appropriate programs and services; available providers with appropriate knowledge, attitudes and behaviour; cultural accessibility (*e.g.*, gay-friendly environment, multiple languages); geographic accessibility (location); physical accessibility (architecture); financial accessibility (affordability); functional accessibility (convenience); awareness (marketing & publicity of services and location); and partners in accessibility (*e.g.*, community, health authorities, government). Each section of this chapter details how Three Bridges addresses each of these elements (the strengths), the challenges (*e.g.*, time, money and personnel) in addressing these issues, as well as suggestions for improving accessibility. These factors would also be relevant for any primary care setting about to embark upon an examination of how (well) it addresses access for gay men, and other vulnerable populations.

**Conclusions:** Partnerships with community-based agencies and recruitment of queer staff are critical in creating cultural accessibility for queer people. Many of the challenges raised by staff need to be addressed at a policy, region-wide level. Cultural accessibility for queer people also needs to be addressed by other healthcare settings.

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## **CHAPTER ONE INTRODUCTION**

### **Statement of the Research Issue**

The World Health Organization states that health is a basic human right (WHO Constitution, 1946), and recognizes that all people deserve equitable access to health services and quality care. Everyone has the right to be treated with respect, and to receive care in a setting free from discrimination. And while Americans have traditionally been concerned with having the technologically best health care system in the world, Canadians have generally been more committed to building an equitable and universally accessible system (Green & Ottoson, 1999). At the same time, Canadians are increasingly recognizing that differences exist in health services available to residents of rural, remote and northern communities, on the one hand, and large urban centres on the other. Despite the fact that all Canadians supposedly enjoy financially unimpeded access to hospital and physician services irrespective of sex, geography, race, ethnicity, age, income, illness or disability, in practice there are wide variations in the use of appropriate and effective services across all of these dimensions. In addition, there is a large disparity in access to health services that are not publicly funded, such as dental services, eye examinations and corrective lenses, mental health services and prescription drugs.

Increasingly, there is recognition that there are many groups in our society who are “marginalized” in the sense of having less immediate access to services that are appropriate for their circumstances. Examples of marginalized or vulnerable populations include people with certain mental health problems or addictions, people with physical disabilities, Aboriginal peoples, injection drug users, women and children in at-risk situations, some ethnic and visible minorities, the homeless, those with minority sexual

orientations, and the poor. These groups are not mutually exclusive. Members of these marginalized groups may either have limited access to appropriate health services or feel constrained in accessing services even if they are available.

Population groups that lack visibility in the health care system are “sexual” minorities. A review of the literature reveals that sexual minorities – gay men, lesbians, bisexuals, and transgender persons – have difficulty accessing health services or have been refused health care, or receive insensitive or inappropriate health care. Sexual minorities may also belong to other marginalized or vulnerable populations and hence face additional barriers.

The circumstances surrounding, and reasons for, impediments to access vary. In some cases access may be restricted because gay men believe their access is restricted because of their perceived or actual marginalized status or because of the ways in which “illness,” “disease” or “disability” are socially or culturally constructed. Disproportionate geographic, linguistic, financial, temporal, physical and social barriers to a wide range of health services have been reported for gay men and other vulnerable populations. It is argued that improved access to health services would improve health and life circumstances and might also lower overall health and other public costs through delivering appropriate services to those who need them before more expensive and extensive intervention is required. For instance, gay men have higher rates of HIV/AIDS than most members of society. Among young gay and bisexual men in Vancouver, the HIV/AIDS epidemic has reduced life expectancy by up to 20 years (Hogg, Strathdee, Craib, O’Shaughnessy, Montaner & Schechter, 1997). If access to a full spectrum of health care was available, this might lower infections and expensive HIV treatments. One

setting that has traditionally sought to address disparities in health service accessibility and health status for vulnerable populations is the community health centre.

### **Purpose of the Research**

The purpose of this research was to examine how the Three Bridges Community Health Centre conceptualizes and addresses the issue of access to health services for gay men. This research explored the intersection and disjuncture of how access for gay men is understood and practiced from multiple perspectives (managerial level, a range of service providers, auxiliary Vancouver Coastal Health Authority (VCHA) staff, seconded staff and clients). It revealed perceived and real barriers and opportunities for gay men in accessing health services, and provides insight into the mechanisms Three Bridges Community Health Centre employs “to provide high quality, comprehensive health care to the local population” (Three Bridges Community Health Centre rotation handout from Peter Granger). This research sought to highlight the challenges, needs and successes of providing a full continuum of primary health services (promotive, preventive, primary curative, rehabilitative, and community support) to a population that is not easily identifiable (Wanke *et al.*, 1995). This research elucidated the complexity and nuances of accessing care for gay men vis-à-vis a community health centre setting.

### **Research Question(s)**

The main research question of this research was:

How does the Three Bridges Community Health Centre conceptualize and address the issue of access to health services and auxiliary resources for gay men?

### *Sub-Questions*

Sub-questions include:

- What are the health issues of the gay men who use the Three Bridges Community Health Centre?
- What are the real and perceived systemic barriers<sup>1</sup> to health services for gay men who use Three Bridges Community Health Centre? What barriers have these gay men experienced in the past?
- What are the relevant characteristics of accessibility for gay men's health care service delivery?
- How is access to health services and collateral resources being facilitated in the Community Health Centre? What features of Three Bridges make it accessible for gay men (strengths)? What features might deter gay men from accessing services there (weaknesses)?
- How are principles of primary health care, population health and health promotion (such as, participation, partnerships, intersectoral collaboration, governance) manifested in Three Bridges Community Health Centre with reference to gay men?
- What changes would enhance accessibility?

### **Premises of the Research**

Many of the premises underlying this research have been alluded to thus far; however, a more explicit statement may be warranted. This research is premised in the belief that

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<sup>1</sup> Systemic barriers to health services include: race, sex, sexual orientation, age, culture, religion, language, physical and mental disability, and socio-economic status.

that the health system (like the legal and educational systems) is a political and ideological system intimately connected with the social inequalities of society as a whole. Accordingly, some gay men have difficulty accessing health services, either because of a lack of appropriate services, or a lack of gay-friendly, knowledgeable health service providers. These issues affect every aspect of health care interactions from a gay man's decision to access care through to the health care provider's diagnosis, treatment and quality of care that gay men receive. In addition, there are some gay men who are more marginalized than others, which may further impede their access to care. Community health centres (CHCs) are more conducive to providing accessible care than other primary care settings, such as physicians' offices, walk-in clinics and emergency rooms, since CHCs include mechanisms such as multidisciplinary teams, have extended hours and have alternative payment schemes for physicians (Forrest & Whelan, 2000). Furthermore, they have flexible, holistic approaches that are necessary for addressing health issues at their societal and environmental roots. These premises are thoroughly examined in Chapter Two.

### **Autobiographically Situating the Researcher**

In a postpositivist era, the researcher can no longer claim to be completely objective, detached and value-neutral. Whether we engage in quantitative or qualitative research, our research questions and methods are inextricably linked to our own identities. Accordingly, the first phase of the research process is to define the researcher's conception of self and the other (Denzin and Lincoln, 1994) since "it has become quite evident that 'what is seen' is more dependent on 'who is looking' than on 'what is being

observed” (Meyer & Davis, personal correspondence). The researcher understands that “his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting” matter (Denzin & Lincoln, 1994, p.3).

Accordingly, it needs to be acknowledged that I am a white, educated, middle class, healthy gay male, which undoubtedly distances me from the kinds of discrimination experienced by those who are not. Life conditions, life chances and life choices reveal how some gay men are more privileged than others, and how measures aimed at improving health are linked to education, social support systems, income, and housing to name a few. My situation brings into perspective the kinds of privileges that I am afforded, and the results of such privilege on one’s health. It is the privilege of white, middle class gay men that has led to criticism by other sexual minorities.

Despite my privilege, I feel closeted by many institutions, such as educational, health and legal systems which, while they may not be overtly homophobic, are either heterosexist or non-sexual in their delivery of programs and services despite the fact that we are inherently sexual beings, and the fact that our sexuality matters. Our health and our feelings about ourselves are fundamentally shaped and inextricably linked to the society in which we live. There is a reciprocal relationship between the health of the community, and individuals who compose the community (Manson Willms & Gilbert, 1990). Ironically, a contributor to the poor health of gay men is the health system since it has historically forced those who seek care and those who work in the health system to conceal or negate their identity.

Many of the lives of the gay male clientele of Three Bridges CHC are somewhat foreign to me, and I did not expect to feel so privileged as a gay man; that is, I did not

expect that so many clients of the Three Bridges Community Health Centre would not have the same comforts that I enjoy. As a population, I expected them to be more privileged, which is not to suggest that there are not some clients of the Three Bridges Community Health Centre that are not as privileged or more privileged than me. I feel fortunate, and ideally, I would like a gay male community where every gay man has the same life chances and life conditions as me, and the ability to make whatever choices he likes, as long as he is truly making a choice rather than being a “victim” of unstable housing, addictions, poverty, race, abuse, and other social problems.

In my own interactions with the health care system, I have not felt overtly discriminated against because of my homosexuality, but I have not identified myself as gay at times when it would have been appropriate. Furthermore, when my own sexual orientation was a health issue (depression during my Bachelor of Education internship which took place in a high school – another intolerant environment), I experienced great stress in deciding whether I should “out” myself. This energy in deciding whether to reveal my sexual orientation should have been used to make myself well. Considerable anxiety was also caused when I wondered if I would or did receive different treatment because health care providers suspected I was gay. Unless a straight man walks into a queer health clinic, he or she would never have to “out” himself to a health care provider because heterosexuality is considered the “norm.”

Therefore, being queer, I want to include queer and other marginalized voices into my research, and thus give a voice to myself and others who have been silenced in the past, and are now just beginning to speak. Without a doubt, my homosexuality has influenced not only how I perceive myself (or my Self), but also how I perceive other

people, whether they are queer or not, and my beliefs about society and my “reality.” As Fine (1994) states: “Only when there is an Other can you know who you are” (p.72). My privilege allows me to conduct this research, but it is not without personal risk to my future economic well-being since there is considerable discrimination by potential employers and in academia towards lesbian, gay, bisexual and transgender (LGBT) populations. What makes the situation more difficult is that homophobia is hard to detect, which is not to suggest it does not exist, and therefore it is hard to take action against it.

My interest in community health centres came about when I had been involved in a research project on “Health Promotion in Primary Health Care.”<sup>2</sup> In a pilot survey for the project, it seemed to me that the primary care settings that most exemplified health promotion values and strategies were community health centres. Initially, I had wanted to focus on all vulnerable populations because, being a minority, I have an appreciation for and interest in other marginalized people, but it was also a way to hide my sexual identity among all the other voices. Due to the unmanageable scope of such an enterprise, it seemed prudent and most important to add to the information on the issue of accessibility for gay men, like myself. Despite the fact that transgender and bisexual populations are particularly under-represented in the literature, it seemed somewhat inappropriate to tackle “their” issues. I focused on accessibility because the dominant wave around gay men’s health has been disease focused (primarily HIV/AIDS), and has often focused on white, middle class gay men. This research underscores that gay men still have many health issues, and accordingly, health interventions should encompass a health promotion philosophy and include a diverse population of gay men.

## Research Design

Case study is the central defining methodological feature of this research. This study applies both inductive and deductive approaches. A critical element of case study research is its reliance on multiple methods of data collection to capture the complexity of a phenomenon (DePoy & Gitlin, 1998). The data are qualitative, derived from semi-structured interviews, document analysis and participant observation. Analysis and interpretation of the data are accomplished through the application of various procedures and techniques associated with qualitative data analysis, including the use of a qualitative software package – NUD\*IST 4.0.

This case study can be characterized as an embedded (multiple units of analysis), single-case design (Three Bridges Community Health Centre) (Yin, 1994). It is embedded because multiple perspectives of accessibility will be examined, but it involved only one community health centre. The case-study research strategy best serves the aims and suits the focus of this study. Yin (1994) suggests that case study is the preferred strategy among the five major strategies in social science research<sup>3</sup>, when “how” or “why” questions are being asked about a contemporary set of events within a real life context, over which the investigator has little or no control. To reiterate, the purpose of this research is to examine *how* the Three Bridges Community Health Centre conceptualizes and addresses the issue of accessibility for gay men. Case study designs are also useful for work (as in the present case) in an unstudied area of inquiry. Case

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<sup>2</sup> This research project is a national validation study of parameters of health promotion in primary health care. It is being conducted by the Institute of Health Promotion Research at the University of British Columbia and national partners from other universities.

<sup>3</sup> Yin identifies five major social science research strategies: experiments, surveys, archival analysis, histories, and case studies.

studies illuminate in detail larger health system issues. These aspects of the research are discussed in greater detail in Chapter Three.

### **Significance or Rationale of the Study**

Why should we work to make the health care system accessible to gay men?

Fundamentally, the health system needs to be responsive to, and inclusive of everyone. However, previous research indicates that the health system has been heterosexist and homophobic towards gay men, or at best, neutral in the area of sexual orientation. These perspectives are problematic for a population that has traditionally been labelled as “mentally ill” or “deviant” by health service providers. Also, there are health problems that are more prevalent among gay men or for which risk factors and appropriate interventions/services may be different. Many gay men’s health issues could be remedied by improving access to care and by working towards recognition and equality in the health system. Community health centres may in part, address such remedies. While literature exists on the issue of accessibility and gay men, there is no or little information in the published literature on how accessibility for gay men is specifically addressed in a community health centre setting.

Traditionally, research pertaining to gay men’s health (globally and in Vancouver) has focused on HIV prevention. This disease-based model is a reaction to disease rather than being conducive to promoting health. In what has been called “the second wave” of HIV in the gay male population, it is increasingly recognized that a population health or health promotion approach is needed. These approaches recognize the importance of a lifestyle/behavioural perspective, and perhaps more importantly, a socio-environmental perspective.

An examination of how the Three Bridges Community Health Centre conceptualizes and addresses the issue of accessibility for gay men is a laudable research benefit in itself. However, the steps we take to make health care accessible to gay men are building blocks for making the system respectful of difference and attentive to the needs of diverse groups. These steps are not about special interests; they are the foundations of good practice and reflect our broadening concept of health and our belief in health as a human right for all. The information produced as a result of this research may affect the delivery of care at Three Bridges Community Health Centre, or it could be transferred to other community health centres to better address the issue of accessibility for gay men and other sexual minorities, either locally, nationally or internationally (depending upon the dissemination). The information contained herein is also of importance for the LGBT population and the agencies that serve this population.

Several lesbian, gay, bisexual and/or transgender organizations and groups in Vancouver, and national research bodies and groups have recently recognized the need for research on the health issues of, and service delivery for sexual minorities; including: The Community-Based Research Centre; the former Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee of the Vancouver/Richmond Health Board; The Three Bridges Community Health Centre; the LGBT Health Association; GayWest; and other national groups and organizations. These organizations also recognize the need for research on health issues pertaining to each of the LGBT populations encompassed under the umbrella of sexual minorities, given the unique issues that each population faces. Similarly, given the diversity within the LGBT population(s), there is also considerable need for research tailored to the specific issues of

each queer sub-population.

### *Community-Based Research Centre*

The Community-Based Research Centre<sup>4</sup> (CBRC) in Vancouver has recently investigated the health-service delivery needs for gay men, as well as other areas of gay men's health. The CBRC released a report in July 2000 entitled "Gay Health in Vancouver: A Quality of Life Survey." It was an initiative of several community-based agencies – CBRC, AIDS Vancouver<sup>5</sup>, Pride Health Services of the Three Bridges Community Health Centre, Vancouver Native Health Society<sup>6</sup>, Asian Society for the Intervention of AIDS<sup>7</sup>, YouthCO AIDS Society<sup>8</sup> and the Centre<sup>9</sup> (formerly the Gay and Lesbian Centre). In the survey, participants were asked "What community facilities do you think should be available for gay men?" Most respondents ranked health services as being important (37%) or very important (51%). Among possible community facilities listed, no other venue received as high a rating as a gay health centre. When asked: "What do you think would improve gay living in Vancouver?" seventy-five percent ranked a gay health centre (medical, dental, mental, *etc.*) as being important (40%) or very important (36%).

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<sup>4</sup> The Community Based Research Centre exists to support the research efforts to HIV community groups through consultation, capacity building and other knowledge development activities, and to undertake research projects in collaboration with other community groups [Marchand, 2001].

<sup>5</sup> AIDS Vancouver seeks to alleviate individual and collective vulnerability to HIV/AIDS through care and support, education, advocacy and research. AIDS Vancouver has a Gay Men's Health Program with a mandate to provide information and support to gay men on issues of sexual health and HIV/AIDS. The Program uses community development, health promotion and harm reduction approaches to prevention.

<sup>6</sup> Vancouver Native Health Society seeks to improve the health status of Native people by encouraging and improving the development of health care services for Native people.

<sup>7</sup> Asian Society for the Intervention of AIDS is a non-profit HIV/AIDS organization serving East and Southeast Asian communities seeking to improve understanding in their communities about HIV/AIDS and to provide support for members in their communities affected by the virus by addressing the emotional, social, political, economical and medical circumstances of their communities.

<sup>8</sup> YouthCo AIDS Society works with positive youth including young gay and bisexual men who are HIV positive. They provide training and education to other organizations and schools around British Columbia.

<sup>9</sup> The Centre is a community resource providing support, health and social services, and public education for the well-being of lesbians, gay men, transgendered and bisexual people and their allies in Vancouver and throughout British Columbia.

Similarly, the importance of having access to gay health professionals was also ranked high. Accordingly, health services that are either gay-friendly or targeted to gay males have been deemed important to gay men in Vancouver. These findings seem to suggest that for gay men in Vancouver, health services may not be accessible. This research explores some of the questions raised by these survey results.

*Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee*<sup>10</sup>

The former Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee (LGBT PHAC) of the Vancouver/Richmond Health Board (V/RHB) was also concerned with the health of “sexual” minorities. The PHAC advised and assisted the V/RHB with their governance functions in the areas of health plans and strategies, delivery of health services, and the development of standards for health care providers and resource allocation. The PHAC’s “vision for our communities is for healthy lesbian, gay, bisexual and transgender people who are able to make informed decisions within a holistic health care system that welcomes diversity and is flexible and proactive on health issues” (Vancouver Richmond Health Board, [http://www.vcn.bc.ca/vrhb/lgbt\\_phac.htm](http://www.vcn.bc.ca/vrhb/lgbt_phac.htm)).

The LGBT PHAC identified several priority health issues, including mental health, substance abuse, lack of information in the health care and education sectors, gender identity, legal recognition, and housing. They also identified several priorities related to accessibility, including a lack of access, refusal of treatment, and insensitive or inappropriate health care services. The PHAC and the V/RHB recognized that lesbians, gay men, bisexuals and transgender people face discrimination in accessing health care and in receiving health care services.

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<sup>10</sup> The LGBT PHAC was dissolved when the newly appointed Vancouver Coastal Health Authority, and its board and executive, replaced the Vancouver/Richmond Health Board.

### *The Three Bridges Community Health Centre*

When approached, the physician leader of the Three Bridges Community Health Centre, Peter Granger, described this research project as of “immense interest for me and the others of Pride Health Services”<sup>11</sup>. Three Bridges CHC has identified the following population groups as potentially vulnerable to ill health: parents and children; street youth; lesbian and gay folks; people with mental health issues; and people with addictions (Vancouver/Richmond Health Board, <http://www.vcn.bc.ca/vrhhb/chc1.htm>). These population groups are not mutually exclusive; that is, gay men may belong to one or more groups further increasing their vulnerability to ill health. Accordingly, this research fits with the mandate and mission of the Three Bridges CHC.

### *LGBT Health Association*

In the spring of 1998, the LGBT Health Association organized several focus groups to consult LGBT community members on identifying the kind of barriers these members experience in accessing health care services in the Lower Mainland (Taghavi, 1999).

### *GayWest*

GayWest is a new non-profit society committed to a new approach to gay men's health (GayWest, [www.gaywest.org](http://www.gaywest.org)). Their website states: “HIV isn't the only issue! Health is how we feel about ourselves and each other. It's our social, emotional, physical, spiritual and sexual well-being.” GayWest will create opportunities for gay men to find

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<sup>11</sup> Pride Health Services is a special clinic of the Three Bridges Community Health Centre. It operates every Thursday, 3:00 - 6:00 p.m., in addition to the main clinic. It serves, in part, members of the LGBT community who may have had difficulty accessing the health system to receive appropriate health services. Pride Health Services is a partnership between the VCHA and community agencies such as AIDS Vancouver, The Centre (a LGBT community centre) and YouthCO AIDS Society. It is discussed in greater detail in Chapter 4.

connection, support, mentoring, esteem, education, affirmation and love. They believe these things form the basis of health.

### *National Groups and Organizations*

As noted above, gay men, the gay “community,” and service providers have reaffirmed that the issue of accessibility is of fundamental concern to them. National and more mainstream research bodies have also recently recognized the specialized health service and health research issues of the LGBT population. For instance, The Canadian Institutes of Health Research recently released a request for applications titled “Improving Access to Appropriate Health Services for Marginalized Groups” which specifically listed “those with particular sexual orientations” as one example of several marginalized groups. Also, the First International Conference of Inner City Health held in October 2002 in Toronto, Canada also listed lesbians, gays, bisexuals and transgendered populations as applicable groups for research.

The need for such research was also identified at a day-long meeting of researchers, practitioners and activists engaged in research on gay, lesbian, bisexual and Two-Spirit<sup>12</sup> (glbt-s) people’s health in Canada. Twenty participants from across Canada, representing academic, public health and community organizations gathered at the McGill School of Social Work in Montreal. Gaps in research on glbt-s health were identified. For example, participants stated that, while some documentation exists on the

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<sup>12</sup> Much evidence indicates that aboriginal people, prior to colonization and contact with European cultures, believed in the existence of three genders: the male, the female and the male-female gender, or what we now call the Two-Spirit person. The concept of Two-Spirit relates to today’s designation of gay, lesbian, bisexual and transgender persons of aboriginal origins. Two-Spirit people traditionally held esteemed positions in their communities. The arrival of the Europeans was marked by the imposition of foreign views and values on aboriginal spirituality, family life and traditions. This term of ancient usage is being reclaimed by many gay, lesbian, bisexual, and transgendered aboriginal people today to invoke remembrance of a time before colonialism and the exploitative contact with Europeans when Two-spirited people were honoured. (Meyer, Goodleaf & Labelle, 2000).

impact of homophobia and heterosexism on health, there is far less information available on best practices. There is a need to focus on what works and in what ways practice can be adapted/transformed. This research project will discuss what works, that is, how accessibility can be enhanced, and identify some practices which could be adapted to other CHCs, other forms of primary care, and to the health system in general.

### **Study Context**

While all community health centres deliver primary health care services, they are distinct in their delivery of services. Accordingly, the Three Bridges Community Health Centre was not chosen because it was deemed representative of community health centers, rather it was chosen because of the potential for learning (Stake, 1994).

The Three Bridges Community Health Centre opened in June 2000 to serve downtown Vancouver, the West End, Yaletown and Fairview. The Centre serves an extremely diverse population, including seniors, families with young children, single professionals, gay and lesbian people, street youth, and individuals with addictions. The Centre is located at the corner of Drake and Hornby in Vancouver's West End, which is home to between 6,000 and 25,000 gay men (Marchand, 2001a).<sup>13</sup> There are no CHCs in Vancouver that serve exclusively the lesbian, gay, bisexual and transgender (LGBT) community as there are in many large American cities. Because of its location within the "gay ghetto," the Three Bridges Community Health Centre was the most appropriate setting for this research. It should also be noted that during the data collection phase of this research, the regional and provincial health system was undergoing considerable

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<sup>13</sup> Due to the effects of social stigma, no jurisdiction has accurate figures on the size of its gay population (Marchand, 2001b).

reorganization, and the body governing the Three Bridges Community Health Centre changed from the Vancouver/Richmond Health Board to the Vancouver Coastal Health Authority. The effects of this reorganization are discussed further in Chapter Four. A more thorough discussion of the site selection is contained in Chapter Three in the section entitled “Site Selection and Population Sampling.”

### **Thesis Overview**

This chapter included a discussion of the research issue; the research purpose; the research question(s); premises of the research; and autobiographically situating the researcher in the research context. It also included a brief discussion of the research design, the study context, and the significance/rationale of the study. Most of these topics are discussed in greater detail in later chapters. The remaining chapters of this thesis include a literature review (Chapter Two); a research design (Chapter Three); results (Chapter Four); and a discussion (Chapter Five).

Chapter Two includes a discussion of major definitions related to the research; intrapersonal and interpersonal issues of (and among) clients and providers; pertinent issues regarding the health system and the gay community; mechanisms to enhance accessibility; and a comparison of community health centres and other primary care settings.

Chapter Three characterizes the research paradigm and research design. It also includes a discussion of the conceptual framework, site selection and population sampling, data collection methods, data analysis and mechanisms employed to assess the trustworthiness of the results.

Chapter Four provides the results of this research project's investigation of accessibility for gay men at Three Bridges Community Health Centre. It is organized around twelve major themes: developing a mission of accessibility for vulnerable populations; assessing gay men's health issues, barriers and needs; utilization of the clinic; delivery of appropriate programs and services; available providers with appropriate knowledge, attitudes and behaviour; cultural accessibility (*e.g.*, gay-friendly environment, multiple languages); geographic accessibility (location); physical accessibility (architecture); financial accessibility (affordability); functional accessibility (convenience); awareness (marketing & publicity of services and location); and partners in accessibility (*e.g.*, community, health authorities, government). Each section of this chapter details how Three Bridges addresses each of these elements (the strengths), the challenges (*e.g.*, time, money and personnel) in addressing these issues, as well as suggestions for improving accessibility.

Finally, Chapter Five discusses my reflections on the twelve major themes of Chapter Four. This chapter also includes a discussion of the implications of the results, the contribution and significance of this research, limitations and challenges of the study, as well as the impetus for future research.

## CHAPTER TWO LITERATURE REVIEW

### Introduction

The purpose of reviewing previous research as part of the research process is not “to determine the *answers* about what is known on a topic,” but rather “to develop sharper and more insightful *questions* about the topic” (Yin, 1994, p.9). Specifically, the literature review serves four broad functions (Marshall & Rossman, 1999). First, it demonstrates the underlying assumptions behind the general research questions. Second, it shows that the researcher is knowledgeable about related research. Third, it demonstrates that the researcher has identified gaps in previous research and that the proposed study will fill a demonstrated need. Finally, the review of the literature refines and redefines the research question by embedding those questions in larger empirical traditions.

A systematic review of literature was conducted using appropriate keywords and computer databases. It included published, peer-reviewed literature, and attention was also made to find non-peer reviewed publications on the internet which yielded reports by several local, national and international organizations and groups. Aspects of accessibility within the primary health care system with particular reference to gay men were examined; specifically, barriers to the access of health services for gay men, and specific mechanisms to remove barriers and enhance accessibility. Also examined was how accessibility was conceptualized, that is, geographically, financially, and culturally as well as other aspects. The theory examined in the literature review was broadly based from theory on primary health care, health promotion/population health, accessibility, gay men’s health, and community health centres. These somewhat diverse theoretical

perspectives provide a thorough theoretical base for this research.

There are nine major topics addressed in this chapter: (a) research/literature gaps; (b) a definition of vulnerable populations; (c) definitions regarding sexual orientation; (d) a definition of accessibility; (e) a definition (or parameters) of community health centres; (f) intrapersonal attributes and issues among gay male clients of the health system, including their health issues, and the psycho-social and historical origins of gay men's health issues, as well as their barriers to accessing care; (g) intrapersonal attributes and issues among health service providers; (f) interpersonal issues among gay male clients and health service providers; (g) pertinent issues regarding the health system; (g) pertinent issues regarding the gay "community;" (h) enhancing accessibility for gay men through potential strategies; and, (i) comparing community health centres and other primary care settings. Accordingly, the literature review is subdivided into three main sections; the first section includes definitions of relevant terms; the second section details relevant issues of **clients, providers, client-provider, primary care settings/health system, and the "gay community."** The final section discusses strategies for enhancing accessibility.

### **Research / Literature Gaps**

While this literature review summarizes existing research findings, clinical and public health research for gay men has been scarce (Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). Typically, the literature focuses on health issues/concerns of gay men, particularly HIV infection and prevention. The *barriers* to accessible health care were also frequently discussed, often accompanied with

recommendations for improvement. Less pronounced was research on initiatives that have attempted to implement a health promotion perspective for gay men in primary health care settings. While there was available literature on community health centres, information on creating an accessible, inclusive community health centre for gay men and other sexual minorities was scant.

Because of the rapid evolution of gay men's social environment and the impacts of the HIV epidemic in particular, research on gay men's health needs can rapidly become dated (New York City Department of Health, 1999). Much of the literature available is from the 1970s and 1980s when homosexual identity formation was studied widely. More recent research tends to focus on gay men in the context of HIV. There is therefore a need to acknowledge that with the changing historical context, individuals "coming out" in the 1990s will not necessarily experience the same level of isolation or discrimination as previous generations (Taylor, 1999). Most of the available literature is American, however, substantial quantities of both American and Canadian research are not published in scholarly journals, but rather reports are produced by community-based, provincial/state, and/or national bodies composed either fully or in part of sexual minorities who have placed these issues on the/their agenda.

Clinical and public health research for gay men is hampered by a lack of public health infrastructure for funding and supporting research on the health of gay men and other sexual minorities (Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). Silvestre (1999) suggests that researchers may have learned to dissimulate their real research focus on homosexuality in order to

sidestep political interference. Although there are methodological obstacles with lesbian<sup>14</sup>, gay, bisexual<sup>15</sup> and transgender<sup>16</sup> (LGBT) people in research, they are not insurmountable. The effects of institutional and individual homophobia and heterosexism on research may prove more difficult to deal with. Accordingly, non-HIV related, gay men's research is needed (Meyer, 2001).

### **A Definition of Vulnerable Populations**

Vulnerable populations are defined as social groups who have an increased relative risk or susceptibility to adverse health outcomes. Groups typically recognized by scholars as vulnerable are the poor; persons subjected to discrimination, intolerance, subordination and stigma; and those who are politically marginalized, disenfranchised, and denied human rights. Vulnerable groups typically may include women and children, ethnic people of colour, immigrants, gay men and lesbians, the homeless, the elderly and people

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<sup>14</sup> A lesbian is a woman whose primary sexual and romantic attractions are to other women. She may have sex with women currently or may have had sex with women in the past. A smaller number of lesbians may never have had sex with another woman for a whole host of reasons (age, societal pressures, lack of opportunity, fear of discrimination), but nonetheless realize that their sexual attraction is mainly to other women. Some lesbians have sex with men and some don't. It is important to note that some women who have sex with other women, sometimes exclusively, may not call themselves lesbians.

<sup>15</sup> Bisexual men and women have sexual and romantic attractions to both men and women. Depending upon the person, his or her attraction may be stronger to women or to men, or they may be approximately equal. A bisexual person may have had sex with people of both sexes, or only of one sex, or he or she may never have had sex at all. It is important to note that some people who have sex with both men and women do not consider themselves bisexual. Bisexuals are also referred to as "bi."

<sup>16</sup> People who identify more strongly with the other gender than the one to which they were assigned (e.g., women who feel like men, or men who feel like women) are called "transgendered." Some transgendered people may "cross-dress" or "do drag" regularly or for fun (and many of these people are comfortable in their assigned gender). Other transgendered people may take hormones of the opposite gender and/or have surgery in order to change their bodies to reflect how they feel inside. These people are also called "transsexual." Transgendered people may identify as heterosexual, homosexual, or bisexual. Female-to-male transsexuals are sometimes referred to as "F to M's" or "transsexual men," and male-to-female transsexuals as "M to F's" or "transsexual women." Pre-operative ("pre-op") transsexuals are preparing for sexual reassignment surgery (SRS) and may take hormones. Post-operative ("post-op") transsexuals have undergone SRS and continue to take hormones, often for the rest of their lives. Some transsexuals ("non-op") either do not want or cannot afford SRS, though they may still take hormones.

with disabilities (Flaskerud & Winslow, 1998). As Vezeau, Peterson, Nakao and Ersek (1998) state

a vulnerable population is a group of individuals who share personal or environmental characteristics and a common risk status. Vulnerable groups generally lack political power, economic resources, and social integrity. Moreover, they may belong to cultures viewed as different from the norm and are generally marginalized from the societal center, resulting in alienation, stigmatization, and segregation. (p. 126)

This differential vulnerability or risk is evidenced by increased comparative morbidity, premature mortality, and diminished quality of life. The fundamental causes of increased susceptibility to disease are attributed to low social and economic status and lack of environmental resources. Moore and Miller (1999) also note that some individuals simultaneously inhabit more than one grouping that may further diminish autonomy (independence). By the same token, ill health can increase one's vulnerability for other stresses, such as socio-economic hardships that may result from losing one's job. There is a feedback association between increased morbidity and decreased socio-economic and environmental resources. This explanation postulates that poor health status in turn depletes socio-economic and environmental resources through, for instance, loss of jobs and income (Flaskerud & Winslow, 1998).

### *Health Gap Paradox*

There is tremendous fiscal pressure by all levels of governments to reduce health care costs, and the health sector is overwhelmed with pressure to do more with less money. This is juxtaposed with a movement towards regionalization, community-based health services, community participation, and a focus on the determinants of health. What is evident, and unfortunate for all stakeholders, is that the current way of doing things, with greatly increased flow of resources into a technologically-based and highly

institutionalized health care system, seems to be having little improvement on the health status of Canadians (Evans & Stoddart, 1994). With its emphasis on curative practices, the health system mostly addresses the community's health deficits. This is not to negate the importance of the health system as a determinant of health, but rather to suggest the critical need to identify strategies and structures that improve the health of vulnerable populations. Researchers of the Canadian Institute for Advanced Research estimate that the illness care system accounts for 20-25% of our health status, whereas the social and economic environment account for approximately 50-60% of our health status (biological endowment and the physical environment each account for 10-15% of our health status) (Evans, Barer, & Marmor, 1994). These notions exemplify the importance and ability of settings, such as community health centres, to remedy some of the ills of the health system.

To address the inequalities in health, health promotion interventions are frequently employed; however, health promotion has been criticized for an inherent paradox – that the individuals who are *not* the target of an intervention benefit more from it than the intended audience (Gutman, Kegler, & McLeroy, 1996). Rather than a fundamental flaw with health promotion, this largely occurs when program planners focus on lifestyle and behaviour, and fail to recognize the importance of a community-based, ecological approach (Green & Kreuter, 1999). Evidence also suggests that those who have the best access to good health care are those who need it least (Tudor Hart, 1971, 2000). This “inverse care law” highlights that access to health prerequisites and services in Canada is not equitable for populations groups with the poorest health status.

In health research, at-risk populations have traditionally been treated as numerical variables. Tudor Hart (1971) developed the inverse care law nearly 30 years ago. In 2000, he stated that, “new ways to *measure* how this battle is going are useful; but a more important task is to win it” (p.19, italics added). Issues of addressing accessibility may be acknowledged as being important in quantitative research, but this research usually provides no explanation of *how* is it achieved, or it may be ignored altogether (Hayes & Dunn, 1999). Increasingly however, health care professionals and decision makers are asking questions (how? and why?) that may not have quantifiable answers (Mays & Pope, 1996). To reiterate, the purpose of this research is to examine *how* Three Bridges Community Health Centre conceptualizes and addresses accessibility for gay men.

### **Definitions Regarding Sexual Orientation**

#### *Sexual Orientation*

Sexual orientation refers to one's sexual and romantic attraction. Those whose sexual orientation is to people of the opposite sex are called “heterosexual.” Heterosexual people are also referred to as “straight.” Those whose sexual orientation is to people of the same sex are called homosexual(or lesbian or gay), and those whose sexual orientation is to people of both sexes are called bisexual. The term “sexual preference” is misleading because it implies that this attraction is a choice rather than an intrinsic personal characteristic. Sexual orientation is not necessarily the same as sexual behaviour. Research demonstrates that there is a disparity between self-identity and sexual behaviour (Diamond, 1993). The scientific literature indicates that homosexual feelings are more frequent than homosexual behaviour, and that same-sex behaviour is more frequent than

lasting homosexual identification (Council on Scientific Affairs, American Medical Association, 1996).

### *Gay Men*

A gay man is a man whose primary sexual and romantic attraction is to other men. He may have sex with men currently or may have had sex with men in the past. Some gay men may have sex with women, or may have had sex with women in the past, while other gay men may have only had sex with other men. A smaller number of gay men may never have had sex with another man for a whole host of reasons (age, societal pressures/stigma, lack of opportunity, fear of discrimination), but nonetheless realize that their sexual attraction is mainly to other men.

Gay men are as diverse as the entire population. Like the general population, gay men vary in terms of race, ethnicity, political affiliation, age, language, income, cultural background, social support, mental and physical disability, housing, education, and place of residence. They are also diverse in the degree to which they identify with other gay men, and the degree to which their sexual orientation is central to their self-definition (Meyer, 2001). Also like the general population, gay men are varied in their physical activity levels, sexual behaviours, diet, health history, and genetics. All of these differences are factors that affect the health of gay men, and are referred to as determinants of health. Accordingly, numerous factors affect gay men's health.

### *Men who have Sex with Men (MSM)*

It is important to note that some men who have sex with other men, sometimes exclusively, may not call themselves gay or even bisexual. In public health practice and research, these men are sometimes referred to as "MSM" or men who have sex with men.

This is a specialized target population in terms of HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) prevention because they may have little or no affiliation with the gay community, and therefore represent unique challenges in health promotion. In public health discourse, MSM is often used as an umbrella term for gay men, bisexual men, and straight men engaged in same-sex behaviour. In this research, the terms “gay man” and “gay men” are used since there are important distinctions between gay men and MSM; that is, the term MSM ignores affectional relations, cultural values and beliefs that exist among gay men (Schilder, Kennedy, Goldstone, Ogden, Hogg, & O’Shaughnessy, 2001), but rather focuses on behavioural and biological data. In the context of this research, the former issues are examined; that is, those of gay men, not MSM. Schilder *et al.* (2001) found distinctions between men who self-identified as gay or homosexual. In their research, they determined that a “homosexual” man identified with sexual behaviour but not with a community culture and preferred not to identify as “gay”, maintaining a “straight” social profile in order to preserve social access, economic status and safety. For good reasons, this semantic issue has itself been the subject of great debate (Stall, Hays, Waldo, Ekstrand & McFarland, 2000).

#### *Prevalence of Same Sex Behaviour and Identification*

As early as the 1940s, Kinsey *et al.* (1948) noted that the prevalence of same-sex sexual experience in the white American male population suggested that the dominance of heterosexuality occurs as a result of restrictive societal norms (Taylor, 1999). Cross-cultural studies support the idea of an inherent biological tendency towards same-sex sexual encounters in both monkeys and humans (Ford and Beach 1991). Laumann (1994)

showed that men living in the central cities of the twelve largest metropolitan areas of the United States report rates of "same-gender sexuality" (identifying as homosexual/bisexual or attracted to members of the same sex) of between 9 and 17%, as compared to rates for all men surveyed of between 3 and 8%. Given the sensitive nature of the subject of homosexuality and the societal stigmatization, underreporting of same-sex attraction, behaviour and identification likely occur (Council on Scientific Affairs, American Medical Association, 1996). Gay men in disproportionate numbers move to large urban centres with concentrated health risks, thereby exacerbating their need for accessible, health promoting services (Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000).

#### *Other Sexual Minorities*

"Gay" is also used as an inclusive term encompassing lesbians, gay men, bisexual people, and sometimes even transgender people. In the last 20 years, this has become less and less common and now gay is usually used to refer only to gay men. The term "gay" in reference to lesbians, gay men, and bisexual and transgender people (LGBT), is being increasingly displaced with the term "queer" to encompass the entire LGBT community, particularly among younger, queer people. For these people, the term "queer" is positive and empowering. The use of the word "queer" or "fag" is an attempt to replace the negative connotations of such words with a more positive connotation. Other LGBT people find the use of the terms "queer" or "fag" degrading. These terms are still the favourite epithets used towards LGBT people in a homophobic manner. Because this is a term that is controversial, in that it has not gained full acceptance in sexual minority

communities, nor is it fully understood by the straight world, caution needs to be taken as to when and in what context it is used.

Lesbian, gay, bisexual, and transgender people are a diverse group of people who have struggled with issues of sexuality and gender identity,<sup>17</sup> and may therefore feel a sense of kinship because they share remarkably similar experiences related to stigma, discrimination, rejection and violence across culture and locales (Meyer, 2001). They may also coalesce for political expediency around a common agenda, or to form communities that provide safe spaces, common norms and values, and institutions where identities and relationships can be acknowledged and respected (Meyer, 2001). Sexual minorities, or LGBT people, are often stigmatized and marginalized in the health care system (discussed later in the literature review). Health research may focus on all LGBT people, or on one group, or a subset of one group, such as the case of this research which focuses solely on gay men 19 years or older who use the Three Bridges Community Health Centre. Since this research focuses on gay men, the issues raised in this review of the literature may or may not have significance for the larger LGBT community.

### **A Definition of Accessibility**

Access to quality health care is important in order to eliminate health disparities and increase the quality and years of healthy living for all persons. The health system has increasingly embraced the rhetoric of service accessibility for vulnerable populations, but one (among many) population group still requiring attention is gay men. The notion of accessibility is complex. It typically denotes access to an “organized supply of health

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<sup>17</sup> At birth, we are assigned one of two genders, usually based on our visible genitals. For many people this gender assignment fits and feels comfortable and they never think about it further. Others do not feel as

services [that] is available to all people with no geographic or financial barriers” (Registered Nurses Association of British Columbia, 1998, p.5). However, such an interpretation of accessibility is problematic since there are barriers beyond geography and finances that affect whether vulnerable populations (in particular) will access care. It is important to underscore that simply by health services being *available*, they may not necessarily be *appropriate*, and they may not be *accessed*. Even when services are theoretically available, they are often either culturally inappropriate or are provided by staff who lack knowledge and education about the health issues of groups most in need of services.

Billings, Anderson and Newman (1996) examined disparities in health outcomes for low-income populations in the United States and Canada, and concluded that the Canadian universal health coverage may help to *reduce* barriers to care. However, it is the individuals with the poorest health status who typically do not access available services. Furthermore, in Canada, low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs (Federal, Provincial, Territorial Advisory Committee on Population Health, 1999). We are increasingly recognizing that there are tremendous inequities in health status, and thus a goal of our health system should be an attempt to reduce such inequities.<sup>18</sup> It is only when we attempt to address the health issues of those hardest to

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comfortable with their assigned gender, either because they find the two-gender system too limiting or because they feel more identification with the gender opposite that to which they were assigned at birth.  
<sup>18</sup> Health inequality is a generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups. Health inequity refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice. (Kawachi, Subramanian & Almeida-Filho, 2002). Health inequities exist largely because people have unequal access to society resources, including education, health care, job security – factors society can do something about. Inequalities that arise from social injustices and are avoidable are considered inequities (Evans, Whitehead, Diderichsen, Bhuiya & Wirth, 2001).

reach populations that health inequities will be reduced. Systemic barriers to the access of health and health services include race, sex, sexual orientation, age, culture, religion, language, physical or mental disability, and socio-economic status.

In this research, accessibility is defined beyond the mere availability of a service. Accessible health care means a continuing and organized supply of health **services** available to all persons with no unreasonable barriers, but as Stewart (2000) points out, accessibility also refers to the accessibility of **health** and **health status**. Accessibility has typically been defined in reference to a number of barriers (Alberta Health and Wellness, 2001). Developing accessible primary health care means examining and enhancing factors that may prevent clients from accessing those services. Elements of accessibility are financial (affordability); physical; attitudinal; values/beliefs; cultural/language; transportation; geographical; availability; appropriateness; and awareness (Alberta Health and Wellness, 2001; Barnes *et al.*, 1995; Remkes & Sibbald, 1992). Making services accessible usually begins by assessing the needs of the population, assembling the appropriate services and providers (availability), publicizing the services and location, and opening the doors (Alberta Health and Wellness, 2001). Another external cause or factor affecting health or well-being is the **utilization** of health services. Ironically, the health system may improve accessibility, but the targeted population may still not use its services. Stevens (1994) also asserts that social justice and social equity are essential conditions for health care to be accessible. Similarly, Barnes *et al.* (1995) argues that “health care encounters must be of equal quality and comprehensiveness for all groups” (p.11). The broad approach to accessibility contained herein would require a profound change in the manner in which health care is delivered in Canada.

### **A Definition (or Parameters) of Community Health Centres**

Community-based health settings, such as community health centres, are ideally suited to enhance access to health services for vulnerable populations, and thereby improve their health and health status. As mentioned previously, the purpose of this research is to examine how accessibility is conceptualized and practiced at Three Bridges Community Health Centre. Therefore, an elucidation of the parameters and objectives of CHCs is warranted. It should be noted that many of the parameters, objectives, or both, of community health centres are related to the elements of accessibility, and hence the choice of a community health centre as the setting for this research, rather than other primary care settings, such as emergency rooms, walk-in clinics, or solo practices by physicians.

#### *Parameters and Objectives*

The British Columbia Health Centre Working Group (1998) notes that six common features generally define health centres:

1. Serving local residents in a geographic community or a defined population group (*e.g.*, youth or the frail elderly);
2. A major focus on health promotion and disease prevention for individuals and families as well as the community as a whole;
3. An interdisciplinary team approach in providing services and programs;
4. Strong community involvement in providing direction about the centre's philosophy and services;

5. Coordination of a range of services that may include medical/curative care, rehabilitation, supportive care, outreach services (such as home support and public health programs) and support groups. In addition to providing services, health centres often take an advocacy role in relation to health issues in the community; and,
6. Part of the publicly funded health system.

The Association of Ontario Health Centres (*Facts about Health Centres*) has also outlined the parameters of CHCs. Community-governed primary health organizations (CHCs)

- are not-for-profit;
- are governed by a volunteer board of directors whose members are largely either residents of a defined area or clients;
- involve clients determining where resources are allocated to maximize outcomes of services provided;
- plan and develop programs using a needs-based impact approach;
- serve an identifiable local population;
- provide a range of primary health and non-institutional services with an emphasis on illness prevention, health promotion, health education and community development;
- offer 24-hour access to coordinated services;
- have multi-disciplinary teams of salaried health professionals;
- work in partnership with other health organizations, such as public health units, hospitals and others to ensure an integrated and coordinated continuum of care;

- work in partnership with organizations in other sectors, such as education, justice, recreation, and economic development to develop a healthy community; and, meet the need for public scrutiny and quality assurance. (no date, from [http://aohc.dvp.net/article\\_display.asp?ArticleID=67](http://aohc.dvp.net/article_display.asp?ArticleID=67))

These parameters of the CHC model represent several objectives that are befitting means to enhance accessibility for gay men, and other vulnerable populations. The objectives of the CHC model, as defined by the Association of Ontario Health Centres (1997), are

- to promote equity in access to health services;
- to strengthen the role of the individual and the community in health and health care delivery;
- to encourage linkages among health services and with social and other community services;
- to develop coordinated primary care services which make the most efficient use of health care providers and health resources; and
- to promote health and prevent illness to enhance the health status of the communities served.

### **The Stakeholders and their Context**

Within this examination of accessibility for gay men vis-à-vis a community health centre, there are many relevant issues and stakeholders that affect the type and quality of care gay men receive in primary health care.<sup>19</sup> Therefore, it is important to examine the stakeholders, and their past and current interactions. Accessibility must be understood

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<sup>19</sup> A distinction, albeit artificial, has been made between real and perceived barriers since the latter term denotes only an intuitive sense by a gay male of a barrier, such as a homophobic provider or system, and

and addressed from the clients' perspectives, the providers' perspectives, the setting's mission and culture, and the health system's perspective, all of which operate under the larger social context/milieu – in this case, the gay community. Also, how all of these perspectives come together to either enhance or detract from accessibility is critical to understanding this research. The knowledge, attitudes and behaviours by all of these parties and entities will ultimately affect the level of accessibility. The level of effort exerted by all of these stakeholders will ultimately affect the level of accessibility. For instance, community health centres are constrained or enhanced by the body governing them, the community, and its' providers.

For purposes of clarity, an artificial distinction has been made between: issues and attributes within (*intrapersonal*) gay male clients; issues and attributes within (*intrapersonal*) health service providers; relations between (*interpersonal*) gay male clients and health services providers; issues that are based in the setting or are system-wide; and finally, issues that are based in the gay community. This dissection into five levels – **client, provider, client-provider, and setting/system, gay community** – is of course artificial, since these levels are constantly interacting with each other, which may serve to either impede or enhance accessibility for gay men when one level either reinforces or challenges the other. Accordingly, relevant issues of each of the above highlighted levels constitute a major section in this literature review. This is followed by a thorough discussion of potential strategies to enhance accessibility, particularly within the community health centre as a setting for primary health care.

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thus may fail to access care or delay in seeking care. It may be based on previous experiences with the

## **Client Issues**

This section discusses the health issues of gay men, their psychosocial and historical origins, and factors that make it particularly difficult for gay men to receive appropriate, adequate and culturally-sensitive health care. This section focuses on the gay male clients' experiences with providers and the health system, as well as their own perceptions and self-concept that affects whether, when and where they seek care, as well as the quality of care they receive.

### *Health Issues of Gay Men*

As part of the rich and varied mosaic of Vancouver's communities and neighbourhoods, gay men, lesbians, bisexuals, and transgendered individuals represent a community whose needs are in many ways the same as those of other residents, and in many ways unique and different.<sup>20</sup> The health status of any community is a function of both its health care needs and its ability to have those needs met (New York City Department of Health, 1999). Gay men may have some particular health concerns, including mental health, eating disorders, substance misuse, and anal cancer (Lee, 2000) to name a few. Only a limited amount of information is available on the health issues of gay men and other sexual minorities since most large-scale studies do not address sexual orientation (Lee, 2000). The exception is HIV infection which dominates the discourse on gay men's health. Most of the research on gay men's health cited in this section is American with the exception of the sub-section on sexually transmitted diseases, including HIV, for

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health system, and must be addressed just as 'real' barriers are addressed.

<sup>20</sup> While some of the research in this section pertains to gay men exclusively, other research focuses on all LGBT populations since data exists for only the latter group.

which provincial data exists. Health care providers may fail to address health issues of gay men because of an ignorance of specific health care issues, or other barriers (to be discussed in the next section). Gay men must also deal with the stigma and psychological issues surrounding these diseases and illnesses (Schilder *et al.*, 2001). This section describes some of the health issues of gay men. Knowing the health issues of gay men and other vulnerable populations fosters improved care seeking, treatment adherence and improved health status. An informed health professional is an important component of accessibility. These issues will be discussed in later sections.

#### *Alcohol and Drug Misuse*

Studies from the 1970s and 1980s led many to the conclusion that rates of alcoholism were higher among LGBT people than in the overall population – sometimes citing rates of alcoholism in the LGBT community as high as 30 percent – much higher than the figure of 10 percent usually ascribed to the general population (New York City Department of Health, 1999). However, most of these studies were seriously flawed, drawing participants from gay bars and other locations in which people who drink are over-represented (Lee, 2000). More recent and reliable studies have been conflicting, but there is some evidence that LGBT youth and possibly LGBT adults have more alcohol problems than the overall population. Stall and Wiley (1988), comparing alcohol use patterns of heterosexual and homosexual males in San Francisco, found no significant differences in quantity and frequency of alcohol consumption overall, though differences at the extreme patterns of use were noted. Gay and bisexual men were approximately twice as likely to be heavy drinkers or abstainers as heterosexual men. McKirnan and Peterson (1989) found that while heavy drinking patterns did not differ significantly by

sexual orientation, gay men and lesbians reported rates of alcohol problems nearly twice as often as heterosexuals. Drinking rates among gay men and lesbians do not appear to decrease with age as quickly as they do in heterosexual populations (McKirnan & Peterson, 1989; Skinner, 1994; Stall & Wiley, 1988).

In addition to alcohol, gay men use a wider variety of drugs, such as marijuana, “poppers” (amyl nitrite or butyl nitrite), methylene-dioxyamphetamine (MDA), barbiturates, ethyl chloride, and amphetamines. Although causality cannot be determined, a history of consistent use of inhalants, amphetamines, and cocaine is strongly associated with HIV seroconversion, independent of injection drug use (Gay and Lesbian Medical Association and Columbia University’s Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000).

#### *Smoking and Tobacco*

Although no large-scale study of the prevalence of LGBT tobacco use has been conducted, current evidence suggests that sexual minority people do smoke more than heterosexuals. A 1999 household-based survey found that 42% of gay and bisexual men reported smoking, a rate far in excess of the overall national rate for men of 29% (Stall, *et al.*, 1999). It is important to note that the tobacco industry has begun marketing cigarettes specifically to lesbian and gay people in the last decade, following a 35% decline in sales of tobacco between 1973 and 1991 (Gay Lesbian Bisexual Transgender health webpages: Tobacco and Smoking, 2000).

#### *Depression and Mental Health*

While we know that homosexuality, bisexuality, and transgender identity are not mental illnesses, the stresses caused by societal stigma, condemnation, and violence can

sometimes result in depression and other types of emotional difficulties for LGBT people. Young adults (18-25) are more prone to depression than people in midlife- perhaps because of the particular stressors of separating from one's family and learning to live on one's own. Elderly people also have higher rates of depression than people in midlife. People who abuse alcohol may become depressed – and excessive use of alcohol often indicates that a person is “self-medicating” a depression. Alcohol and related drugs like valium and barbiturates are themselves depressants, and exacerbate problems.

Our society still attaches significant stigma to mental illnesses – much in the way we used to, and still do with AIDS. This stigma often leads people to try to hide a mental illness, preventing them from seeking the assistance that can help them feel better. For LGBT individuals, the multiple stigma of being a sexual minority as well as a person struggling with a mental illness may be extremely challenging, and may make day-to-day existence difficult. LGBT populations may be at increased risk for mental distress, mental disorders, substance use, and suicide because of exposure to stressors related to societal antigay attitudes. Known social stressors include prejudice, stigmatization, and antigay violence (Meyer, 1995; Rosario, Rotheram-Borus, & Reid, 1996). Since some males do not realize their sexual orientation until adulthood, they may face social isolation, fear of discrimination at work, and loss of loved ones when they begin to identify as gay (Gay Lesbian Bisexual Transgender health webpages: Depression and Mental Health, 2000).

Individuals in the LGBT community also may experience a variety of other types of mental illnesses. The evidence pertaining to the risk for mental illness among lesbians, gay men, and bisexual and transgender individuals is conflicting. Some assert that gay men are at no more risk for mental illness than heterosexuals. However, Pillard (1998)

found elevated rates of bipolar disorders among gay men; Atkinson *et al.* (1988) found elevated rates for most mental disorders among gay men; and Cochran *et al.* (in press, as cited in Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000) found homosexual men to have higher rates of major depression disorder than heterosexuals.

### *Suicide*

Forty percent of LGBT youth have either attempted or seriously contemplated suicide. Gay men are six times more likely to attempt suicide than their heterosexual counterparts. A study in Calgary, Alberta examined suicidal behaviour in gay and bisexual males, revealing stark results. Gay and bisexual men are 6 to 11 times more likely to have made a life threatening suicide attempt than heterosexual males. Homosexually-oriented men (including both currently homosexually active and celibate homosexual males) were almost 14 times more likely to have made a serious suicide attempt at some point in their lives, than their heterosexually oriented counterparts (Mule, 2000). In general, suicide attempts in gay men are more severe than those of their heterosexual counterparts. Risk factors associated with an increased likelihood of suicide attempts include nonconforming to gender (such as men with more feminine gender roles), self-identification as gay or bisexual at a young age, first homosexual experience at an early age, history of sexual or physical abuse, and rejection by important social supports.

### *Safety and Hate Crimes*

LGBT hate crimes are those in which victims are chosen because of their actual or perceived sexual orientation or gender identity. Hate crimes are also committed based on

religion, disability, race, ethnicity and national origin. Hate crimes may include property crimes (like robbery), threats, intimidation or actual acts of physical violence. Hate crimes are unique because they send messages to entire groups – as well as to their families and other supporters – that they are unwelcome and unsafe in particular communities, including “gay communities.” Most LGBT hate crimes are committed by otherwise law-abiding young men who often believe that they have societal permission to engage in anti-gay violence. Anti-gay violence and harassment are common (Gay Lesbian Bisexual Transgender health webpages: Safety and Hate Crimes, 2000), but exact numbers are difficult to assess since most crimes go unreported because law enforcement is often deemed homophobic. It has been estimated that up to 80% of bias-crimes are never reported to the authorities. Minority groups, including LGBT communities, historically have had strained relations with law enforcement and fear that crimes against them will not be taken seriously or that the police reaction will be unsympathetic or hostile.

Although any type of victimization carries with it psychological consequences, certain types of emotional reactions are more frequent among survivors of hate crimes. These feelings include depression, anxiety, fear, stress and anger. The American Psychological Association has determined that victims of hate crimes suffer the symptoms of post-traumatic stress for up to five years, in comparison to two years for victims of non-bias-related crimes.

Survivors of LGBT hate crimes may also be concerned that reporting attacks against them may expose them to increased risk by being “outed” to families, employers and communities as a sexual minority. Many hate crime survivors suffer the trauma of

victimization in silence rather than to expose themselves to these forms of “secondary victimization.” Hate crime laws are laws that enhance the penalties imposed by the courts for individuals convicted of acts of bias-related violence. These laws, although controversial, are designed to act as a deterrent by punishing hate crime perpetrators more severely than those who commit similar types of violent acts that are not motivated by hatred.

### *Domestic Violence*

In recent years, LGBT survivors of domestic violence have begun speaking out about their experience in increasing numbers. New organizations have been created to address the issue and provide support to survivors. Historically, though, there has been an overwhelming silence about same-sex domestic violence. Many people still do not believe that same-sex domestic violence really exists, and people who are victims are often ashamed to tell their communities or families. In fact, numerous studies have shown that violence in heterosexual and same-sex relationships occurs at approximately the same rate (one in four) (Gay Lesbian Bisexual Transgender health webpages: Domestic Violence, 2001).

Although domestic violence is largely the same in heterosexual and homosexual relationships, gay, lesbian and bisexual victims of domestic violence have some additional problems, such as fewer services and increased isolation. To receive help victims of domestic violence have to come out; however, there are few or no shelters and services for male victims of domestic violence, gay or straight. Being a gay male in a homophobic society can compound the isolation that accompanies domestic violence. Silence about domestic violence within the LGBT community further isolates the victim,

giving more power to the batterer. One of the weapons that batterers in same-sex relationships may use involves “heterosexist control.” This means that the batterer takes advantage of the homophobic and heterosexist nature of the larger society – as well as our own internalized heterosexism – to further dominate and control their partner, such as threats to “out” the victim.

### *Sexual Abuse and Assault*

In addition to the abuse itself, it is believed that the stigma associated with sexual abuse, combined with that of being a member of a sexual minority group complicates the study of this phenomena (Klinger & Stein, 1996). In addition, both the conceptualization and definition of sexual abuse and assault vary widely from study to study, making comparisons and the estimation of prevalence and incidence of these behaviours across populations almost impossible. Existing data, however, suggests that gay men may in fact be at elevated risk for sexual abuse and assault. Moreover, data indicates that these experiences may impact on other health-related concerns such as mental health, substance use, and HIV risk behaviour (Gay and Lesbian Medical Association and Columbia University’s Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000).

Rates of sexual abuse and assault experienced by gay men may be higher than those found in studies of men generally. Investigators of one large study (N=1001) of gay and bisexual men 18 years and older (Doll, *et al.*, 1992) observed that more than a third (37%) of the men reported having a sexual encounter with an older or stronger partner (usually a man) before the age of 17. About half (51%) of these early encounters involved the use of force, and almost all (93%) met the investigators’ definition of sexual abuse.

This study also indicated that the risk of sexual abuse was higher for the young men who had stereotypically feminine characteristics. To literally add insult to injury, “physicians tend to be especially insensitive to gay men and lesbians in cases of sexual assault. There is an unwillingness to believe that a man, especially a gay man, can be sexually assaulted” (Cotton, 1992, p. 2999).

### *Eating Disorders*

Gay men have higher rates of dieting and binge eating than heterosexual men. Social stressors may impact body image and eating patterns among gay and lesbian adolescents. Significant literature suggests that adolescence and the social stress that accompanies it may place gay men at increased risk for body dissatisfaction and problem eating behaviours. The onset of these disorders commonly occurs during this period. In addition to this social stress hypothesis, other research suggests a socio-cultural hypothesis linking body image dissatisfaction and eating disorders with the cultural valuation of a thin body (Silberstein, Mishkind, Streigel-Moore, *et al.*, 1989; Hefferman, 1994). According to this view, emphasis on thinness normally placed on feminine bodies may also influence gay men, who are more likely to demonstrate atypical gender role behaviour (Fichter & Daser, 1987), and may place greater cultural emphasis on appearance (Herzog, Newman, & Warshaw, 1991; Siever, 1994).

### *Sexually Transmitted Diseases*

The stigma associated with sexually transmitted diseases (STDs) and infections in general and with homosexual acts make accurate estimates of the prevalence rates for these conditions in gay men (and other MSM) almost completely unavailable. STDs for which homosexually active men are at risk include urethritis, proctitis, pharyngitis,

prostatitis, hepatitis A (HAV) and B (HBV), syphilis, gonorrhea, chlamydia, herpes, genital warts, and HIV infection. STDs can lead to weeks or months of painful and debilitating illness. From the early 1980s until recently, rates of HIV and other STDs among gay and bisexual men declined, and then held steady. The scale of behaviour change among gay and bisexual men during this time was unprecedented. But even these lower rates of HIV and STD transmission that were achieved in the late 1980s remained several times higher than that of the general population.

Compared to HIV, other STDs may seem relatively harmless, but they take a heavy toll on the person affected and health care expenditures. Health consequences of STDs in men range from mild acute illness, like burning and itching of the urethra (the opening of the penis), to serious long-term complications such as anal and liver cancer and, in the case of syphilis, stroke and blindness. Both genital herpes and genital human papillomavirus (HPV – the virus that causes genital warts and is associated with penile and anal cancer in men) cause lifelong infections. Some STDs, like gonorrhea, chlamydia, and syphilis, are easily curable with antibiotics, and if treated promptly, they rarely have long-term consequences (Gay Lesbian Bisexual Transgender health webpages: Sexually Transmitted Diseases Among Gay and Bisexual Men, 2000).

Studies have already documented passage of a drug-resistant HIV-virus from one gay man to another, and one recent study among newly infected gay men found that as many as 16% had HIV that was somewhat resistant to one or more AIDS drugs (Boden, *et al.*, 1999). Highly active anti-retroviral treatments (HAART) efficacy may also impact HIV prevention efforts and other health supports for homosexually active men. Fuelling the perception that AIDS has become a manageable, chronic infection, the advent of

HAART has been accompanied by reports of sharp drops in funding for community based AIDS prevention and service organizations serving gay men and increases in high-risk behaviour. One study, for example, found that 18% of HIV-positive gay men were now practicing safe sex less often because of treatment advances (Kelly *et al.*, 1998; Kelly & Kalichman, 1998). Other factors speculated to be contributing to an increase in HIV infections among gay men include proliferation of internet chat rooms and phone sex lines; increasing popularity of gay bathhouses; HIV burnout/condom fatigue; transmission optimism (perception that a lower viral load equals less infectivity); new cohort of young gay men; and increased use of crystal methamphetamine, Viagra and Ecstasy (Rekart, 2001). The ever-changing social milieu of gay men creates further challenges in promoting their health. Unfortunately, both public health officials and gay men have lost vigilance in preventing HIV infection.

#### *The Vanguard Project - Vancouver-based Research*

In Vancouver, a prospective cohort study involving gay and bisexual men aged 18-30 years who had not previously tested HIV positive is underway. Subjects are/were recruited through physicians, clinics and community outreach in Vancouver. Annually the participants are/were tested for HIV antibodies and asked to complete a self-administered questionnaire pertaining to socio-demographic characteristics, sexual behaviours and substance use. Prevalence of HIV infection and risk behaviours were determined for eligible participants who completed a baseline questionnaire and HIV testing as of May 1998. The primary outcome was the proportion of men who reported having protected sex during the year before enrolment and who reported any episode of unprotected sex by the time of the first follow-up visit. Preliminary results suggest a

disturbing trend toward increasing levels of unprotected anal intercourse. Among young gay and bisexual men in Vancouver, the HIV/AIDS epidemic has reduced life expectancy by up to 20 years (Strathdee, *et al.*, 2000).

Compared with subjects who remained HIV-negative, those who became seropositive were younger and more likely to report high-risk behaviours. The small number of seropositive men precluded a multivariate analysis of risk factors. However, among participants aged 25 or less, the incidence of HIV was 2.5 per 100 person-years (95% CI 0.54.5), and among those exchanging sex for money, goods or drugs, the incidence was as high as 9.5 per 100 person-years (95% CI 1.217.9). (Strathdee, *et al.*, 2000). Recent data from the Vanguard Project has demonstrated that incidence rates are on the rise in young gay and bisexual men in Vancouver. In the year 2000, there were 10 new infections, for an annual HIV incidence rate of 4.6%. This is five times higher than the annual infection rate of 0.9% seen in the first four years of the study (Hogg, 2001). Furthermore, the British Columbia Centre for Disease Control has reported an increase in new positive tests in gay men in the year 2000 – up from 95 in 1999 to 128 in 2000, representing a one-year increase of 35% with most of the increases among Caucasian gay men (Rekart, 2001).

Previously Strathdee *et al.* (1998) demonstrated that low education level, use of amyl and butyl nitrites, low level of social support and a history of sexual abuse were independent risk factors for unprotected anal sex with casual partners. Other studies by Vancouver-based researchers and others have confirmed the important role of alcohol and drug use in sexual risk-taking among gay men (Calzavara, Coates, Raboud, Farewell, Read, Shepherd, *et al.*, 1993; Strathdee, *et al.*, 1998; Hogg, *et al.*, 1993; Ostrow &

McKirnan, 1997). Among other factors, complacency toward HIV infection may have arisen because of optimism surrounding recent advances in antiretroviral therapy (Dilley, Woods & McFarlane, 1997). Other researchers have proposed that sexual risk-taking may be due to feelings of fatalism and inevitability (Katz, 1997), lack of direct experience of the AIDS epidemic among the younger generation of gay men (Kippax, *et al.*, 1997) or a desire to escape the rigorous norms and standards required for a lifetime of safer sex (Ostrow & McKirnan, 1997).

### *Anal Cancer*

Gay and bisexual men, especially those with HIV, are at significantly higher risk for anal cancer than the general population (Gay Lesbian Bisexual Transgender health webpages: Anal Cancer, 2000). Risk factors for the development of anal cancer are a history of anal-receptive intercourse; history of genital warts; herpes simplex virus (type 2 infection); hepatitis B virus infection; history of chlamydial infection; and being a current smoker (Daling, Weiss, Hislop *et al.*, 1987). Statistics show that the rate for anal cancer in gay and bisexual men (without HIV) is about the same as the rates of cervical cancer in women before pap smears became routine. Routine pap smears have decreased the incidence of cervical cancer from 30-40 per 100,000 women to approximately 8 per 100,000. The incidence of anal cancer among gay and bisexual men who are long-term HIV survivors has increased greatly. This is probably due in part to the fact that men are now surviving longer with recent effective HIV treatments, and are thus experiencing rising rates of other, previously uncommon cancers.

Some anal cancer and cervical cancer are caused by the same viruses – “high-risk” varieties of the human papillomavirus (HPV). Warts are mostly caused by “low-

risk” strains of HPV that do not lead to cancer. However, they often need to be treated. Treatment usually consists of freezing them with liquid nitrogen, or the use of surgery or cautery. A few strains of HPV can lead to anal cancer if not caught and treated early. Most often, though, infection even with those “high risk” strains of HPV does not result in cancer. Men become infected with anal HPV through receptive anal intercourse. One study estimates that approximately 95 percent of gay men with HIV and 65 percent of gay men without HIV have HPV in their anal canals or the surrounding skin.

These disturbing trends in risk behaviour have forced a rethinking of STD prevention strategies for gay and bisexual men. This has included the acknowledgment that the old prescription for everybody to “use a condom every time” has not worked over an extended period of time for many, and had almost never worked for some specific population groups. More complex articulations have been integrated into prevention theory including: distinctions between the needs and motivations of HIV-positive men, HIV-negative men, or men who do not know their status; the role of desire in sexual practice; the different issues and challenges about sexual practice within the context of unequal power relationships; specific differences related to cultural identity as well as gender identity and sex role; and the complicated relationship between substance use and sexual decision-making. Marchand (2001b) asserts that rising infection rates have been coupled with the “de-gaying” of HIV/AIDS programs internationally, and in Vancouver. He states: “De-gaying is an expression that was coined earlier in the [HIV] epidemic to describe shifts in the concentration of prevention resources away from gay men to address other risk populations. Health promoters...cautioned that leaving such a large affected group unattended could cause another HIV catastrophe” (p.7).

## **Psychosocial and Historical Origins of Gay Men's Health Issues**

Thus far, the health issues of particular relevance for gay men have been organized by specific diseases and illnesses. It is also important to consider illness, disease and health in the context of their psychosocial origins. Etiological research, focusing on the causes and origins of disease, reveals that chronic illnesses have multiple causes leading to a single effect. The metaphor "web of causation" is frequently used to explain this phenomenon (Gay and Lesbian Medical Association and LGBT health experts, 2001). It is time to devise a broad health agenda for gay men that includes, but is not restricted to, a concern with HIV. It is reasonable to hypothesize that, by dealing with the many intertwining epidemics, and psycho-social variables that confront gay men, important positive effects may well be observed in the health status of gay men, including specific diseases (Stall, Hays, Waldo, Ekstrand & McFarland, 2000).

Unfortunately, all too often attempts to integrate an ecological perspective often regress to individual behaviour modification. Individual, behavioural risk factor outcomes are still often the ultimate criteria (Frohlich & Potvin, 1999). Population health provides sound evidence for health promotion to focus interventions on populations, rather than on individuals, and to bypass individual-behaviour-related risk factors as the principal targets for change. Social and contextual conditions are not just instrumental to behaviour changes, but rather are in constant interaction with behaviour. Lifestyle has come to refer to a few habits of daily living measured as discrete unrelated behaviours (Frohlich & Potvin, 1999). This reductionist view also separates individual behaviours from the social and situational context. Accordingly, health status is measured as aggregates in populations with little appreciation for context. It is important to underscore

that culture is not restricted to racial and ethnic identification or heritage; instead, culture is the customs, beliefs, values, knowledge, and skills that guide a people's behaviour along shared paths. Culture defines and broadens the concepts of health/wellness and disease/illness. Culture is pervasively intertwined among determinants influencing health; these include: genetics, environment, health services and habits (Gay and Lesbian Medical Association and LGBT health experts, 2001). Trussler, Perchal and Barker (2000), Vancouver-based researchers, note that "everyday interaction with...other [gay men] and with members of [the] dominant society produces, manages and sustains the public sense of gay existence" (p.296). This section discusses the social and contextual conditions which serve as the backdrop for gay men's health issues.

### *Criminals, Sinners and Sick*

Oppression among lesbian, gay, bisexual and transgendered people in Canada is vast and widespread. Four major pillars in society have played crucial roles in the oppression of sexual minority people in Canada, namely the legal, educational, religious and health systems (Mule, 2000). Homosexuality was deemed a criminal offence until 1969 when it was decriminalized with the now famous quote of former Prime Minister Pierre Elliott Trudeau: "the state has no place in the bedrooms of the nation." Homosexual behaviour is still criminalized in 16 states in the United States (Meyer, 2001). Organized religion has a predominant past of labeling homosexuals as sinners and homosexuality as a sin. Today, a number of religious institutions have begun to embrace sexual minority communities, others have made some movement such as "love the sinner, hate the sin," while numerous others remain intransigent (Mule, 2000). And it is only recently that we are beginning to acknowledge the profound amount of bullying which takes place in schools, and how

much of this may be rooted in homophobia.

The health system, specifically the American Psychiatric Association, had listed homosexuality as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until 1973 when it was removed following campaigns by American gay rights groups (Rose, 1994). Homosexuality continued to be categorized as a pathological disorder by the World Health Organization until 1988 when it was also removed from the United Kingdom's *Diagnostic & Statistical Manual of Mental Disorders* (Rose, 1994). Thus, a history in which society has labeled gay men as “criminals,” “sinners,” “fags,” and “sick” has had a significant and negative effect on the well-being of gay men. Oppression of this magnitude impacts on a community’s mental, physical, emotional, psychological and spiritual health (Mule, 2000). While laws and medical classifications may have changed, homophobic and heterosexist assumptions are commonplace in the legal, educational, religious and health systems.

### *Internalized Homophobia*

These systemic forms of discrimination manifest themselves in various ways in gay men, including self-concept, risk behaviour and health status. The obvious stresses of gay life (social stigmatization, discrimination, and internalized feelings of isolation, inadequacy and alienation) and negative social attitudes can manifest themselves as discomfort with one's sexual orientation (Paul & Stall, 1991).

Gonsiorek (1988) explains that while homosexual individuals present a full spectrum of psychological adjustment from the well adjusted to the severely disturbed, the effects of homophobia and prejudice have adversely affected many gay and lesbian individuals. He describes one of the greatest impediments to the mental health of gay and

lesbian individuals as “internalized homophobia.” Internalized homophobia refers to negative feelings that one incorporates into one's self-image as a result of being raised with culturally sanctioned anti-homosexual biases. Gonsiorek (1988) states that symptoms may range from a tendency toward self-doubt in the face of prejudice to unmistakable, overt self-hatred. Internalized homophobia may affect both the progression of illness and health-related decision-making processes with significant effect on the prevention of illnesses such as HIV infection (Williamson, 2000). Gonsiorek asserts that internalized homophobia has various expressions. The overt type presents in persons who consciously accuse themselves of being evil, second-class or inferior because of their homosexuality. They may abuse substances or engage in other self-destructive abusive behaviours, however, covert forms of internalized homophobia are the most common.

Gonsiorek states:

affected individuals appear to accept themselves, yet sabotage their own efforts in a variety of subtle ways. For example, homophobic gay and lesbian individuals may abandon career or educational goals with the excuse that external bigotry will keep them from their objectives. Internalized homophobia may take the form of tolerating discriminatory or abusive treatment from others. (p. 117)

There are concerns however that the concept of internalized homophobia may re-pathologize the “sick” gay man and focus attention away from the more salient issues of cultural and institutionalized heterosexism. Williamson (2000) asserts that its contextualization may focus prejudice within the individual rather than in society and its structures.

### *Risk-Taking Behaviour*

Internalized homophobia results in many risk-taking behaviours among gay men which is the cause of many of their health issues. As Bognar (2001) states: “The same type of not-

caring-about-yourself that leads young men who are confused about their sexuality to contemplate suicide is the same type of not-caring-about-yourself that leads to unsafe sexual practices” (p.29). While many health issues for gay men parallel those in the heterosexual community, others relate to their distinctive experiences: estrangement from families, the challenge of adjusting to a minority sexual orientation, the hostility or abuse that many gay men experience throughout their lives, and the lack of social support for gay relationships or family structures. Research of risk-taking behaviour has begun to move from purely cognitive explanatory models of risk-taking behaviour to the consideration of affective and non-rational processes among gay men.

A wide and sometimes contradictory range of other psychosocial factors has been shown to influence health issues. For instance, sexual risk-taking is influenced by self-esteem, mood prior to sexual encounter, optimism, fatalism, age, education, income, and alcohol or drug use (Hospers & Kok, 1995; Stall, Hays, Waldo, Ekstrand, & McFarland, 2000). A variety of studies have found significant associations between risk behaviour and negative mood states including loneliness, depression, anger, and low self-esteem. Lenderking *et al.* found that men who were abused reported more lifetime male sex partners, and were more likely to have had unprotected receptive anal intercourse in the past 6 months (Stall, Hays, Waldo, Ekstrand & McFarland, 2000). Men who report engaging in unprotected anal intercourse also tend to report greater numbers of male sex partners and higher levels of sexual activity (Stall, Hays, Waldo, Ekstrand, & McFarland, 2000).

Numerous studies have indicated internalized homophobia in alcohol and drug use, and intimacy and sexual problems and other adjustment difficulties, as well as high

HIV risk-taking behaviours among young gay and bisexual men (Meyer & Dean, 1995). For example, a 1988 Chicago study demonstrated that “subjects reporting more negative affectivity than others were more likely to see alcohol as a means of reducing tension and were more likely to use bars as a primary social setting” (Paul & Stall, 1991, p. 154). The researchers concluded that “alcohol abuse among those who used bars as a social resource was significantly related to experienced discrimination and to personal stress of low self-esteem, alienation and depression” (Paul & Stall, 1991, p. 154). Numerous studies have found that engaging in unsafe sex was related to being under the influence of alcohol or recreational drugs (Stall, Hays, Waldo, Ekstrand, & McFarland, 2000). Gay men not only face stigmatization, but also lack many mainstream coping and support resources, and many use bars as a significant social focus. Assessing recent trends in risk behaviour among gay men is extremely difficult since only limited longitudinal data have been collected on the sexual practices of this population (Wolitski, Valdiserri, Denning & Levine, 2001).

In addressing the question of risk, it is also important to consider both risk factors and risk conditions. Many gay men have risk factors (often behaviour patterns which tend to predispose people to poorer health that are more malleable and proximal) such as smoking (Green & Kreuter, 1999). Many other gay men have risk conditions (determinants of health that are more distal in time, place or scope from the control of individuals), such as poverty and unstable housing which further put them at risk for poor health (Green & Kreuter, 1999). Risk conditions are usually a result of public policy and are modified through collective action and social reform.

## **Barriers to Gay Men Accessing Health Care**

There are many barriers that may prevent a gay man from accessing health care, such as mental, physical or psychosocial condition. Examples include attitudes or biases, mental disorders or illnesses, behavioural disorders, physical limitations, cultural or linguistic factors, availability of appropriate services, a lack of awareness of available services, and geographic and financial constraints.

Gay men involved in the sex trade or individuals searching for assistance with a drug or alcohol problem face further barriers and hostility. Clients entering treatment are dealing with shame and fear of being rejected, not only for their alcoholism, but also for their homosexuality (Paul & Stall, 1991). For gay people who have a psychiatric illness, participation in a treatment milieu often necessitates the suppression of sexual identity, so that some limited sense of belonging can be experienced (Lesbian, Gay, Bisexual and Transgender, 1997, unpublished as cited in New York City Department of Health, 1999).

Cultural differences in assessing sexuality, differences in homophobia levels within cultural and ethnic groups, and conflicts between racial and sexual identity may also contribute to reluctance to access care. It is important to note that many gay men of colour often prefer to frame their HIV care and other health issues in terms of ethnic identity rather than gay or bisexual identification. They would opt to seek care within their racial/ethnic communities, as they believe this would aid in the delivery of effective, culturally competent, and prejudice-free services (New York City Department of Health, 1999). Also, some gay men, such as Aboriginal men, and those in rural communities often feel even less well served than the majority of sexual minorities (Ryan, Brotman and Rowe, 2000).

### *Concealing or Revealing Sexual Orientation*

Some of the aforementioned barriers, such as financial and geographic accessibility, are not unique to gay men or other sexual minorities; however, sexual orientation exacerbates barriers to accessing care. A gay man has to choose whether to reveal or conceal his sexual orientation. Because of the homophobia in society, many gay men conceal their sexual orientation from teachers, employers, families, and health service providers, to name a few. Disguising or hiding sexual orientation because of social stigma results in increased risk of HIV morbidity for both men and women. In ethnic groups where the stigmatization of men who have sex with men is severe, AIDS occurs disproportionately among men, women, and children. "Closeted" gay men are likely to be less affiliated with the gay community and may therefore have less access to safer sex information and resources. Pole *et al.* (1996) found that disease incidence increased in direct proportion to the degree to which participants reported concealing their homosexual identity. The results were not related to age, ethnicity, occupational or educational status, health practices, depression or anxiety.

Since gay men are at greater risk for some illnesses and diseases, a "failure" to disclose sexual orientation to health service providers may put them at increased risk. However, simply encouraging gay men to be open about their sexuality is not enough, many gay men feel lectured to when they are open, and feel their treatment is based on sexual orientation, not illness or behaviour. Gay men also feel they are often treated as "risk factors" and not dealt with as a whole person (Schilder *et al.*, 2001). The expectation or reality of such treatment can lead gay men to seek health care less frequently, or to withhold pertinent information from the physician or other provider.

While many gay men are still uncomfortable revealing their sexual orientation to health professionals for fear of discrimination, internalized homophobia or other reasons, many gay men are inclined to reveal their sexual orientation when they deem it important or when asked depending on the environment. When sexual minorities disclose their sexual orientation, they are more likely to seek health and preventive care, and to report comfort in communication with providers.

Although concealing sexual orientation and the accompanying mindset is detrimental to good health, “coming out the closet” cannot be assumed to improve gay men's physical health (Taylor, 1999). More research is needed in this area. The more open a gay or lesbian person is with relatives and colleagues, then the more likely they are to be open with their primary health professional (Taylor, 1999). Kus (1985) asserts that the essence of the coming out process is not self-disclosure but the acceptance of one's gayness as a positive aspect of self. It involves adopting a non-traditional identity, restructuring one's self-concept, and adjusting one's relationship with others and society.

Homosexual identity formation needs to be viewed in a social context rather than solely on an individual level, a key element of the construction and fixing of identity being through social construction. The gay community and its impact on accessibility is discussed later. Cox & Gallois (1996) suggest that inter-group processes are an aspect of homosexual identity formation which is not adequately acknowledged in the existing models of homosexual identity formation and that homosexual identity formation is an issue of group identity as much as individual identity (Cox & Gallois 1996). Gay men's peers (*i.e.*, interpersonal factors) also play a key role in influencing risk behaviour. Studies have found that self-efficacy and self-control to be associated with engaging in

safer sex, along with belief in the efficacy of condoms. Several studies have found acculturation into the gay community and gay self-acceptance to be associated with safer sexual behaviour (Stall, Hays, Waldo, Ekstrand, & McFarland, 2000).

### **Health-Service Provider Issues**

In order to enhance accessibility for gay men, barriers of health professionals, such as a lack of knowledge, and a lack of skills or appropriate attitudes towards gay male clients, must also be addressed. Although homosexuality has been removed from the list of diagnoses in the diagnostic manual of the American Psychiatric Association, the relationship between homosexuality and sickness has proved more enduring in the minds of many providers. Physicians and other health providers are sometimes uncomfortable providing care to gay men and focus on sexual orientation in a hostile and negative manner. Access to health services may be barred in a number of ways – at worst, by a provider's outright refusal to treat a gay man (Vanberberg, 2001), or health providers may make prejudiced and hostile comments about a patient's sexuality or reduce the standard of service or treatment when they discover a patient is not heterosexual (Anonymous, *CMAJ*, 1998). When a patient revealed his or her homosexual sexual orientation, 31 to 89% of health care providers manifested negative reactions which included being embarrassed or anxious, responding in an inappropriate way, rejecting their patients directly, showing hostility, and displaying excessive curiosity, pity, and condescension (Harrison, 1996).

While many health providers have negative attitudes toward gay men, some health providers lack sensitivity or knowledge about particular health risks and needs of gay men. For instance, health providers routinely ask heterosexually-biased questions.

Even when physicians have been supportive, they have sometimes been ill informed or inadequately prepared to answer questions and manage the care of their gay patients (Simkin, 1998). It is often difficult for health providers to understand sexual identity when gay men themselves often have discomfort self-identifying, and stating their needs since their sexual orientation is associated with stigma and health disparities (Schilder *et al.*, 2001). Provider assumptions of heterosexuality are also quite common. Providers are often in denial regarding sexual orientation, just as ageism regarding sexuality creeps into the thinking and practice of health care providers (Simkin, 1998).

Clinicians unaware of their patients' sexual orientation may fail to accurately diagnosis, treat or recommend appropriate preventive measures for a range of conditions. Some providers may feel that the needs of gay men are not different from those of heterosexuals, and any deviation from the "norm" constitutes special service. For example, in 1996, William D. Gutowski, a physician from Chilliwack, British Columbia wrote a letter to the *Canadian Medical Association Journal* in response to an article in which another physician, Dr. Gary Gibson "comes out". Gutowski states:

Our justice system is symbolized by the figure of a woman who is blindfolded. In race relationships we want people to be colour-blind. But Gibson feels that, when it comes to sexual orientation, it is better not to be blind; it is better to treat homosexual people as "special." Gibson also seems to have identified a new disease, "heterosexism." It is disturbing that the editorial staff of our prestigious medical journal have not sharpened their pencils. Terms that have no meaning except for expressing bias against what most people consider normal sexual orientation should be eliminated. I certainly agree that all people need to have the same basic human rights and professional attitudes and treatment skills applied to them. (p.1664)

Gutowski openly asserts that sexual minorities believe they are "more equal" than others, and thus they feel that they should be treated specially.

One of the biggest mistakes physicians make is confusing sexual identity with sexual behaviour. They are not the same. It is behaviour that puts gay men at risk for illness, not their identities, unless we include hate crimes. Men can identify themselves as gay and not be sexually active, and other men can be sexually active solely with other men and not identify themselves as gay (Simkin, 1998). Some mental health providers go as far as to continue to practice “reparative” therapy on gay men. Reparative therapy refers to any formal attempt to change a person’s sexual orientation from homosexual to heterosexual.

Physicians tend to interpret gay men’s health problems in sexual terms, whereas individuals not identifying themselves as homosexual tend to receive other types of diagnoses (Davison & Friedman, 1981). Another investigation showed that when a patient is known to be gay, physicians tend to interpret the presenting problems in sexual terms; however, when a patient is not identified as homosexual, other diagnoses are more often considered (Harrison, 1996). A variety of studies describe provider hostility or instances of gay men being described as “deserving” of illness or unworthy of treatment. Compared to heterosexuals, with exactly the same clinical presentation, gay male patients were viewed less favorably in terms of, causes and consequences of illness (more responsible for illness and suffering less pain), their relationships with others (more offensive, more dangerous to others, and less “appropriate”), and their personality and physical characteristics (less intelligent, less assertive, less truthful, less likable, and less attractive) (Harrison, 1996). In research conducted in the Lower Mainland of HIV-positive men who have sex with men (MSM), often providers would make judgments

implying promiscuity and immorality associated with sexual orientation (Schilder *et al.*, 2001).

Furthermore, health professionals may not believe that changing behaviour, such as diet and exercise, will greatly affect one's risk factors, and that patients may lack motivation. Health professionals may be doubtful as to how appropriate it is to give patients lifestyle advice, and believe it is a moral intrusion that may increase patient anxiety. Also, they may lack confidence in the efficacy of health promotion in general, or in their ability to change patient behaviour (Bowler & Gooding, 1995). Health professionals also cite a lack of time, lack of financial incentives, and lack of staff (Bowler & Gooding, 1995). In addition, medical training is curative, rather than preventive. Many physicians consider health promotion and prevention tedious, dull and boring, and detracting from curative medicine (Bowler & Gooding, 1995). Such inhibitors are more pronounced for physicians than nurses. Unfortunately, the use of nurse practitioners is relatively rare except in isolated communities and in the far north. As a matter of fact, reverse substitution is often practiced in Canada, in that, highly qualified or extensively trained practitioners have taken over the functions that have been adequately performed by lower-level providers (Wanke *et al.*, 1995, p.4).

### *The Breadth and Depth of the Problem*

Whether health providers or sexual minorities themselves are surveyed about the treatment of the latter by the former, the numbers are troubling. Half of the 711 lesbian, gay, or bisexual physicians and medical students responding to a 1994 national survey reported "actually observing colleagues providing reduced care to patients because of sexual orientation," 88 % recalled "hearing colleagues making disparaging remarks about

lesbian, gay and bisexual patients,” and 67 % knew of “lesbian, gay or bisexual patients who had received substandard care or been denied care because of their sexual orientation” (Krieger and Sidney, 1997).

A New Brunswick study (New Brunswick Coalition for Human Rights Reform, 1993, unpublished, as cited in Mule, 2000) noted that health care professionals themselves expressed the following problems and concerns:

- 76% report a lack of knowledge on gay/lesbian/bisexual issues, yet only 63% want information on these issues;
- 67% lack skills to work effectively with gay/lesbian/bisexual clients, yet only 50% want skill development in this area;
- 63% have problems obtaining information on lesbian/gay/bisexual issues and 58% do not know where to refer lesbian/gay/bisexual clients. Yet only 31% want better access to lesbian/gay/bisexual organizations;
- 16% fear discrimination because of their work with lesbian/gay/bisexual clients. 42% lack support from peers/workplace to affirmatively work with this population, yet only 18% want support from their peers, 20% from the workplace;
- 60% struggle with acceptance of client's sexual orientation when it conflicts with personal belief, yet only 21% want assistance with personal feelings regarding homosexuality.

This study reveals health care professionals themselves face barriers in working with this population, based on lack of formal education, knowledge, skills, support and personal comfort. A more disturbing barrier is the contrasting fewer numbers of professionals who see the need to address these issues.

Similarly, a Winnipeg, Manitoba study (Winnipeg Gay/Lesbian Resource Centre, 1996, unpublished, as cited in Mule, 2000) surveyed the needs of health professionals; it noted

- 56% reported their organization never provided information on working with gays and lesbians as clients and co-workers;
- 31% were not exposed to information on lesbians and gays and their health concerns in any of their previous education and training;
- 41% were unaware of any gay and lesbian services or resources in their area;
- 25% had no access to any information on lesbian/gay issues and health concerns.

#### **Client – Provider Issues**

As alluded to previously, the knowledge (or lack thereof), attitudes and behaviours (skills) of *both* gay male clients and health service providers often create barriers to gay men accessing and receiving appropriate treatment. This section discusses the point at which clients and providers intersect in the health care system. The client-provider relationship is a critical factor in a patient's physiological and psychological responses to treatment, compliance with medical advice and overall satisfaction with the medical care received (Taylor, 1999). The manifestations of perceived and real barriers to accessing care may lead to a gay male to receive inappropriate or substandard treatment; be refused treatment; delay seeking care; have decreased levels of adherence to physician advice and treatment plans; have decreased rates of satisfaction; or choose not to access care at all. These scenarios may become extremely problematic: “as a result of negative experiences with providers, many lesbians and gay men delay seeking care until health problems become serious or chronic” (Ryan & Bogard, 1994, p. 5). Barriers to accessing care may

also add to alienation and mistrust of the authority of public health recommendations (Meyer, 2001).

### *Disclosing Sexual Orientation*

Disclosure of sexual orientation in the health care setting is crucial to the provision of appropriate, sensitive and individualized care. Disclosure of sexual orientation in a health care setting remains infrequent for the majority of gay men (Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). For gay men, the disclosure of their sexual orientation is very important and the most problematic component in seeking healthcare. Gay men are often reluctant to come out about their sexuality for fear of discrimination and fear of breach of confidentiality, and are likely to feel anxious and mistreated when they do (client-based). Heterosexuality is frequently assumed (provider-based). There is often discomfort for both providers and patients. A client's disclosure may be met with disgust, fear, hostility, or misunderstanding; similarly, the anticipation of such a reaction may discourage a gay man from "coming out." The fear of receiving homophobic treatment means that some gay men pass as heterosexual in health care settings, providing incomplete or inaccurate information in an effort to camouflage their gay identity, or they delay seeking care or do not access care at all. Gay men may be especially wary of disclosing their sexual orientation to heterosexual male doctors, or seeking care from such doctors because of discomfort because of past homophobic experiences (Schilder *et al.*, 2000).

Patients often try to provide clues as to their sexual orientation however providers often miss the clues (Roberts & Sorensen, 1995). When sexual orientation is disclosed, it

is usually raised by the patients themselves. Health service providers frequently ask heterosexually-based questions, such as, 'are you married?' or 'do you have a girlfriend?' which do not provide an opportunity to disclose same-sex orientation. Whether patients disclose their sexuality and sexual practices to providers may depend on where patients are in their coming out process. This is particularly true for adolescents and young adults, however the coming out process may take place at any point in a person's life. For homosexually-active men who identify as heterosexual or bisexual, they may also choose not to disclose their sexual histories to a health care provider (this group is beyond the scope of the current research).

The basic social process of personal risk taking (in disclosing sexual orientation) consists of two phases, the anticipatory and interactional phases. During the anticipatory phase, the risk of self-disclosure is considered using both imaginative and cognitive strategies. Hence the individual considers the recommendations of friends as well as the particular health care environment and imagines the consequences of disclosure to that health care provider. There is a need for visible evidence of a tolerant environment before individuals feel confident; such evidence might include gay literature in waiting rooms and a space for sexual orientation and gender identity on forms since so often the assumption is heterosexual. In the interactional stage, there is constant monitoring of the health care provider's responses, again making use of both cognitive and emotional interpretation (Taylor, 1999). "Coming out" is compounded by both stigma that relates to expectations of rejection and discrimination, and by actual experiences of discrimination and violence. Unfortunately, individuals' experiences in face-to-face interactions with health care providers often reinforce alienation in the health system (Taylor, 1999). When

care is sought, but action in seeking care is delayed, medical risks may occur as a result of delayed medical examinations and treatments.

When gay men do not disclose their sexual orientation to health service providers, not only may misdiagnoses and failure to provide patient education result, but also the development of a trusting provider-patient relationship is severely hindered. An example of gay male clients failing to receive appropriate preventive treatments either due to their own unwillingness to disclose their sexual orientation, or health practitioners' lack of knowledge or regard for gay health is vaccination for hepatitis A virus (HAV) and hepatitis B virus (HBV). Vaccination recommendations for gay and lesbian people do not differ significantly from those for the general population, with notable exceptions for gay men, who are at increased risk of contracting viral hepatitis. Immunization against HBV for all homosexually active men has been recommended since the 1980s, and vaccination against HAV was recommended in 1996 for gay and bisexual men, as well as for certain other high-risk groups. Although HAV and HBV vaccination is recommended for gay and bisexual men, national prevalence rates for these vaccinations are currently unknown, hampering efforts to assess the successful implementation of vaccination campaigns for these men. However, available data suggest that rates of vaccination for men who have sex with men are low.

### *The Breadth and Depth of the Problem*

The breadth and depth of the aforementioned problems are profound. Of approximately 1000 respondents to a recent survey of gay, lesbian and bisexual Ontarians, 87% felt that they had been discriminated against within the health care system, and 70% reported that they had been insulted on the basis of their sexual orientation (Project Affirmation,

Coalition for Lesbian and Gay Rights in Ontario, Toronto, unpublished data, 1995 as cited in Robinson & Cohen, 1998).

A New Brunswick study (New Brunswick Coalition for Human Rights Reform, 1993, unpublished data, as cited in Mule, 2000) that looked at a broader age range in the lesbian and gay population found the following problems experienced by respondents:

- 52% received inappropriate attitudes, actions and comments on the part of their physicians;
- 42% felt uncomfortable discussing lesbian and gay issues with their physicians; 47% experienced the same with mental health professionals;
- 45% said language used by their physician assumed the patient was straight; 34% said the same of mental health professionals;
- 32% felt their physician lacked knowledge of gay and lesbian issues; 66% felt the same of mental health professionals;
- 20% said they were provided with incomplete or inaccurate information by their physicians; 32% said the same of mental health professionals.

In recent research conducted in the Lower Mainland of British Columbia of HIV-positive MSM, Schilder *et al.* (2001) reported that the majority of participants reported histories of current or past homophobic care.

These issues are often compounded for gay men belonging to other vulnerable populations. For instance, adherence to medical treatment is affected by depression, mental distress, substance abuse, poverty, low literacy and unstable housing (Schilder *et al.*, 2001). The asymmetry of interactions between sexual minorities and health care providers widens at the lower end of the socio-economic spectrum, and becomes

particularly apparent for persons of colour. Stevens (1994) notes that, “they are more likely than other groups to be scolded, treated hostilely, patronized, categorized as ‘difficult,’ and provided fewer explanations” (p.218). Therefore, sub-populations of gay males may have further difficulty in accessing care because of their race, age, literacy level, to name a few.

### **Setting and/or System-wide Issues**

Many of the issues raised under previous sections (client, provider, client-provider) must be addressed at the institution or system-wide level since the heterosexist and homophobic assumptions underpinning providers’ thoughts and actions are so prolific. At a macro-level, systemic discrimination is characterized by heterosexist and homophobic structuring of the health care system and its settings. System-wide barriers are conditions within a health care system that prevent people from accessing needed services or prevent health care providers from delivering those services. System barriers include physical, cultural, linguistic, geographic, and financial barriers, as well as the lack of available health care facilities or providers with special skills (Gay and Lesbian Medical Association and LGBT health experts, 2001).

Historically the gay male population has been defined medically as sick or mentally ill, “thus rendering the health care system one of the primary arenas through which control over their lives was exerted” (Ryan, Brotman & Rowe, 2000, p.5). The health system has allowed gay men to be institutionalized by health care practitioners because of their expression of same-sex attraction, often undergoing treatments to cure them. Ryan, Brotman and Rowe posit that “while explicitly oppressive practices such as aversion therapy and electro-shock therapy are largely a thing of the past, the underlying

prejudices at the root of these practices are still apparent in health care systems” (p.6).

They continue: “What results is a current system in which, at worst, gay, lesbian, bisexual and two-spirit people’s health is damaged because of oppressive practices, and at its best, glbt-s people are simply rendered invisible and their particular needs unconsidered” (p.7). Many gay men feel that active and passive homophobia, and heterosexism are still widely present in the education of health and social services professionals, as well as in health services and policies (Ryan, Brotman & Rowe, 2000).

Today, sexual orientation is still medicalized in the health system rather than being considered in its social context (Schilder *et al.*, 2001). For instance, policy and practice prefer to use such terms as “homosexual,” referring to behaviour, rather than “gay” which is the social and cultural identity. Examples of cultural homophobia and heterosexism include intake and assessment forms used by most organizations which do not provide opportunities for simple disclosure, but rather assume heterosexuality, or remain indifferent to matters of sexual orientation. To reiterate, the onus is thereby placed on the client who is faced with determining if is safe to come out to the provider and discuss sexual orientation or gender identity. Whether one comes out depends on both a willingness to disclose, and a perception that the environment and the people in it are not homophobic. This is assessed by the reading material in waiting rooms, and next-of-kin policies that fail to recognize same-sex partners.

The barriers preventing an increase in access to health services and auxiliary services (*e.g.*, income support, housing) are vast. Problems may need to be addressed at the organizational level, such as its mission, or more specifically, related to health professionals, such as their beliefs and attitudes towards vulnerable populations. Work

must be instituted to address the perceived and real feelings of vulnerable populations.

For example, Ryan *et al.* (2000), in their work around sexual orientation, noted that:

feeling safe [psychological and physical] was articulated as one of the main components necessary to successfully access health services and achieve good health. The absence of safety, as demonstrated through violence and discrimination faced by gay, lesbian bisexual and transgender people, had a significant impact upon participants' health and well-being. (p.144)

In their focus groups, they repeatedly heard stories of harmful everyday experiences with health care and social service organizations, which demonstrates the prevalence of systemic barriers to care. Participants noted that while laws and policies had changed substantially within the last twenty years, front line services, and often the attitudes with which these services are delivered, do not always reflect this evolution.

As mentioned, patients' support systems often go unnoticed and invalidated by health providers and the health system (Simkin, 1998). In clinics and hospital emergency rooms, visitation and decision-making policies frequently exclude partners of gay men. Health professionals often do not allow gay male clients to be accompanied by a partner due to either institutional policies or provider beliefs about the inequality of same-sex partnerships. Such homophobic policies and beliefs resulting in exclusion of a partner, especially in circumstances requiring family involvement (such as drug treatment or mental health therapy), may cause treatment to be incomplete or unsuccessful.

Participants also noted that their experience of being excluded and the lack of safety in the health system had a direct impact on their mental and physical health, as well as their ability to access appropriate services.

### *Lack of Appropriate Providers*

Most Canadians receive their health care services on a one-on-one basis in physicians' offices. The concentration of gay men in urban areas is sharply increased in comparison to non-urban areas. This makes the need for appropriate providers greater; similarly, it makes the likelihood greater that gay men in non-urban areas will not have access to appropriate care. Rural and suburban health practitioners were viewed as especially hostile or phobic when presented with variations in sexual identity (Schilder *et al.*, 2001). This needs to be addressed at a health-system level. In research in Ontario, psychiatrists were identified as the most problematic of health providers, but they are also the mental health profession that sexual minority communities in Ontario turn to the most for assistance with mental health. This underscores both the financial barriers for some gay men, as psychiatrists are covered under Ontario's Health Insurance Plan, and the lack of adequate professional resources for others depending upon their geographical location (Coalition for Lesbian and Gay Rights in Ontario, 1997, unpublished data, as cited in Mule, 2000).

### *The Breadth and Depth of the Problem*

A Vancouver, British Columbia study (Taghavi, 1999) revealed the following results of negative treatment received by respondents because of their sexual orientation: 28% at emergency departments, 24% at drop-in medical clinics, 19% when visiting their general practitioner, 16% at hospital out-patient services, 85% at hospital in-patient services, and 5% at gender dysphoria clinics.

### *Community Health Centres*

Although the access to health services and collateral resources for gay men is (or may be) facilitated in CHCs (discussed extensively later), the notion is somewhat problematic. Drevdahl (1999) found discrepancies in meanings of community between staff and board members, and users of a community health centre. Health centre personnel referred to “community” as the target for their services, while clinic users spoke about “community” as the process that made feeling connected with others possible. Health centre staff and administrators described the community as having limited economic, educational, physical and psychological resources and saw little that could be labelled a community strength.

Conversely, health centre users spoke primarily of their abilities to support each other. These contradictory understandings of the meaning of community are significant since the characteristics that unite at-risk populations serve as an asset in promoting a health promotion perspective, which is in keeping with McKnight’s (1994) position of focusing on the strengths of a community rather than its deficits. Accordingly, the manner in which health centre personnel and researchers define the “target” community and its attributes (or lack thereof) can either enhance or detract from increasing service accessibility affecting health status. That is, by focusing on deficits and differences when the community itself does not focus on its deficits, inaccessibility may be nurtured. Talking about the community as an object or target, not only de-personalizes community members, but homogenizes them as well. Drevdahl found that board members provided a picture of health centre users based on what they had been told by other board members or staff or through demographics provided in board meetings. Board members rarely

came to the clinic when it was open, and most interactions with health centre users were limited to their monthly meetings. Within community health, there is recognition of the expertise held by the community and belief in equality and reciprocity among partners. Accordingly, it is important to investigate multiple perspectives, including, service providers and clients of the Three Bridges Community Health Centre.

### **The Gay “Community”**

It is easier to establish community engagement in areas where gay men cluster. It is unclear if living in a “gay ghetto” enhances or detracts from health status. Whatever the effect, health services providers and decision makers must be increasingly aware of the role of geography in health. Where an individual lives is the result of a complex intersection of economics, ethnicity, family ties, community values, and personal aspirations. These factors also affect one’s health. Hence, health service providers, such as community health centres, that are located in the community are more attuned to identifying and meeting the needs of vulnerable populations. In large urban areas, gay men often inhabit gay ghettos (Mills, Stall, Pollack, Paul, Binson, Canchola, and Catania, 2001). In its classic definition, a ghetto requires four elements of a geographic area and its defining minority: concentration of minority commercial institutions, minority cultural dominance within an area, minority residence within the area, and minority social isolation from the larger community. An alternative definition includes social cohesion with the minority community instead of the social isolation criterion.

Mills *et al.* (2001) found that the main differences between gay men residing and those not residing in ghettos were age (those not residing in ghettos were more likely to be younger than 30 years), race/ethnicity (those not residing in ghettos were less likely to

be White), individual income (those not residing in ghettos had lower incomes), sexual orientation (those not residing in ghettos were less likely to identify as gay, queer or homosexual), domestic partnership status (those not residing in ghettos were less likely to be involved in domestic partner relationships) and gay-community involvement (those not residing in ghettos were less involved). Also, those not residing in gay ghettos had informed fewer people of their sexual orientation/behaviour, and they were more likely to have had sex with a woman in the previous year and less likely to ever have been tested for HIV. There were no differences in rates of unsafe sex between ghetto-dwelling and other MSM. MSM who did not live in ghettos were less involved in the gay community, but more involved in the non-gay community. The authors of this research maintain that “it is not unreasonable to generalize these findings to other cities and to other ghetto and non-ghetto areas, but caution should be exercised” (Mills *et al.*, 2001, p.981).

Researchers conducted qualitative research with 71 men on gay life in Vancouver (Trussler, Perchal & Barker, 2000). They state that “these men described deep feelings of isolation in Vancouver in terms of loneliness, difficulty breaking-in, making friends and forming bonds that would support developing the healthy relationships they desire” (p.302). The men in this research did not believe a coherent gay community exists simply because of the mere presence of so many gay men. The West End was “a welcome first home” for many of the gay men, but soon gave way to a “sense of disconnection” (p.303). The men in the study “thoroughly dismissed” the LGBT Centre as an option for development of a social venue, even though it is located in the heart of the gay village (p.303).

### **Enhancing Accessibility for Gay Men – Potential Strategies**

Despite Canada's socialized health care system, with its supposed geographic or financial accessibility, not all Canadians equally or appropriately access health care services.

Unfortunately, there are many systemic barriers for gay men in the Canadian health care system which need to be addressed. These have been discussed in preceding sections.

Most of the research to date details these barriers, rather than seeking to implement and assess appropriate interventions. The research also highlights that to improve the health status of gay men, a population health or health promotion perspective must be systemically developed and employed. Simply increasing the status quo of health care delivery will do little to alleviate the poorer health status of gay men.

To have a substantive impact on health status, accessibility is ideally conceptualized from a population health perspective. Below are relevant parameters of accessibility from a population health, primary health care, and health promotion perspective that would facilitate increased access to health services and improved health status for gay men. They are concrete steps required to re-orient health services and its culture to one that is conducive to health promotion in primary health care settings such as community health centres. A focus on interventions of a one client-one provider is insufficient to alter the health status of vulnerable populations. Since individuals-families-groups-communities are interrelated, interventions at one level affect other levels. A focus on a single level of client is insufficient to alter the health status of vulnerable populations. Accordingly, no less than a focus on the collective will suffice to improve the health status of at-risk populations. Population health, health promotion and primary health care all seek to improve access to health and health services for vulnerable

populations; they each have parameters or principles that enhance accessibility. Furthermore, due to the similarities within the fields, these parameters overlap. These parameters are not mutually exclusive. Accessibility is a parameter of primary health care. Other parameters enhance accessibility, and vice versa. Parameters that enhance accessibility are intersectoral collaboration, citizen participation, outreach, multidisciplinary teams, policy support, upstream investment, applying multiple strategies, and a focus on the collective. Underpinning these parameters are values of empowerment, equity and social justice.

With the increasing recognition of the role of the determinants of health in health status, it is important to consider examining and enhancing accessibility with notions that have traditionally been outside the purview of the health system. While the health system is still largely traditional in its approach to service provision, community health centres have historically sought to address these “external” barriers to health services and factors affecting improved health status. These barriers for gay men can include outright discrimination in employment, housing, services, and legal protections (New York City Department of Health, 1999). The HIV pandemic has forced decision makers and prevention educators to increasingly recognize the difficulty in effectuating sustained change in sexual behaviour, and has increased attention on the so-called determinants of health.

As mentioned previously, whether or not individual clients and their peers choose to access health care services is based upon a complex interplay of intrapersonal factors within clients and providers, interpersonal factors between clients and providers, characteristics of the primary care setting, and societal and policy factors. Accordingly,

accessibility needs to be conceptualized from many perspectives. While such a perspective goes beyond the current conceptualization of accessibility in the *Canada Health Act*, a broad view of accessibility needs to be adopted and embraced if we are to improve health disparities. Furthermore, it is in keeping with many current population health policies of federal, provincial and territorial governments.

This section discusses potential roles and responsibilities of gay clients, the gay community, health service providers, the health system and community health centres to effect sustained change in health behaviour and thus improve health status. The roles of client, the community, providers, community health centres and the health system are not mutually exclusive since there is continual interaction, both positive and negative, among these categories. This section details actions that have been taken, or could be taken to enhance access to primary health care for gay men.

#### *Client*

Gay men, as individuals, are not passive recipients of primary health care services, but actively engage in health care decision making to counter the ill effects of negative health care provision and a heterosexist and homophobic health system. As the social context within which gay men and lesbians live has changed, so, of course, have their health needs and ability to access services.

#### *Seeking Out and Educating Providers*

Young gay men make efforts to inform themselves and seek out physicians found by word-of-mouth from other gay men. Experience has taught gay men to become self-reliant in finding care that would address their specific care issues (Schilder *et al.*, 2001). Older gay men, through trial and error, are able to locate culturally competent care

(Schilder *et al.*, 2001). Unfortunately, younger gay men often chose a doctor based on sex appeal and experienced more difficulty in establishing balanced relationships with their physicians (Schilder *et al.*, 2001). Many gay men seek physicians who have a greater understanding of their social context and identities. The majority of these physicians are gay men. Gay men also hold positive views of straight women as physicians (Schilder *et al.*, 2001). This may be attributable to the absence of same sex attraction and the ability to understand sexual health, provide safety, and support empowerment. Many gay men believe they are responsible for educating their non-gay practitioner on their health issues and its social context.

### *The Gay Community*

Lesbian, gay, bisexual, and transgender communities and their allies began to promote LGBT health concerns in the 1950s when education, health care, and other government and private systems proved inadequate. Organizing began with efforts to have homosexuality declassified as a medical illness. These efforts extended through the 1960s and intensified in the 1970s. In related early efforts, LGBT communities created a variety of professional and volunteer health care initiatives to offer non-judgmental treatment and education about sexually transmitted diseases (STDs) and mental health issues related to coming out and stigmatization. Gay counselling sessions, peer education groups, and STD screenings at ordinarily non-gay community health facilities were also organized. Then, as the gay community faced the HIV epidemic, work ensued to expand the focus of mainstream organizations, and to create new and powerful lesbian and gay-focused health education, treatment, and advocacy organizations (Gay and Lesbian

Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000).

### *Community Activists*

Gay men, as a collective, are also instrumental in enhancing the quality of primary health care they receive. Gay men and other sexual minorities routinely position their health issues on the agenda of local, provincial and national policy and decision-making authorities by creating non-profit, community-based organizations to address health care accessibility.

The gay and lesbian community has seen a remarkably rapid social and cultural evolution over the past two decades, as more people have "come out" and have chosen to be public about their sexual orientation, and as public visibility and acceptance of homosexuality has increased. Similarly, while the HIV pandemic has caused enormous loss for the gay community in a rather brief period, it has also stimulated community mobilization and institution-building. Although the number of lives of gay men lost to HIV is staggering, the pandemic for gay men was "substantially mitigated by grassroots efforts within the gay community that led to significant declines in risk behaviour in the 1980s" (Wolitski, Valdiserri, Denning & Levine, 2001). As the social context within which gay men and lesbians live has changed, so have their service needs, their ability to access services, or articulate their service needs. However, many gay men are still closeted, and often believe the onus is on more privileged or self-affirmed LGBT individuals to advocate for the majority within the community who cannot advocate on their own behalf (Ryan *et al.*, 2000).

### *Social Support and Community Engagement*

Like members of other minority groups, gay men are not passive recipients of stigma and discrimination but engage in active coping to counter the ill effects of negative social stressors. Minority status is related not only to stigma and discrimination (stress) but also to structural resources, such as group solidarity and cohesiveness, that protect minority members from the adverse mental health effects of social stress (Crocker & Major, 1989; Kessler, *et al.*, 1985). A study among Canadian lesbians found lower depression rates among women in relationships, lesbians who had more social support from friends and family, and those who were more open about their sexual orientation (Ayala & Coleman, *in press*, as cited in Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). Kippax *et al.* (1993) in their study of 535 Australian gay men found that two measures of gay community attachment (social engagement with other gay men and gay community involvement) were predictors of engaging in safer sex practices.

### *Community-Based Prevention*

A community-based program is a planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of a community. Community-wide prevention in this context refers to the systematic application of prevention strategies throughout the community in a sustained, highly integrated approach that simultaneously targets and involves diverse social systems, such as families, media, health care and community centres, workplaces and other entities composing the defined community entity. Behavioural problems have

their roots in the community; likewise, the community is the repository of solutions (Gay and Lesbian Medical Association and LGBT health experts, 2001).

### *Health Service Providers*

Health professionals are an obvious and integral component of the health system.

Accordingly, individual health professionals may enhance the accessibility of the health system for individual gay men.

### *Continuity of Care*

Having the same provider manage one's care over time typically leads to better care.

People with a usual source of health care are more likely than those without a usual source of care to receive preventive health care services (Gay and Lesbian Medical Association and LGBT health experts, 2001). A usual source of primary care facilitates clients being directed to appropriate health services, including specialty care. Providers who know their patients and have established a rapport can provide better care than providers who change frequently because a patient uses a different walk-in clinic or emergency room each time they need medical care. Such care settings usually only address current medical concerns, and the problem may not be considered in conjunction with the person's overall medical history and health needs. Many Canadians are in favour of mechanisms that encourage a usual source of care. In January 1996, over 80 percent of surveyed Canadians approved of registering with a family physician for necessary medical care, referrals to specialists and other providers, and after hours care (Canada Health Monitor, Survey 13, as cited in Advisory Committee on Health Services, 1995).

### *Gay and Gay-positive Providers*

Gay clients of health services and the gay community are instrumental in creating an accessible health care system; so too are health service providers who are gay. Gay physicians and trainees who are “out” and comfortable with their orientation described a duty to better educate their peers and lobby for improved curricula and policies (Risdon, Cook & Willms, 2000). Gay-positive and gay health service providers could also advertise their services to gay clientele and other vulnerable populations, in a gay press, as well as mainstream media to identify professionals who are comfortable with gay issues (Roberts & Sorensen, 1995). An additional benefit of the use of advertising health services for gay men in “straight” media is that heterosexuals seeing this information may be more likely to view homosexuality as a variant of “normal” which may eventually lead to an easier time for the gay patient (Harrison, 1996). As primary health care is the first level of contact with the health system, referrals should include other providers and community-based resources sensitive to the needs of gay men (Harrison, 1996). An understanding of culture is a skill of identifying the components of a patient’s whole social and physical being (Schilder *et al.*, 2001). Health providers need to take into account gay men’s specific lived reality and acknowledge their identities (Schilder *et al.*, 2001).

### *Receptive Environment*

Simkin (1993) suggested creating a positive, receptive health care environment for gay patients using posters, brochures, gay magazines in waiting rooms, medical forms using the phrase “spouse or partner,” discussing the confidentiality of the patient’s sexuality, and by involving significant people in decision making and planning. Roberts and

Sorensen (1995) suggested that during history taking, a useful approach is to ask the following questions of all clients: 'Do you have sex with men, women, or both?' 'Do you have a partner?' 'Who is important to involve in your care if you become ill?' They noted however that providers may be reluctant to use this approach for fear that their heterosexual patients will be offended. Unfortunately, such an approach may be only used when a health professional suspects a client is gay which is highly inaccurate.

### *Documenting Sexual Orientation on Charts*

Opinions on the preference of the inclusion of sexual orientation on medical charts vary with individual clients. Because of issues of confidentiality, it is important for physicians to discuss explicitly with gay men the documentation of sexual orientation in their chart. Some physicians adopt their own shorthand to cover issues pertaining to sexual orientation. For example, some physicians might use a double-man symbol; others may use a triangle instead of the traditional circles and squares in the genogram (Harrison, 1996).

The obvious disadvantage of documentation of sexual orientation in the chart has to do with patients' reluctance to have it known that they are gay. Although medical records are "confidential," a large number of people other than the physician have potential access to a patient's chart. In some cases, this might include office staff, other physicians, or insurers. The ramifications of such possible disclosure should be thoroughly discussed with the patient (Harrison, 1996).

One advantage of documentation is that a more thorough understanding of the patient can be immediately grasped by anyone reviewing the chart. For instance, in situations when patients are unable to speak for themselves, a patient's partner can be

identified and help with decision-making. In addition, it is detrimental to be unable to record information that is relevant to the patient's care. Knowledge of sexual orientation or behaviour may be relevant to discussions of life stressors and social support, family planning, and STD prevention. Finally, because of some of the health risks associated with being gay, such documentation may prompt the physician to concentrate on specific aspects of the medical encounter. For example, knowing that gay men are at higher for depression and suicide, a provider may be more likely to inquire about the man's affect, mood, and relationships with family and peers (Harrison, 1996).

### *Health System*

For some time, the sense that the health system was failing vulnerable populations was intuitive and personal. Over time however, awareness has grown to recognize that shortfalls in the system are more pervasive and require a comprehensive response — including changes in attitude and practice. This section details mechanisms that the health system (such as regional health authorities) and health settings can adopt to improve access to health services and collateral resources, and thereby improve health status.

### *Partnerships and Intersectoral Collaboration*

To address barriers to health services and disparities in health status, partnerships between gay men, other sexual minorities, communities and the health care system need to be established. A population health approach recognizes that improving health is a shared responsibility (Frankish, Veenstra & Gray, 1999). “Intersectoral collaboration” is the joint action among health and other groups to improve health outcomes. A population health approach calls for shared responsibility and accountability for health outcomes with groups not normally associated with health, but whose activities may have an impact

on health or the factors known to influence it. It requires both vertical integration (promotion/prevention, diagnosis, treatment, rehabilitation) and horizontal integration (national, provincial, local, family, individual) (Frankish, personal communication). Intersectoral collaboration in a population health approach includes the horizontal management of health issues. Horizontal management identifies common goals among sectoral partners. It then ensures coordinated planning, development and implementation of their related policies, programs and services. Wanke *et al.* (1995) state that:

influencing the broader determinants of health and their impacts requires a strong alliance with other community organizations and government departments. Although highly desirable and necessary, this multi-faceted approach poses considerable difficulty in any attempt to attribute changes in health status solely to a particular community-based health service.  
(p.5)

A population health approach takes action based on analyses and understandings of the entire range of the determinants of health. A population health approach recognizes the complex interplay between the determinants of health. It uses a variety of strategies and settings to act on the health determinants (*e.g.*, housing, social support) in partnership with sectors outside the traditional health system or sector because our current state of knowledge rests on the notion that the health of populations is correlated with factors that fall outside the health system or established health sector. This understanding has set the context for new approaches to health improvement that draw upon multiple strategies applied within multiple settings. It calls for innovative and interconnected strategies that give due consideration to the full spectrum of social, economic and environmental health determinants. Based on the analysis of evidence, strategies are developed that will have the greatest relative impact on population health risks and conditions. Strategy development includes the identification of (a) who will employ strategies, (b) to whom,

(c) when, and (d) where, in order to ensure maximum contribution to desired health outcomes.

### *Enhanced Services and Delivery*

The basic constellation of health services has remained the same for several decades, although the model and assumptions under which they have been delivered have changed drastically (Stowers, 1999). A critical stage in a model of enhanced service delivery for gay men is the development of programs to provide service to individual groups.

Programs for gay and bisexual men must be developed and, once developed, must be sensitive to their constituents. Current services should be examined to determine if they are being provided in a culturally sensitive fashion. These outreach programs should focus on lesbian, gay, and bisexual media, community-based organizations, cultural settings, businesses, and religious organizations (Stowers, 1999).

Enhanced service *delivery* is not specific to gay men. A primary health system should be responsive to the health needs of clients 24 hours a day, seven days a week. In Ontario, Community Health Centres have contractual obligations with the Ministry of Health to provide 24-hour care unlike most primary health care providers. This provides a continuum of coordinated services in a cost-effective manner. Extended office hours, including evening and weekend hours, and on-call services, all help to manage the patients' need for services. It also reduces the costly burden on hospital emergency departments that already have a significant number of cases that are not emergency in nature, but are primary care. Other mechanisms include telephone advice from a registered nurse.

Frankish, Moulton and Gray (2000) noted several means to enhance access to health services geographically, financially, culturally and functionally (see Table 2.1). Wanke *et al.* (1995) listed other, similar means to enhance service accessibility. These were increasing the number of service delivery sites; attempting to offer all community health services from one location (*e.g.*, home care, public health, mental health, primary health care services); one phone number for the organization; same day or walk-in service policy; ensuring that there is no single gatekeeper to the various disciplines; and using a case managed approach whereby one person is assigned to guide the client through the system.

**Table 2.1. Enhancing Access to Health Services**

**Geographical**

Multiple locations; travel to rural and remote locations; on transportation routes in urban areas; a free driver service and community van in a rural community for persons requiring local and urban health services.

**Financial**

Free health services; free parking; nominal fees for counselling services and auxiliary services; free language interpretation.

**Cultural**

Services offered in both official languages; translation services (often in conjunction with an external agency); making content “culturally sensitive” – start where people are and incorporate their values and traditions; employ personnel belonging to the community, such as, aboriginal workers serving aboriginal clientele.

**Functional**

Extended hours; in-home visits (particularly those serving at-risk children or involving post-natal care); outreach sites; telephone, e-mail and web access; flexible hours (evening and weekends); printed materials and videos based upon an elementary literacy level using “plain language” and pilot tested; use of multi-disciplinary teams; and wheel-chair accessible buildings.

More after-hours care, shorter travel time to the site of care, and shorter waiting times for care have been associated with health care clients' initiation with a usual primary care provider. Greater continuity has been observed for individuals with shorter appointment waits, insurance and access to more after-hours care (Gay and Lesbian Medical Association and LGBT health experts, 2001).

### *Citizen Participation*

A population health approach promotes the participation of *all* Canadians in developing strategies to improve health. The approach ensures appropriate opportunities for Canadians to have meaningful input into the development of health priorities, strategies and the review of outcomes (Frankish, Veenstra, & Moulton, 1999). A benefit of public involvement is that public confidence in decision-making and information sharing is increased as those citizens who are most affected by a health issues contribute to possible solutions early in the planning process. Similarly, Barnes *et al.* (1995) point out:

defining *access* to health care from a primary health care perspective implies a focus on the communities to be served, and suggests continual community participation and involvement of individuals and families in defining (1) what are essential health care services and resources, (2) what are culturally and socially accessible health care services, and (3) what are affordable health care services. (p. 13, italics added)

A distinctive feature of community health centres (CHCs) is community governance that enhances accessibility. CHCs are typically governed by a board of directors in which the majority of members are either residents of a defined area or clients. The community determines where resources are allocated to maximize the benefits from services provided. This is unlike most primary care settings that are provider-owned and driven.

While the concept of participation is a laudable value, it is also problematic in practice. It is based on two fundamental assumptions: citizens want to participate, and citizen participation leads to better decision-making. There is little clear evidence to support either of these assumptions (Abelson, Lomas, Eyles, Birch & Veenstra, 1995; Wanke, *et al.*, 1995, p.35). There is a lack of clarity surrounding the notion of citizen participation; that is, it means different things to different groups. It falls along a continuum of information sharing only; consultation (*i.e.*, round tables, royal commissions, public forums, advisory committees); power-sharing (*i.e.*, joint policy boards and planning committees); and lay decision-making (*i.e.*, full transfer of decision-making power to lay individuals) (Arnstein, 1969). A desirable model of community-based health services should include partnership between clients and providers in the planning, delivery and evaluation of the health services delivery system (*i.e.*, client involvement occurs beyond a token level).

In an examination of one CHC in the United States, Drevdahl (1999) found that over several years there had been limited success in recruiting clinic users to the board, and those who were enlisted attended meetings infrequently. Users were characterized by health centre personnel as not being interested in board activities and as lacking the stamina and preparation needed for the position. Inexperience with administrative concerns contributed to the clinic users' silence during board meetings supporting Cervero and Wilson's (1994) assertion that simply by being "at the table" does not insure all voices are heard. Drevdahl asserts that, "in essence, users were asked to conform to an image the board participants had created for themselves" (p.422). Accordingly, "unable to traverse the distance between the impoverished women who used the clinic and clinic

board members, the women withdrew from board participation” (Drevdahl, 1999, p.422).

Drevdahl concludes: “In the end, both board members and clinic users wielded the (supposed) discrepancies between themselves to keep each other at a distance and justify the lack of participation in the administration of the health center” (p.423). Wanke *et al.* (1995) noted that:

the site visit findings [of community-based health services] suggested that the types of decisions in which individuals desire to be involved are directly related to the extent to which a decision directly affects them.... When decisions involve the delivery of health services through a neighbourhood or community with which the individual perceives a strong identity, the desires of individuals to become involved will be greater than when the decisions are removed to a less tangible regional or central levels. (p.36)

Related to citizen participation is the notion of governance. The literature sheds little light on the identification of optimal governance structures for the delivery of community-based health services. Traditional means of ensuring accountability and enhancing community control of community-based health delivery models do not appear to have been very effective. It is suggested that greater attention should be paid to identifying client preferences for participating in health services decision making (Wanke *et al.*, 1995, p.4).

#### *Research, Education and Training of Health Professionals*

Today, silence and/or indifference tend to characterize university-based and health system training on the subject of sexual orientation and gender identity. The medical education system has failed to educate providers and researchers about the unique aspects of gay health including examination techniques, taking of patient histories, preventive recommendations and their lived realities. Wanke *et al.*’s literature review suggested the need to incorporate the following content areas into formal training programs for health

service providers: a broad understanding of health and its determinants, familiarity with community-based health service delivery, team approaches, and a focus on promotion/prevention and early intervention. To improve the health of gay men, health issues addressed in research must broaden beyond the prevention and treatment of AIDS among gay men. Many of the barriers listed previously underscore the need for better education and training for health professionals. Many professionals may be sympathetic to the needs of gay men, but lack a repertoire of skills about social and sexual clinical issues about gay men, or be unaware of why they might be necessary. In fact, some providers express an eagerness to learn about the needs of sexual minorities (Bradford & Dye, unpublished manuscript, as cited in Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). Robinson and Cohen (1996) suggest a framework that supports the development of knowledge, attitudes and skills necessary to the provision of sensitive and comprehensive care for these patient groups through four types of learning experiences: didactic instruction, small-group discussions, simulated patient encounters, and supervised encounters with real patients.

### *Policy Support*

In a case study, Lambrew, Ricketts, Thomas and Morrissey (1993) suggested that the integration of a local health department and a community health center had less to do with the need for or the benefits of the arrangement, but rather that strong policy support may override any local and internal resistance to integration. In examining the integration of a local health department and a CHC, Lambrew and colleagues noted that the goal of reducing fragmentation of care was not sufficient to create the inter-organizational

alliance, but rather was precipitated by the crisis of a hospital closure and outside (policy) assistance (Lambrew, *et al.*, 1993). Accordingly, health authorities may need to take the lead in creating accessible community health centres as a alternative to traditional primary care delivery.

### *Upstream Investment*

In a population health approach, efforts and investments are directed at root causes to increase potential benefits for health outcomes. Although government documents have advocated greater emphasis on prevention and health promotion (Epp, 1986), most jurisdictions in Canada have yet to provide adequate funding for upstream work. In Ontario, for example, only four percent of the Province's health allocation goes to disease prevention and health promotion. There is a concern that health promotion and population health are taking money away from (re-allocating) what is viewed as essential services. There is a discrepancy between the rhetoric of health promotion at a national and provincial level, and its practice at a settings and local level. Accordingly, few resources are invested in health promotion, yet we expect health promotion should be achieving a lot more and demonstrating its effectiveness. It is feared that the "fiscal challenges faced by all governments raise concerns that economic policies may become the overriding foundation of health care reforms at the peril of primary health care principles" (Duncan, 1996, p.312). Forster, *et al.* (1994) suggest "two budget components, one for individual health care and one for population health care" (p.1527).

### *Multidisciplinary Teams and Human Resources*

Human resources play an especially prominent role in, and account for an even greater share of costs of community-based health services when compared with institutional

services due to less reliance on facilities and advanced technologies (Wanke *et al.*, 1995, p.1). Human resources refers to service providers in community-based health services. Differentiating between informal and formal service providers is not necessarily based on training or competency; rather the most important differentiating factor is employment status. Whereas formal providers are remunerated for their work, informal providers provide their services on a voluntary basis. Little information exists as to the extent of voluntary human resources in community-based health services, and discussions of formal providers are much more widespread and usually limited to a focus on multidisciplinary teams.

Multidisciplinary teams are an important feature of primary health care and CHCs. The presence of a multi-disciplinary team enables residents to receive a full range of services from a variety of professionals. Team members may include a family physician(s), a nurse practitioner(s), a nurse(s), a social worker(s), a health promoter(s), community developer(s) and a dietitian(s).

While the Canadian health system guarantees access to health services despite geography, rural areas are typically under-serviced with fewer health and social service providers. The use of multidisciplinary teams in a CHC setting may serve to alleviate some of the differential service delivery between Canada's urban and rural areas. While CHCs are not totally exempt from the problem of recruiting and retaining health professionals, the problem is not as acute. The presence of a multi-disciplinary team and a coordinated approach to community primary health care is attractive to most health professionals including physicians. Since this research is firmly located in an urban setting, this issue is beyond the scope of the current research.

Like citizen participation, Wanke *et al.*'s (1995) research suggests that a "multidisciplinary team" is a rather ill-defined concept. It is not clear what constitutes a team and how a team in a community setting differs from a team in an operating room or a dentist's office. It is also not clear what actually contributes to making a team approach work (Wanke, *et al.*, 1995, p.27). In their research, managers interviewed during the site visit process suggested that, although desirable, internal integration is not easily achieved. It takes time to develop common values to build and understand the same language. Internal integration is reported to be facilitated by regular contact, program rather than functional organizational structures, joint problem-solving and the participation of all providers in staff meetings. Inter-professional training for health professionals and continuing "medical" education also facilitate the workings of multidisciplinary teams (Bowler & Gooding, 1995). Many service providers in community-based health services advocate strongly for alliances with natural community partners, where common issues and functions are evident (Wanke *et al.*, 1995). Integration of health and social services, public health, mental health, home care and primary medical care within the community-based system was thought to be important, whereas integration of community-based health services with the institutional sector (*e.g.*, hospitals) of the health system is generally seen as detrimental (Wanke *et al.*, 1995). The greatest concern expressed about the latter was the potential for being absorbed by and forced into an "institutional" paradigm, thereby losing the health promotion, holistic and flexible approaches necessary for addressing health issues at their societal and environmental roots. Nevertheless, close liaison and efficient referral processes between the community and institutional sectors were advocated (Wanke *et al.*, 1995, p.27).

To increase health promotion practices in primary health care, the stature of nursing must also be enhanced within multidisciplinary teams. Rachlis (1997) asserts that nurses and others could effectively provide many services currently performed by doctors. He continues that many nurse-led primary health care interventions could dramatically reduce deaths from chronic illness. However, if the decision about the use of utilization of nurses and others is left to the doctors, nurses may never achieve their full potential to add value to the system because of professional dominance.

### *Supporting Gay Colleagues*

Gay health providers are instrumental in improving accessibility for health services for gay men and reducing health disparities. Education and health systems must move to increasingly support gay colleagues. As Risdon, Cook and Willms (2000) state:

gay and lesbian medical students and residents reported expending considerable energy constantly assessing their environments, trying to find a balance between self-protection and self-disclosure; this energy represents a net loss to training programs and the profession. We found that those who were coping with their first awareness of themselves as gay or lesbian during their medical training were especially vulnerable. In general, the more comfortable participants were with their sexual orientation, the less stress they experienced. (p.334)

While the comfort of disclosing one's sexual orientation is unique to the individual, supportive environments for gay health professionals are critical.

### *Mission and Culture*

Underlying the preceding parameters, and fundamental to the integration of health promotion in primary health care settings is the notion of mission and culture.

"According to experts in systems integration, the foundation for any system is not structure or governance, but mission and culture" (Centre for Health Promotion & Toronto District Health Council, p.7). Sufficient motivation and commitment to health

promotion is a prerequisite for improving the health status of vulnerable populations. A supportive mission and culture should not only be reflected in a setting's mandate, but should be demonstrated in practice. For health care organizations to make any shift in the direction of becoming more health promoting, a range of fundamental elements is required. These include a supportive philosophy, culture and policy framework; an organizational and governance infrastructure that values and facilitates health promotion; adequately trained staff; and budgetary management that contributes to sustainable health promotion activities (Fawkes, 1997). Once created, health-promoting organizations require nurturing. Stowers (1999) suggests specific education and consciousness-training in health settings should occur around issues of cultural mores, norms, and the proper usage of language and terms. The next step is for service providers to critically examine their own agencies and actions to ensure they are affirmatively reaching out and dealing with cultural issues within their own organization. The organization should then be making policy and procedural changes that explicitly include, acknowledge, and validate members of all groups. Several authors (Birse, 1998; Jones *et al.*, 1999) have underscored the importance of mission and culture that are based on health promotion principles and values, and a holistic health model that should permeate the whole institution (Tones, 1995). Without a strong mandate and requisite resources, primary health care settings will likely be unable to reorient their services and culture toward health promotion (Birse, 1998). Health promotion practice is not so much *whom* one works with or *where* one works but rather *how* one practices (Hills, *in press*).

## Comparing CHCs and Other Primary Care Settings

Are CHCs better at health promotion and population health than other primary care settings? Are populations served by CHCs the same or similar to populations served by other primary care settings? Since this research is concerned, in part, with enhancing access to health services and collateral resources for gay men, a community health centre was a deliberate choice for the setting of this research. This section discusses the rationale for the use of community health centres. This research project is based on the premise that CHCs are better at incorporating population health promotion, both as a philosophy and an approach than other primary health care settings. It is also premised on the belief that CHCs often serve populations more vulnerable to illness and disease than other primary care settings.

### *Incorporating a Health Promotion Approach*

In their research comparing primary care settings, Baum *et al.* (1998) concluded that the “community health centre model based on salaried medical practitioners and a socio-environmental view of health has much to offer in terms of promoting a holistic and multi-faceted approach to health promotion” (p. 205). They continued:

health promotion which focuses on the health of the local community is best conducted within multi-disciplinary health centres. GPs in private practice are limited by the structure of their setting (particularly the fee-for-service basis and reliance on a single discipline) to health promotion which focuses on the needs of individual patients. (p. 200)

Other barriers to a population health or health promotion in general practice include a lack of skills and knowledge of general practice in relation to health promotion strategies; the traditional focus of medicine on curative practices; a lack of time; and a lack of recognition or endorsement (Baum *et al.*, 1998). Such barriers do not negate the

importance of other health care settings, such as hospital emergency rooms and private practice physicians, from incorporating or enhancing a population health perspective since currently, eighty per cent of primary care occurs in doctors' offices (Lepnurm, 1995).

### *Cost-Effectiveness and Patient Outcomes*

Lepnurm (1995) notes that "the overall evidence shows that the provision of primary health care through CHCs is cost effective and that the quality of care is at least as high in these settings as in traditional fee-for-service settings" (p.40). In 1990, Angus and Manga extensively reviewed CHC models and concluded they could not find a study showing that a CHC did not provide more cost-effective care in comparison to fee-for-service models. McPhee (1973) and Shillington (1983) concluded that community clinic patients required fewer hospital days and prescription drugs than fee-for-service patients. Furthermore, the latter study also found that clinic patients used fewer general practitioners services than fee-for-service patients.

Several commissions and task forces across Canada have supported the concept of CHCs (Lepnurm, 1995). The generalizability of literature comparing whole models of primary health care is contested and limited (Rachlis, 1997). Some research is considered dated, while other research is dismissed because studies are considered to be too different for extrapolation to other provinces. Furthermore, there is disagreement about which components of the models make a difference. Also, the population/client base served in CHCs and other primary care settings is probably varied (Lepnurm, 1995).

The research is further hampered by the interests of physicians' groups who argue that the community health centre model, which has salaried personnel, including

physicians, is not more cost-effective or does not have corresponding improvements in health outcomes. For example, the Canadian Medical Association (1994) argues that although it is claimed that community health centres constitute a cost-effective method of providing health care, there is little information available to support this claim or on patient health outcomes compared with private office practice. Rachlis (1997) notes that “physician groups are quick to claim that better primary care performance could still be achieved by continuing doctors exclusive right of ‘ownership’ and gatekeeping and simply tinkering with other components” (p.3). He posits that “the lesson should be clear. If aspects of the physician payment are changed *without* incorporating elements of the CHC model then there will likely be no improvement in primary health care performance” (p.12, italics in original).

Rachlis (1997) concludes that the “literature is consistent in showing better economic and patient outcomes when physician payment is changed *and* elements of the CHC model are incorporated” (p.12). Albrecht (1998) states that “some governments try to avoid confrontations with physicians and often will support CHCs only in areas that fee-for-service physicians do not want to be such as the north and in rural areas, or with challenging and demanding populations like the urban poor, homeless and refugees” (p. vi). In Quebec for example, CLSCs (Centre Local de Services Communautaires) “were seen as threats to private practice physicians who often banded together to compete with these centers” (Albrecht, 1998, p. vii). Community-based health services, such as CHCs, remain marginalized rather than offering a substantial, and complementary alternative to institutional care. Such marginalization of CHCs further marginalizes vulnerable populations, such as gay men, because access to culturally-competent care by health

providers located in their community, and aware of their lived realities and socio-environmental determinants of health, are less accessible. Accordingly, because of the predominance of private practice physicians, drop-in *medical* clinics, and emergency rooms, and the marginalization of CHCs in the health system, gay men and other vulnerable populations have few options in accessing primary care services.

#### *Client Composition and Primary Care Settings*

In many communities, CHCs provide their programs and services for those people who have difficulties accessing a full range of appropriate primary health-care services. CHCs have a long history of working with people who are disadvantaged, that is, people whose needs go beyond basic health care. Some examples of priority groups are members of linguistic or cultural groups, individuals who live in remote under-serviced communities, individuals with low incomes, street youth, individuals who are homeless, the elderly and ethnic and racial minorities, some of whom might be recent immigrants or refugees without an adequate base support in their new home communities (Association of Ontario Health Centres, 1997).

Taghavi (1999) determined that emergency departments and drop-in clinics have been frequently mentioned as being the medical providers of choice for many LGBT individuals, especially for youth and transgendered populations. Reasons include the possibility of remaining anonymous and the unavailability of LGBT-friendly health care providers. Taghavi's research was conducted in the Lower Mainland of British Columbia. Schilder *et al.* (2001) determined that in the Lower Mainland, transgendered persons, bisexuals and gay youth sought care in emergency rooms at times of a health crisis whereas older gay men had learned to go directly to their primary care doctors.

Experiences in the emergency room consistently impaired future care seeking and promoted avoidance. Unfortunately, there are very few health care providers who target their services to gay and lesbian populations. In the Vancouver Coastal Health Authority, CHCs have only existed in recent years, and therefore do not, as yet, make up a substantial component of health service provision for the general population, or for gay men and other sexual minorities.

CHCs provide care to clients who might not be reached by a system which depends solely on those who require service taking the initiative themselves. CHCs are proactive, rather than reactive, in their approach to health. Investing in the health of the community means a population-based approach to planning and service delivery. The Association of Ontario Health Centres has described this approach as follows:

our system of health care is passive: it waits for the individual to seek help. We must work towards a population-based approach for our health services and health promotion... The separation of clinical health services and public health is both artificial and undesirable. Clinical health services have the vehicle without the message and public health has the message without the vehicle. (1997, online document)

Lepnurm (1995) notes "the evidence shows that community clinic patients are a different group of people than those of a general population. Between 32% and 51% of community clinic patients stated that the setting was a conscious factor in their choice of practice. However, there is no evidence that community clinics or fee-for-service practices attempted to select patients" (p.41). Based on Beck's (1972) research, Lepnurm (1995) indicated the possibility that patients selected the clinic ideology of care.

### *Everything "Old" is "New" Again*

Many of the remedies that are now being proposed for the health care system as a whole have already been working in community health centres for years. CHCs have long been

showing that there are viable alternatives to fee-for-services (Association of Ontario Health Centres, *The best kept secret in health care*). Similarly, Rachlis (1997) argues that Canada's primary care services have major problems, many of which could be alleviated by the promotion and development of the CHC model. Accordingly, professional organizations, such as the Registered Nurses Association of British Columbia, are advocating for "new" approaches to interdisciplinary service delivery such as community health centres (RNABC, 1998).

*Community Health Centres for Lesbian, Gay, Bisexual and Transgender People*

Gay men still largely depend on self-created community-based and professional organizations to address their special health care needs (Gay and Lesbian Medical Association and Columbia University's Joseph L. Mailman School of Public Health, Center for Lesbian, Gay, Bisexual, and Transgender Health, 2000). Not surprisingly, the literature available on community health centers which serve LGBT people is scant. In the United States, there are 9 LGBT-specific community health centers that either solely treat or emphasize the care of sexual minorities (Mayer, Appelbaum, Rogers, Lo, Bradford and Boswell, 2001). While these centers "may provide a model of comprehensive LGBT health services that have a local impact" (Mayer, *et al.*, 2001), the literature of how they do it, rather than simply what services they provide, is lacking.

The most complete listing of LGBT community health centers in the United States was found in *Healthy People 2010: Lesbian, Gay, Bisexual, and Transgender Health* (Gay and Lesbian Medical Association and LGBT health experts, 2001) (see Appendix A: Listing of American Community Health Centers for LGBT people). A review of the websites revealed a listing of services (screening, testing and care for HIV,

breast cancer, and STDs; mental health services; family planning services, including artificial insemination and adoption; and support services related to violence and coming out), opportunities to donate, research projects, employment opportunities, educational materials related to STDs, *et cetera*. While in the United States, listings of CHCs exist for LGBT populations, no such listings were available for Canada. Mayer, *et al.* (2001), American researchers, stated:

the premise of Fenway Community Health [Center] is not that LGBT individuals cannot receive competent care from heterosexual health care providers or in settings where LGBT patients are not a primary focus. Rather, Fenway's unique, culturally specific programs can serve as models of care for LGBT individuals in other settings throughout the country. The goal is for LGBT individuals, wherever they are, to receive the most culturally competent and clinically proficient services possible. (p.894)

#### *Barriers in LGBT CHCs*

To reiterate, many men who have sex with men (MSM) do not define their sexual orientation as gay or homosexual. Accordingly, a CHC designed specifically for LGBT people may fail to attract MSM or closeted gay men. A gay community health centre may be viewed as cultural space, and when an individual is seen in these spaces, it assumes the person is gay or bisexual.

#### *LGBT Community Centres*

Lesbian and gay community centres may provide similar or additional services to those offered by health care clinics. Many of these offer counselling and support for people in crisis, youth, the elderly, people living with HIV and AIDS, people struggling with substance abuse, and survivors of anti-gay violence. Many community centres provide a "safe space" to diminish the sense of isolation and

self-judgement that are among the particular stresses of minority sexual orientation.

### Summary

This chapter began with a discussion of gaps in the research literature in the area of gay men's health since most of the literature focuses on HIV/AIDS. It then focused on definitions of relevant terms, including vulnerable populations, various definitions around sexual orientation, a definition of accessibility, and a definition (or parameters) of community health centres. The literature that was examined highlights the profound health issues of gay men and how these issues are affected by complex psychosocial and historical factors. Also discussed were significant barriers that gay men have in accessing health services. For instance, gay men may receive inappropriate or substandard care, or they may not receive pertinent information about treatments or prevention because their health providers make incorrect assumptions about them, or providers are not aware of how to solicit relevant information from them.

The literature also noted vulnerable sub-populations of gay men who may experience multiple layers of vulnerability, such as men of colour or men with disabilities, elderly men, young men or men with a low socio-economic status, to name a few. The literature also emphasized that while services may be *available*, they may not necessarily be *appropriate*, and hence they may not be *utilized* because of a variety of barriers in terms of *accessibility* (e.g., geographic, financial, cultural, convenience). On a more positive note, the literature also revealed potential strategies that have worked in making the health system more accessible for gay men and other vulnerable populations, as well as the general population. These strategies include partnerships (intersectoral

collaboration), citizen participation, policy support, education and training of health professionals, upstream investment, multidisciplinary teams and a supportive mission and culture. These strategies foster a health promotion perspective.

What the literature has not fully addressed or elucidated are the relevant characteristics of an accessible health care system for gay men within a community health centre setting. This setting has a long history of working with vulnerable populations and addressing the underlying roots of illness and disease. While CHCs that serve many or mostly queer clientele do exist, they have not been examined or described as to what makes them accessible. Therefore, this research will address: How does the Three Bridges Community Health Centre conceptualize and address the issue of access to health services and auxiliary resources for gay men?

## **CHAPTER THREE RESEARCH DESIGN**

### **Chapter Overview**

This chapter outlines the research design strategies and processes that guided this examination of how the Three Bridges Community Health Centre conceptualises and addresses accessibility for gay men. There are eight major topics addressed in this chapter: (a) the research paradigm and research design; (b) development of the conceptual framework; (c) site selection and population sampling; (d) data collection methods; (e) inductive and deductive reasoning/logic; (f) data analysis strategy; (g) and assessing the quality of case study research (trustworthiness features).

### **Characterizing the Research Paradigm and Research Design**

#### *Constructivist Paradigm*

Mertens (1998) defines a paradigm as “a way of looking at the world. It is composed of certain philosophical assumptions that guide and direct thinking and action” (p.6). She lists three major paradigms: positivism/postpositivism<sup>21</sup>; interpretive/constructivist; and emancipatory/critical. This research is located within a constructivist paradigm meaning its ontology (the nature of reality) is socially constructed wherein realities are local and specific, dependent for their form and content on the persons who hold them (Labonte & Robertson, 1996). In a constructivist epistemology (our assumptions about what we can know about that reality), the researcher is part of the reality that is being researched. The

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<sup>21</sup> Mertens (1998) asserts that “the underlying assumptions of positivism include the belief that the social world can be studied in the same way as the natural world, that there is a method for studying the social world that is value free, and that explanations of a causal nature can be provided” (p.7). The post/positivism paradigm “holds that objectivity is the standard to strive for in research; thus, the researcher should remain neutral to prevent values or biases from influencing the work by following prescribed procedures rigorously” (Mertens, 1998, p.10). Postpositivists have recognized that many of the

methodology is hermeneutic, that is, interpretive and dialectic, in that it involves a constant comparison of differing, multiple interpretations of this reality. Constructivist methodology focuses on people's lived experiences, these experiences being located in a particular socio-historical context. Whether or not some absolute and singular reality exists, our understanding of reality is only ever, and always, a socially constructed account (Labonte & Robertson, 1996). Since this research sought to understand the nuances of accessibility for gay men at Three Bridges Community Health Centre, it falls under the interpretivist paradigm.

### *Critical Paradigm*

Although this research is located with an interpretivist paradigm, it is also informed by a critical paradigm (Guba & Lincoln, 1994; Labonte & Robertson, 1996) since it is premised in the belief that the health system is a political and ideological entity intimately connected with the social inequalities of society as a whole. I appreciate that the social hierarchy serves society's dominant (*e.g.*, heterosexual) political, cultural, and economic interests at the expense of those excluded (*e.g.*, sexual minorities) (Rubenson, 1989). A critical perspective begins from the assumption that people act to promote their own interests, including those of the researcher. Certain groups of interest dominate others, and hence social hierarchies are created. These hierarchies allow a dominant group's interests to subordinate others. Critical theorists believe that oppressed voices should challenge existing hierarchical and exploitative structures in society that produce and reproduce rules that influence the construction of knowledge and the exercise of power. The critical world-view has been developed by those who believe "that neither the

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assumptions required for rigorous application of scientific methods were not appropriate for research with people, and thus created quasi-experimental methods (Mertens, 1998).

positivist nor the hermeneutic world view goes far enough in transforming and improving individual learning, educational systems or societal norms” (Melrose, 1996, p.51). Since the purpose of this research was not to create social change, it does not fit within the rubric of the emancipatory/critical paradigm.

### *Issues of Representation*

Representation refers to “how and by what authority we’ll represent our participants through our data and interpretations” (Palys, 1997, p.76). As discussed previously, within research, particularly qualitative research, there is an important issue of whether an “objective truth” really exists, or can it ever really be known. Positivists would argue that there is an objective reality that can be determined. In contrast, constructivists assert that qualitative research represents the researcher’s way of ‘knowing,’ but there are the equally legitimate perspectives that may vary from the researcher’s perspective. This research attempts to incorporate other viewpoints, using informants’ own words (*i.e.*, quotes), as a means to alleviate this conundrum. Their words come from interviews. Mechanisms to identify contradictory perspectives are discussed in the sections on data collection and assessing the quality of case study research later in this chapter. (Issues of reciprocity and ethical issues are also discussed later in this chapter).

### *Case Study Research Design*

From within the major research *paradigms* arise different research *designs*. Denzin and Lincoln (1994) state that

a research design describes a flexible set of guidelines that connects theoretical paradigms to strategies of inquiry and methods for collecting empirical material. A research design situates researchers in the empirical world and connects them to specific sites, persons, groups, institutions, and bodies of relevant interpretive material, including documents and archives. (p.14)

The most common research designs for qualitative research include case studies, ethnography and participant observation, phenomenology and ethnomethodology, grounded theory, biographical method, historical social science, participative inquiry and clinical research (Denzin & Lincoln, 1994). Constructing this research qualitatively is justified since the research delves in depth into complexities and processes; the research is on little-known phenomena and/or innovative systems; the research seeks to explore if, where and why policy and local knowledge and practice are at odds; the research on relevant variables has yet to be fully identified; and the research is about informal and unstructured linkages and processes in organizations.

Case study is the central defining methodological feature of this research. This study applies both inductive and deductive approaches. A critical element of case study research is its reliance on multiple methods of data collection to capture the complexity of a phenomenon (DePoy & Gitlin, 1998). The data are qualitative, derived from semi-structured interviews, document analysis and participant observation. Analysis and interpretation of the data are accomplished through the application of various procedures and techniques associated with qualitative data analysis, including the use of a qualitative software package – NUD\*IST 4.0. These aspects of the research are discussed in greater detail later in this chapter.

This case study can be characterized as an embedded (multiple units of analysis), single-case design (Three Bridges Community Health Centre). It is embedded because multiple perspectives of accessibility will be examined, but it involved only one community health centre. The case study research strategy best serves the aims and suits the focus of this study. Yin (1994) suggests that case study is the preferred strategy

among the five major strategies in social science research<sup>22</sup>, when “how” or “why” questions are being asked about a contemporary set of events within its real life context, over which the investigator has little or no control. Case study designs are also useful for work (as in the present case) in an unstudied area of inquiry. The use of a case study involves systematically gathering enough information about a particular person, setting, event or group to permit the researcher to effectively understand how it operates or functions (Berg, 1998). Case studies illuminate in detail larger health system issues. If this research had incorporated participant observation to a greater degree, it may have been more appropriately labeled an ethnographic study. This is discussed further under limitations of participant observation.

#### *Exploratory and Descriptive Research*

Palys differentiates among four main research objectives. He characterizes them as follows: 1. *exploratory* (or formulative) research which aims to achieve new insights into a phenomenon; 2. *descriptive* research which aims to portray the characteristics of a particular individual, group, or population; 3. *relational* research which seeks to determine how two or more variables are related within a given sample or population; and finally, 4. *explanatory* research which aims to investigate causal relationships or other patterned conduct that is thought to characterize social processes. While Palys notes that “any distinctions among research objectives are bound to be arbitrary, and the divisions between them frequently ambiguous [and that] not every textbook draws the boundaries in exactly the same way” (p.77), he argues that we must begin somewhere.

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<sup>22</sup> Yin identifies five major social science research strategies: experiments, surveys, archival analysis, histories, and case studies.

This research demonstrates the ambiguity and arbitrariness of Palys' distinctions since this research could be described as seeking new insights (exploratory) and portraying the characteristics of groups (descriptive). This study is exploratory in that it considers a phenomenon which has rarely (if ever) been the topic of previous study, in that the issue of accessibility for gay men in a community health centre setting has not been substantively examined previously. The study is also descriptive in that it will elucidate how accessibility is conceptualised and addressed for gay men at Three Bridges Community Health Centre.

### **The Literature Review and Development of the Conceptual Framework**

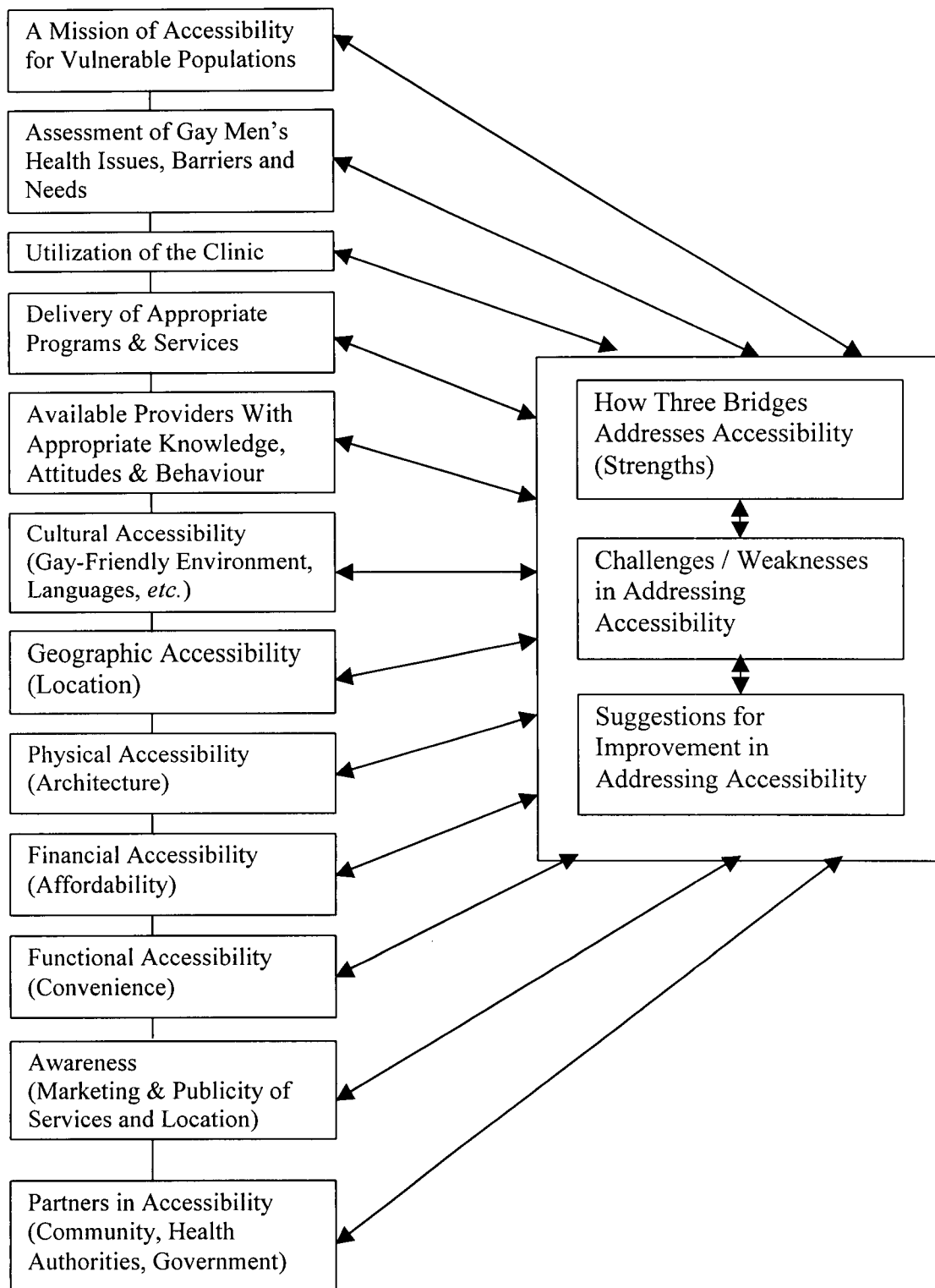
The development of a conceptual framework began with a review of the literature. Other sources used in the development of the conceptual framework included the research question(s) and the researcher's personal knowledge. This approach was consistent with McMillan and Schumacher's (1997) assertion that there are five sources researchers use for classification systems (conceptual frameworks) to organize data: 1. the research question and foreshadowed problems or subquestions; 2. the research instrument such as the interview guide; 3. themes, concepts, or categories used by other researchers in prior studies; 4. prior knowledge of the researcher; and, 5. the data itself (p.509).

A framework/template of various aspects of accessibility for gay men was developed and organized around various themes or components for use in the data collection and data analysis phases of the research. The theory examined in the literature review, which served as the main basis of the conceptual framework, was broadly based from theory on primary health care, health promotion/population health, accessibility, and barriers and opportunities in the health system related to gay men's health. These

somewhat diverse theoretical perspectives provide a comprehensive conceptual framework. Marshall and Rossman (1999) also note: “because writing is a developmental, recursive task, the writer may find it necessary to rewrite the research questions or problem statement after reviewing the literature or to refocus the significance after the research design is developed” (p.24). The research question(s) were reviewed after the literature review, and modifications were made accordingly. For the final conceptual framework of accessibility used in this research, see Figure 3.1.

The left-hand side of Figure 3.1 contains the twelve major themes that subsequently correspond to major sections in Chapter 4: Results. The first three boxes (upper left) contain sections (**a mission of accessibility for vulnerable populations; assessment of gay men’s health issues, barriers and needs; and utilization of the clinic**) that provide the contextual background for the reader to assess the legitimacy of the subsequent strategies to address access for gay men at Three Bridges. These three sections would also be prerequisites for any primary care setting about to embark upon an examination of how (well) it addresses access for gay men, and other vulnerable populations. The remaining nine boxes (lower left) deal with aspects on how accessibility is conceptualized and practiced at the clinic. Accordingly, the fourth box details the **delivery of appropriate programs and services** offered by Three Bridges Community Health Centre. The fifth box discusses the **availability of providers with appropriate knowledge, attitudes and behaviours**, and how they affect accessibility. This is followed by a box on the **cultural accessibility** of the clinic. Boxes seven through ten respectively define how **geographic accessibility** (location), **physical accessibility** (architecture), **financial accessibility** (affordability), and **functional accessibility**

**Figure 3.1 Framework of Accessibility**



(convenience) are addressed at Three Bridges. The final two boxes on the left-hand side discuss **awareness** (marketing and publicity) and **partnerships**. The right side of the figure has three major sections that address the **strengths, challenges** and informants' **suggestions for improving accessibility** at Three Bridges Community Health Centre. The figure exemplifies the interrelationships among the various aspects of accessibility, and how based upon strengths, challenges and suggestions for improvement, these aspects of accessibility are adjusted in a reciprocal manner.

### **Site Selection and Population Sampling**

This section describes the preparation involved for data collection to commence, including, site selection and gaining access, as well as population sampling (including benefits and limitations of the sample). It also includes a discussion of receiving ethical consent from the University of British Columbia and the Vancouver Coastal Health Authority.<sup>23</sup>

#### *A Brief Description of Three Bridges Community Health Centre*

The Three Bridges Community Health Centre opened in June 2000 to serve downtown Vancouver, the West End, Yaletown and Fairview. The Centre serves an extremely diverse population, including seniors, families with young children, single professionals, gay and lesbian people, street youth, and individuals with addictions. The Centre is located at the corner of Drake and Hornby in Vancouver's West End, which is home to between 6,000 and 25,000 gay men (Marchand, 2001a). There were no community health centres (CHCs) in Vancouver that serve exclusively the lesbian, gay, bisexual and transgender (LGBT) community. Because of its location within the gay male community

and the only CHC in the downtown core of Vancouver, the Three Bridges Community Health Centre was the most appropriate setting for this research.

Family doctors, nurses, counsellors, addiction specialists, community developers and support staff are among the staff at the Vancouver Coastal Health Authority's Three Bridges Community Health Centre. In addition, community health nurses, case managers, nutritionists, physiotherapists and others deliver services in community settings such as homes, community centres and schools. While the Three Bridges CHC is not a lesbian, gay, bisexual and transgender (LGBT) CHC, it does serve many gay men as part of its overall clientele. It also has a specific program for the LGBT community known as "Pride Health Services." The program serves, in part, members of the LGBT community who may have had difficulty accessing the health system to receive appropriate health services. Pride Health Services is a partnership between the VCHA and community agencies such as AIDS Vancouver, The Centre (a LGBT community centre) and YouthCO AIDS Society and operates every Thursday from 3:00 - 6:00 p.m. Specific services of the Three Bridges CHC, and how they pertain to gay men, are discussed in Chapter Four.

### *Negotiating Entry*

Before submitting a formal proposal and collecting any data, the researcher sought assistance from the Three Bridges Community Health Centre in May 2001 from Peter Granger, Lead Physician, as to the utility and appropriateness of the research to the Three Bridges Community Health Centre, specifically its staff and clientele. The researcher became aware of Dr. Granger's role by attending a panel discussion of gay, lesbian and

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<sup>23</sup> At the time ethical approval was sought, the current Vancouver Coastal Health Authority was known as the Vancouver/Richmond Health Board. The consent was transferable; resubmission was not required.

bisexual physicians to medical and dental students at the University of British Columbia, and through introductions at a Roundtable on Gay Men's Health held in Vancouver organized by the Gay Men's Health Program of AIDS Vancouver. This relationship served to maximize access to key informants, information, and the setting itself. This is known as negotiating entry through formal and informal gatekeepers of an organization (Marshall & Rossman, 1999). Marshall and Rossman (1999) caution however that sponsorship can backfire, setting the researcher up for difficulties in accessing other participants within the organization. After appropriateness of the research project was determined, and in conjunction with the thesis committee members, a formal proposal (which included a rationale, short literature review and methods section) was submitted to the thesis committee, and accepted in June 2001.

The researcher sought ethical consent to proceed with the study from the Behavioural Research Ethics Board at the University of British Columbia (UBC) on July 27 2001, and received conditional approval dated October 2 2001 (pending Vancouver Coastal Health Authority (VCHA) approval). On October 16 2001, I submitted a "Research Agreement" to the VCHA for their review of the research project based upon standards for ethics, relevance, feasibility and validity. Approval from the Health Authority was dated December 3 2001 (received by mail December 5 2001) and submitted to UBC for final approval on December 6 2001. An approval form from UBC was dated December 20 2001, and received by mail early in January 2002. From the time the research proposal was accepted by the research committee, to the time the final approval from UBC was received by mail, spanned 6 months.

### *Research with Vulnerable Populations*

Many vulnerable populations have been “over-researched,” while other investigators have chosen not to involve vulnerable populations in research endeavours for fear that research protocols will become particularly cumbersome, fear of disapproval of the proposal by a review board, and the belief that vulnerable groups are inaccessible (Moore & Miller, 1999). Furthermore, some groups, such as older adults, are frequently excluded without clear justification (Moore & Miller, 1999). These issues were relevant within the context of this research; for instance, a deliberate choice was made to exclude minors from the research because of difficulty in attaining ethical approval. Although these concerns have legitimacy, researchers – particularly those operating from a critical theory viewpoint – must increasingly seek to remedy the under-representation of vulnerable populations in research and in the literature. Challenges of researching this population are further addressed under the section “Limitations and Challenges of the Study” in Chapter Five. At the same time, researchers must also be vigilant in the assessment of risks versus benefits for research participants.

### *Selection of the Site - Three Bridges Community Health Centre*

Research on barriers and opportunities for gay men in accessing primary health care services should be conducted in a setting where these complexities operate. These complexities include space, resources, rewards, and internalized notions of norms, traditions, roles and values. Examining these barriers and opportunities entails immersion in the setting and rests on both the researcher’s and the participants’ worldviews (Marshall & Rossman, 1999).

This site constituted a realistic choice, in part, because entry was possible. There was also a higher probability that a rich mix of processes, people, programs, interactions and structures of interest would be present than other primary care settings; the researcher was also likely to be able to build trusting relationships with the participants of the study; and data quality and credibility of the study were reasonably assured (Marshall & Rossman, 1999). The choice of a community health centre over other primary care settings (such as, emergency rooms, drop-in clinics, physicians' offices) was also purposeful. Community health centres have a long reputation of working with vulnerable populations including gay men (see the literature review for a more extensive discussion of this topic).

### *Sampling Strategy*

Once the initial decision has been made to focus on a specific site, waves of subsequent sampling decisions are made (Marshall & Rossman, 1999). How do we identify a sample of people (or documents) that can best help us achieve our research objectives? An "adequate" sample depends on one's research objectives, on the type of phenomenon being study, and on practical constraints (Palys, 1997, p.119). Palys states that

researchers must decide what data to use; those who await 'perfect' data are in for a very long wait, and will probably never do any research at all. It's no sin to use 'imperfect' data; the sins arise when one begins to assume that the available data are necessarily the most important data and/or fails to continue asking about the meaning of the data and about the organizational, cultural, and/or methodological context in which they were produced. (p.239)

Obtaining a representative sample of any target population is very expensive and time-consuming (Palys, 1997, p.135), and in this research obtaining a representative sample was neither useful, desirable, nor possible to acquire since many gay men conceal

their sexual orientation. Quantitative researchers generally think randomly, and statistically when considering sampling, while qualitative researchers are more likely to think purposively and conceptually, and not randomly (Huberman & Miles, 1994, p.441). Morse (1994) and Stake (1994) recommend that researchers should choose data by the richness of information they may provide which is best achieved when sampling is driven theoretically or purposively, rather than by statistical requirements. The non-probabilistic (the probability of selecting each sampling unit is unknown or unknowable) sampling method that is relevant here is purposive or theoretical sampling since the research was not meant to be generalizable, but rather it sought to delve in depth into complexities and processes of a little-known phenomena and/or innovative systems (Marshall & Rossman, 1999; Palys, 1997, p.137).

Individuals and groups who comprised the study's sample represented five subgroups: (a) community developers of the Population Health Advisory Committee for Lesbian, Gay, Bisexual and Transgender People and Community Health Area 1; (b) senior staff at the Three Bridges Community Health Centre; (c) program staff; (d) seconded staff; and, (e) gay male clientele. Since there was considerable reorganization of the VCHA at the time of this research, and the board members of the VCHA were appointed during the research process, new to their roles, and preoccupied with fiscal matters and reorganization, they were not sought for interviews. Also, the board members that established community health centres in Vancouver/Richmond through the former Vancouver/Richmond Health Board, were no longer involved in decision-making, and had been 'relieved' of their duties. These five subgroups listed previously were chosen because it was believed they would represent the key, salient perspectives of various

stakeholders since their power and roles varied. It was thought that service providers (a physician, a nurse or community developer) would be most familiar with how accessibility is actualized in practice and implementation issues. In contrast, clients would have a more functional approach. Since the purpose of this research was to examine how Three Bridges Community Health Centre conceptualizes and practices accessibility for gay men, staff informants made up the bulk of the semi-structured interviews. Recognizing the overall small sample size (particularly N=3 clients) the results must be interpreted with appropriate caution. Had board members (policymakers) been available, their perspective would have been broader, and in conjunction with the overall region's health needs. As a member of the thesis committee stated: "In theory, board members develop policy, whereas staff administer the policy" (Whyte, personal communication). While all sub-groups spoke from different perspectives, they were also asked about their perceptions of the other groups.

Within these subgroups, essentially "those most involved or interested" represented the overarching criterion for inclusion. Strategically sampling particular individuals is desirable since some interviewees are more informative and/or provocative. Morse (1994) states that a good informant "has the knowledge and experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study" (p.137). Clients were solicited through leaflets distributed throughout the CHC, as well as through various service providers who drew the leaflets to the attention of clients (see Appendix B for a copy of the leaflet). Staff informants were sought because of their role through a letter (see Appendix C). A preliminary list of informants was developed from information from Dr. Granger and

from the researcher's own knowledge, and modified based on participant observation, archival materials and interviews.

Other than those most involved or interested, attention was also paid to different types of informants as listed by Palys. He lists several types of informants which include, in part, the outsider, the rookie, the old hand, and the "outs" (informants who formerly held power and were well informed, but has now lost power and so have no need to protect the current administration). Palys also recommends an intentional search for disconfirming or heterogeneous cases which are clearly inconsistent with the theory being tested or developed to enrich the researcher's pondering (p.139).

#### *Interview Criteria for Client Group*

The interview criteria for the client group was more refined than other sub-groups. The criteria for the client group were as follows:

- gay male
- 19 years of age or older
- a client of Three Bridges Community Health Centre
- English-speaking

These criteria served to fulfill the research purpose. The requirement of fluency in English was unfortunate, but necessary because resources did not allow for translation. Gay males under 19 were excluded because of the potential difficulty in obtaining ethical approval which is also unfortunate since youth are also at risk (Wells, 1999). Only those who did not meet the above criteria, chose not to participate, responded after the data collection phase had ended, or could not be contacted to set up appointments were excluded from participation (discussed in "Limitations and Challenges of the Research")

in Chapter Five). This research included a broad spectrum of gay men that use Three Bridges Community Health Centre; however, it emphasizes gay men that have multiple vulnerabilities. Further research may be needed to fully ascertain the relevance of the present findings to the broader gay community.

#### *Sampling of Key Documents*

In addition to the sampling of key informants, there was also a sampling strategy for key documents. The selection of these documents was based upon: the researcher's knowledge of the area under study; through library searches of the VCHA; suggestions from Dr. Granger; as well as from recommendations of interviewees. Unfortunately, the documents collected were mostly of the former Vancouver/Richmond Health Board (V/RHB), and not the Vancouver Coastal Health Authority (VCHA), and were thus used sparingly since the future policies of the VCHA may not be represented in documents produced by the V/RHB.

#### *Benefits and Limitations of the Sample*

The advantages of non-probability sample design include its usefulness and expediency; its appropriateness when there is particular interest in members of a population; when it is exploratory and descriptive research (to determine the nature of a particular problem or phenomenon – accessibility for gay men); and when there are limited resources (Andres, personal correspondence). Disadvantages to a non-probability sample design also exist; for instance, when there is a risk of a lack of validity because of bias in the selection process (Andres, personal correspondence). This was minimized by choosing a variety of key informants. Also, since this research is exploratory – to determine the *nature* of the

phenomenon, rather than the *extent* of the problem – generalizability to other populations is not relevant (discussed later).

*Clientele.* Since the gay male clientele of the Three Bridges Community Health Centre were self-selected through solicitation by leaflets at the Three Bridges CHC, this raises issues which both enhance and limit the study. Often in sampling techniques used in studies like this one, researchers are more likely to use gay-positive venues, and are most unlikely to recruit reasonable numbers of more closeted gay men who feel alienated from organized gay communities (Williamson, 2000). Study subjects may be more likely to be politically and/or socially connected to the gay community (Harrison, 1996). Also, given the expected level of intimacy and commitment required by the research process, subjects volunteering for this study would be more likely to be highly motivated, open about their sexuality and positively gay-identified. Accordingly, gay males disassociated with the larger, gay male community may not be reached. Individuals associated with the Three Bridges Community Health Centre but less comfortable with discussing issues of sexuality may have been missed since this research required them to “declare” their sexual orientation.

Other potential reasons for clients not participating include those not meeting the criteria as defined above. As mentioned earlier, due to budget restraints non English-speaking participants were not solicited; nor were youth under 19 years old. Also with this kind of research into people’s experiences, clients who may have had negative experiences in the past or currently (*i.e.*, have a story to tell) may have been more likely to respond than clients whose experiences are more typical. One interviewee was mostly concerned with relaying a one-time negative experience. The use of a monetary incentive

(honorarium) for people unemployed or underemployed is one way to appeal to participants who may have otherwise not participated. Unfortunately, since the researcher could not establish rapport with clients directly, attempts to lessen some of these issues were restricted. For instance, if the researcher had greater access to the clients, he may have been able to establish positive relationships and thus acquired a more diverse sample. Accordingly, the accuracy and precision of statements about the population can only be determined by subjective judgment based upon participant observation and interviews with other data sources. To determine the frequency of experiences, generalizable survey research needs to be conducted. This is further discussed later in this chapter in the section on "Assessing the Quality of Case Study Research."

### **Data Collection Methods**

This section describes the various methods and procedures applied during the data collection phase of this study. It includes a discussion of the three data collection methods employed – archival materials, participant observation and semi-structured interviews, including benefits and limitations of each, and securing the data. The data collection methods used in this research form the core of qualitative research – "the staples of the diet" (Marshall & Rossman, 1999, p.105). The data collection methods (the spoken, the unspoken and the written) were chosen because it was anticipated the procedures would elucidate different aspects of accessibility, and also to ensure trustworthiness of the data. "What people say" is often very different from "what people do" which is often very different from "what people write." Western social science has long privileged the spoken over the written and the written over the nonverbal (Hodder, 1994, p.394).

### *Archival Materials (Document Analysis)*

Archival materials comprise any information that is contained in 'hard copy' records or documents<sup>24</sup> (Palys, 1997, p.218). Hodder (1994) describes written texts and artefacts as "mute evidence" (p.393). He notes that "such evidence, unlike the spoken word, endures physically and thus can be separated across space and time from its author[s]" (p.393). Documents do not give a better but simply a different picture from that provided by other artifacts. Hence, documents can be used with other forms of evidence so that particular biases can be understood and compared. Documents have to be understood in the contexts of their conditions of production and reading. Other than interactive and observational techniques, we can learn about ourselves/others by analyzing the things that we/they produce. Interactive methods of data collection create 'direct contact' which create 'reactivity' or 'centre of attention' effects since the research participant is generally aware of being observed. In contrast, archival materials are unobtrusive. Palys (1997) argues that these techniques are non-reactive because the 'data' are typically produced without the thought that the 'evidence' might someday be scrutinized by social scientists, and that the researcher usually arrives on the scene after the 'participants' have left. The researcher is in effect a detective.

### *Conducting the Collection of Documents*

A request for documents (such as policy statements, annual reports, business plans, evaluation reports, newspaper clippings, meeting minutes, program lists, organizational structure/staff listings, orientation package, and any other pertinent documents) of the Three Bridges Community Health Centre and the Vancouver/Richmond Health Board

was undertaken. It included a specific request for material on accessibility or systemic barriers for LGBT populations. A total of 25 documents were reviewed ranging from 1 to 104 pages (with a mean of 16 pages, and a total of 398 pages). The documents reviewed are listed in the "References" section, and listed under "Downtown South Community Health Centre," "Three Bridges Community Health Centre," "Vancouver Coastal Health Authority," and "Vancouver/Richmond Health Board." The review of documents contributed a somewhat better understanding of perspectives of accessibility; however, it elucidated perspectives by policymakers and staff more than clients. Based upon document analysis, interview questions were slightly refined. This phase was carried out in conjunction with the participant observation. The documents collected and analyzed from the V/RHB and the VCHA, and the Three Bridges Community Health Centre specifically related to the context of the research question(s), and the conceptual framework.

#### *Benefits and Limitations of the Documents*

As with any research method, there are both advantages and disadvantages from using archival materials in research.

*Benefits.* Archival materials allow longitudinal analysis, at least within the context of past events. Furthermore, archival sources, unlike some oral histories, exist over time.

Accordingly, we/others can return to a given document with greater or different scrutiny. Therefore, a significant advantage of archival methods is that "we may disagree on our interpretation of what a document means, but at least we are working with the same document" (Palys, 1997, p.218). Another advantage of archival study is that it costs

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<sup>24</sup> Unlike Lincoln and Guba (1985 in Hodder, 1994), I do not differentiate between documents and records. They distinguish between records, attesting to some formal transaction, and documents which are prepared

much less than many other research methods (Palys, 1997). Archival data is less prone to reactivity (the degree to which, if at all, the participant changes his behaviour/responses due to the research) than are interactive techniques.

Research or formal reports by the VCHA (or V/RHB) describing initiatives related to accessibility for gay men, the purpose of establishing CHCs in the region, or the health issues of gay men and their subsequent barriers to service accessibility, even if written by only one or a few members of the Board with senior staff, would likely convey a more “realistic” picture than interviewing one member of each group since the research reports usually required drafts to several members, and might contain conflicting viewpoints.

*Limitations.* Archival data are secondary sources - the information was prepared by someone else, and for some other purpose other than supplying evidence to researchers. Palys reminds us to consider the “context of production” in archival methods, as in all methods (p. 219). “The intermediary (and inherently political) process between event and datum, or having the thought and putting it on paper, must be considered and articulated” (Palys, 1997, p.219). And while archival data may be created without a belief that a researcher might analyze them, they may nonetheless be prepared for possible public consumption in a political context, and again, ‘what people do’ which is often very different from ‘what people write.’

Palys (1997) notes that a disadvantage of physical trace measures centres on the sometimes unknown representativeness of the information that survives, or is at least discoverable by the detective. Palys describes these limitations as “selective deposit” and “selective survival” (p.217). Selective deposit refers to the fact that some individuals and

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for personal rather than official reasons.

groups are more likely to have placed their beliefs and experience into a historical record. For example, wealthier and/or more powerful groups are more likely to document their views in historical records, and since historians can only study history based upon what's on record, our understanding of history is influenced by the factors that shape selective deposit in that instance. Selective survival reminds us that among those things that are initially put into the historical record (via the already-biased process of selective deposit), some have a better chance of surviving the ravages of time than others. As such, "researchers must be sensitive to the ways in which data availability constrains their conclusions and the range of theory that can be developed" (Palys, 1997, p.218). Also, privileged decision makers and/or academics often write research reports, and thus may not represent less privileged viewpoints. In the case of this research, it is important to underscore that these documents are constructed usually for or by policy makers, and not necessarily with input from front-line staff or clientele (hence the importance of interviewing these stakeholders in this research project).

The legitimacy of documents is further questioned by Hodder (1994) who argues that meaning does not reside in a text but in the writing and reading of it. Therefore, as "text is reread in different contexts it is given new meanings, often contradictory and always socially embedded" (Hodder, 1994, p.394). Accordingly, there is no "original" or "true" meaning of a text outside specific historical contexts. Hodder states: "The text can 'say' many different things in different contexts. But also the written text is an artifact, capable of transmission, manipulation, and alteration, used and discarded, reused and recycled – 'doing' different things contextually through time" (p.394).

As mentioned earlier, the major limitation of the use of documents in this research was that the documents mostly represented the views of the former Vancouver/Richmond Health Board. In the “Results” chapter, a clear delineation is made between documents produced by the V/RHB and the VCHA. When this research was initially proposed, the change in authority (dissolving of one health board and establishment of another health authority) was not foreseen; however, by the time the data collection had commenced, it was more a matter of when than if changes would be made.

### *Participant Observation*

Participant observation is the “firsthand involvement in the social world chosen for study” (Marshall & Rossman, 1999, p. 106). Involvement in the setting allowed me to see and hear – to learn directly – and begin to experience to some degree reality as the participants do (Marshall & Rossman, 1999). In qualitative research, some sort of participation usually becomes necessary as the researcher helps out with small chores (or large ones), wants to learn more about a particular activity, or feels compelled to participate to uphold the notion of reciprocity. The notion of reciprocity suggests that the researcher cannot simply be a sponge-like observer (Marshall & Rossman, 1999). Such interaction is usually highly informative while remaining informal. The researcher’s role may vary in intensiveness (daily) and extensiveness (over time).

In this research, while participant observation would not readily answer questions on participants’ views on accessibility, it did help to conceptualize it in practice. Marshall and Rossman (1999) state that “observation entails the systematic noting and recording of events, behaviours, and artefacts (objects) in the social setting chosen for study. The observational record is frequently referred to as field notes – detailed, non-judgemental,

concrete descriptions of what has been observed” (p.107).

### *Conducting Participant Observation*

Daily field notes were kept on multiple aspects of accessibility during site visits. As typical of qualitative researchers, I entered the setting with broad areas of interest, and only a few predetermined categories or *strict* observational checklists of specific aspects of accessibility as discussed in the literature (Marshall & Rossman, 1999). For instance, the literature frequently discusses the use of gay-friendly symbols (posters, rainbow flags) and literature (brochures, magazines) in the waiting area, as well as gay-friendly language on medical forms, such as “partner.” I was also looking for evidence of other features of accessibility which are not specifically designed for gay men, but may affect whether or not they use the CHC, such as, extended office hours; availability of evening and weekend appointments; on-call services; availability of telephone advice from a nurse; and the variety of staff and the services they provide.

The participant observation was conducted in conjunction with the document collection and analysis, and mostly before the interviews to refine and provide important questions for subsequent interviews. In this research, because of practical considerations for completion of the project, intensiveness (rather than extensiveness) was the underlying variable; that is, visits were intensive but only lasted for four weeks. The visits also varied in terms of the time of day and days of the week. Since the range of activities for participant observation were limited, extending the weeks of participant observation would likely not have resulted in more (or better) data. While participant observation revealed information not available from other sources, saturation was achieved rather quickly. Cumulatively, participant observation lasted for approximately

33 hours.

Because of the highly personal nature of the care provided at Three Bridges Community Health Centre (by far, mostly one-on-one interventions) and the protective nature of providers and the manager, participant observation consisted mostly of an observation role, and did not allow for casual conversations with providers or clients, although I did have lunch a couple of times with Peter Granger to discuss the project. Prior to beginning the participant observation, a meeting was held with the manager and Peter Granger, Lead Physician and the champion of this research, to discuss possibilities for participant observation. Since gay men are generally an “invisible” minority, it also makes it more difficult to identify gay or straight men. Since providers are generally with clients on a one-on-one basis, it did not provide much time for casual conversations. Participant observation entailed mostly “hanging out” in the main waiting area of Three Bridges CHC, and the waiting area for Pride Health Services. I was also able to attend a staff meeting for Pride Health Services. It also included a tour of the facility, which led to several introductions. Through these experiences I was able to view clients’ interactions with front-desk staff, and with other clients. I was also able to see the range of clients (age/sex), see how they were dressed, and hear their conversations with each other and staff in public places. I was also able to examine and document the layout of the Health Centre since this affects how a multidisciplinary team works together. Attending the staff meeting also allowed greater insight into pertinent issues since it included a discussion of a rainbow flag (Pride symbol) and marketing of Pride Health Services. For instance, a discussion of Pride symbols in the Health Centre was one item on the meeting agenda.

Negotiating entry does not only exist at the beginning of the participant

observation, but is an ongoing process. Although the staff and manager were genuinely interested in the research, caution had to be taken not to overburden staff and overextend my welcome. For instance, negotiating entry to the staff meeting was somewhat difficult because there was a concern by some staff that they did not want “visitors until they have all the kinks worked out.” My requests to participate/observe were not new to the staff and manager since other researchers, bureaucrats and community groups were also interested in learning about their programs and delivery of care. Accordingly, I also had to be aware of the latitude extended to other people in similar positions as mine, and was cognizant of not making too much work for them. Accordingly, there were regular staff meetings and Pride Health meetings that would have provided valuable insight, but if I had pushed too hard, and annoyed or inconvenienced the staff too much, I may have jeopardized access to interviews with staff, and their subsequent distribution of leaflets to clientele. The staff that I approached for access to meetings had to negotiate my entry with other staff or members of committees since some decisions were made by consensus.

### *Benefits and Limitations of Participant Observation*

As with archival materials, there are both advantages and disadvantages from using participant observation in research. Participant observation provides knowledge and an understanding that may not be available through interviews and documents. It is a way to study and explore interactive processes and social relationships. What is unspoken may be as important as what is spoken. However, closeness can compromise researcher’s distance and ethical dimensions of research. Trying to control for observer effects is difficult. Situations may also arise that would require the research project be ended.

Given the nature of the participant observation in this study, difficult situations for the researcher did not arise.

### *Semi-Structured Interviews*

The third type of data collection method employed in this study was the use of semi-structured interviews. Rubin and Rubin (1995) consider main interview questions to be focused, linked questions that provide direction in the interview; they cover an overall process, event or subject, and divide and organize the research topic in ways that make sense (such as phrases in a process, or parts of a concept, or roles of actors). They are generally worded broadly enough to encourage open answers from participants, yet narrowly enough to provide the necessary data (Rubin & Rubin, 1995). Follow-up questions are more specific and create “scaffolding” for the interview (Rubin & Rubin, 1995). They help to keep the questioning on topic and link what is asked in individual interviews to the overall interview design. Further, follow-up questions allow the researcher to get richer, more-in depth answers; to explore themes and concepts fully; and to clarify, test and modify existing themes (Rubin & Rubin, 1995).

The refinement of the research purpose after a thorough literature is common since qualitative research is an iterative process. This also leads to revisions of the research question(s) and interview questions (Marshall & Rossman, 1999). After the literature review was conducted, the research purpose was slightly refined, and subsequently the main research question and sub-questions were also slightly refined. The interview guide was shortened and slightly refined after the approval of the formal research proposal and a more thorough literature review was conducted. All of the interview questions were taken and organized under one of the research sub-questions.

For remaining interview questions, they were either discarded or incorporated under a new research question. Accordingly, a blueprint ran through the thesis (See Figure 3.2: From Research Purpose to Interview Questions).

**Figure 3.2 From Research Purpose to Interview Questions**

research purpose > research question > research sub-questions > interview questions

Data collection included 14 face-to-face semi-structured interviews. Semi-structured interviews were particularly suited to this inquiry since they guided the examination of the research topic with pre-established questions, while allowing for some deviation from the interview agenda. Interview questions were also stimulated, refined or omitted based upon observations and document analysis, and due to “reforms” with the Vancouver Coastal Health Authority. For instance, when the interviews of key informants began the former board of the Vancouver/Richmond Health Board had been dissolved, and another Board had yet to be appointed, so questions pertaining to the Board were somewhat moot, and thus were refined or omitted.

*Conducting the Interviews*

As Marshall and Rossman (1999) assert, “the most important aspect of the interviewer’s approach concerns conveying the attitude the participant’s views are valuable and useful” (p.108). The purpose of the study, that is, to examine how accessibility for gay men is conceptualized and practiced at Three Bridges Community Health Centre was stated to all participants before commencing the interviews. Also, how their input would contribute to this purpose was emphasized. I conducted 14 interviews between March 1, 2002 and May 30, 2002. A list of staff and client interview questions is contained in Appendices D and E respectively. The interview guide for staff was adjusted as

appropriate; for instance, staff of the community and public involvement committees were not directly responsible for service delivery in the Community Health Centre, and consequently questions were more hypothetical in nature, or dealt with their work and how it related to Three Bridges CHC. A different interview guide also was developed for the gay male clientele.

At the beginning of each interview, a consent form was given to the informant to read and sign (see Appendices F and G for staff and client consent forms respectively). After consent was obtained, permission was sought to tape record the interview even though it was stated in the consent form. All agreed to be tape-recorded. Due to technical difficulties in one instance, and human error in another, two interviews were not tape-recorded; however, in the first instance, the interviewer had difficulty with the equipment immediately prior to leaving for the interview, so copious notes were taken to offset the circumstances. In the second situation, I recognized my error immediately after the interview finished, and notes taken during the interview were enhanced.

As discussed in the sample selection, the main groups interviewed, represented five subgroups: (a) community developers of the Population Health Advisory Committee for Lesbian, Gay, Bisexual and Transgender People and Community Health Area 1 (N=2); (b) senior staff at the Three Bridges Community Health Centre (N=2); (c) program staff (N=4); (d) seconded staff (N=3); and, (e) gay male clientele (N=3). Staff were emphasized in data collection since they were most informed regarding how Three Bridges Community Health Centre addresses accessibility for gay men. For a further discussion of why these groups were deemed appropriate, the reader is referred to the section on sampling.

Three current/former employees of Three Bridges Community Health Centre were solicited through letters, but did not respond to the request. Since the application for ethical approval did not specify that a follow-up letter would be mailed, only one letter was mailed to potential interviewees. I conducted all interviews. Except for the gay male clientele, a convenient time at the person's workplace was arranged for interviews. Conducting the first interview with a senior staff person was strategic because this person was the 'gatekeeper' of the setting and other staff, and I believe it also served to ease this person's mind as to the legitimacy of the research purpose. Similarly, conducting staff interviews before client interviews also helped to inform the staff of the research purpose, the areas of interest, as well it provided the staff person(s) an opportunity to get to know the researcher. This was important since staff were integral in the recruitment of clients.

One-page, coloured leaflets (see Appendix B) were distributed to nine service providers, who worked either fully or in part at Three Bridges Community Health Centre. Leaflets were also distributed to a person at the Centre to post/distribute. In total, 180 leaflets were distributed to these ten people. Leaflets were also posted in the Health Centre's main waiting area, as well as the waiting area for Pride Health Services. Leaflets were also posted in exam rooms. Finally, leaflets were placed on magazine tables in the waiting area. An email (very similar to the leaflet) was distributed to a list-serve of email recipients of the Vanguard Project<sup>25</sup>. Unfortunately, circumstances beyond my control delayed the posting of this email.

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<sup>25</sup> In brief, the Vanguard Project is an ongoing prospective study of HIV incidence and risk behaviours in gay and bisexual men which started recruiting in May 1995. Men are eligible to participate if they are aged 18 to 30, live in the Greater Vancouver region and self-identify as gay or bisexual or have sex with other men.

Obtaining and arranging interviews of clients proved more cumbersome than had been expected. In the leaflet soliciting clients, there was a cellular phone number and an e-mail address for clients to contact me. Interviews were conducted at locations mutually agreed to by the interviewer and interviewee. One client requested to be interviewed at a coffee shop in his neighbourhood; two others were interviewed at St. Paul's Hospital since the preclusion of conducting client interviews at Three Bridges Community Health Centre was written into the ethics protocol because it was thought that doing so would reveal clients' identities to staff. I believe this stipulation severely hampered the number of client interviews that were possible, however, any departure from the protocol would have been a violation of the ethics agreement. Client interviews were not conducted at Three Bridges Community Health Centre because it was feared that doing so would reveal clients' identities to staff, which might jeopardize them receiving care, or the quality of care they received, if they recalled negative experiences, which would subsequently be revealed in the report/thesis. Not having a designated, convenient location for client interviews was cumbersome for the interviewer and the interviewees.

In retrospect, I would have submitted an ethics application in which clients would have been given the option of conducting the interview at Three Bridges Community Health Centre, or another location. They could have been informed of the possible risks, and the limits and extent of confidentiality that could be assured. A discussion of how, or even if, to include negative encounters with health care providers in the results of the study between the client and myself could have ensued. If interviews had been allowed at Three Bridges Community Health Centre, I could have "hung out" there, and clients could have been introduced to me by the providers, as they are in other situations with

other providers. It is important to recognize that clients of Three Bridges Community Health Centre seek health services there, in part, because of its convenience.

Accordingly, some of them became impatient and frustrated at the cumbersome nature of the research process, and decided not to participate because of the difficult nature of arranging an interview.

St. Paul's Hospital was mostly a good choice for the interviews since it was three blocks from Three Bridges Community Health Centre, and it was known to clients. Clients were met in a waiting area near the front entrance, and we then proceeded to the Conference Centre in the basement of the hospital. Other venues (AIDS Vancouver, the LGBT Centre) that I suggested to the clients as possible locations for the interviews were either not known by the client, or they were uncomfortable going there. Other venues, such as, the West End Community Centre or Gordon Neighbourhood House, were not in their neighbourhood, and so were inconvenient for that reason. Ironically, I was studying accessibility, and yet the accessibility to which they have been accustomed to at Three Bridges Community Health Centre did not exist in the research process.

Another difficulty in conducting client interviews was a result of clients' unstable housing, or them having no home telephone. For instance, one client left a message with a phone number wishing to be a part of the research project, but when I returned his message, he had moved out of his hotel room. The use of a cellular telephone (carrying it with me and/or keeping it turned on) was very helpful since some clients called from pay phones, and had no home phone number which they could leave for me to return their phone call. Also, two of the three clients called me the day of interview to confirm my

attendance, which was also beneficial to me since I knew they had not forgotten about the interview.

### *Benefits and Limitations of Semi-Structured Interviewing*

To reiterate, interviewing in qualitative research has both benefits and limitations. When used in conjunction with other data collection methods, limitations are lessened.

*Benefits.* Andres (course correspondence) lists the advantages of face-to-face interviews as: flexibility; greater complexity; more success in contacting hard-to-reach populations; high response rate; and assurance that instructions are followed. They also allow researchers to gather large amounts of data quickly. Interviews provide depth rather than breadth. Since the purpose of this research is exploratory and descriptive, and seeks to uncover 'how' rather than 'how much,' depth is preferred over breadth.

*Limitations.* Disadvantages of interviewing include: high cost; interviewer bias; respondents' reluctance to cooperate; respondents' may be unable, unwilling or uncomfortable sharing all that the interviewer hopes to explore; greater stress; less anonymity; and potential risks to personal safety (Andres, course correspondence). Interviewers may also lack the ability to evoke long narratives because of a lack of experience.

### *Securing the Data*

Confidentiality of the data were maintained by limiting access of the data to the principal investigator (supervisor), the co-investigator (graduate student), and thesis committee members. At no time were service providers of the Three Bridges CHC given access to identifiable subject data. In addition, the documents, field notes, audio tape recordings and transcriptions of interviews were stored in a locked filing cabinet. Computer files

were password-protected. When reporting the results of the study, subjects will not be named, but rather identified by numbers (*e.g.*, [Staff 1]). There was no access to clients' medical records in this research.

The raw data (transcripts of interviews) will be stored in secure facilities for 5 years after completion of the study, and will be subsequently shredded or erased. Summary data, reports, and publications will be kept beyond the 5-year period. In accordance with Vancouver/Richmond Health Board Research Agreement (Item 14), individual identifiers associated with the *clients* were removed or destroyed at the earliest time at which removal or destruction can be accomplished consistent with the research purpose (maximum 2 years).

### **Inductive and Deductive Reasoning/Logic**

Qualitative researchers rely on complex reasoning that moves dialectically between deduction and induction (Marshall & Rossman, 1999). For deductivists, theory defines what the important variables are. In deductive logic, one reasons from the general to the specific; that is, one begins with broad theoretical generalizations and tests their ability to deal with specific instances. In inductive reasoning, one begins with specifics and uses these to generate general principles (Palys, 1997). Palys defines theory generation as inductive research, and theory probing and testing as deductive research.

Qualitative data analysis is "primarily an inductive process of organizing the data into categories and identifying patterns (relationships) among the categories. Unlike quantitative procedures, most categories and patterns emerge from the data, rather than being imposed on the data prior to data collection" (McMillan & Schumacher, 1997, p.501). Typically in qualitative research, content analyses rely less on coding schemes

and checklists (usually a more quantitative form of analysis), and more on a well-defined research question and a thematic reading of the materials (Palys, 1997). Consequently, it generates a more abstract, descriptive synthesis of the data. Palys states:

Even inductivists begin with an orienting strategy...or some preliminary "common-sensical" understanding that leads them to focus on certain bits of information to the exclusion of others.... At the other extreme, deductivists are guided to particular variables by whatever theory they attempt to test or impose. (p.239)

The early stages of this research applied an inductive logic model in the development of the study's conceptual (accessibility) framework. Evolving from a review of the literature based upon theory on accessibility, primary health care, health promotion/population health, community health centres, and gay men's health, the accessibility framework identifies the multiplicity of factors that characterize and influence access to primary health services (and auxiliary resources) for gay men at a community health centre setting. This inductive exercise yielded a framework comprised of generalized principles (themes and dimensions) based on the results of related research. Semi-structured interview questions were generated from the framework to gather data from study participants, and were refined based upon document analysis and participant observation. Later stages of the study relied more on deductive reasoning when the conceptual framework was applied to the Three Bridges Community Health Centre case, and the noninteractive and interactive qualitative data. The framework was then refined inductively when themes and dimensions not alluded to in the literature were revealed.

## Data Analysis

This section outlines the various methods applied to analyze the qualitative data collected in this study. It includes discussion of: (a) the overall analytic strategy; (b) transcription of taped interviews; (c) coding of interview transcripts, field notes and source documents; and, (d) detailed data analysis and write-up.

### *Overall Analytic Strategy*

There is no one 'right' way to analyze qualitative data. Most qualitative researchers are wary of prescriptive methods. As McMillan and Schumacher (1997) posit, a hallmark of qualitative research is the creative involvement of the researcher. For qualitative researchers, the operations of organizing, analyzing and interpreting data refer to data analysis. For both types of qualitative data – noninteractive (documents) and interactive (interviews, participant observation) – the general process of developing topics/categories through comparison of data parts and pattern-seeking techniques is similar (McMillan & Schumacher, 1997).

Miles and Huberman (1994) view the analysis of qualitative data as a process that entails **three, concurrent** activities: (a) data reduction, (b) data display, (c) conclusion drawing and verification. *Data reduction* refers to the process of selecting, focusing, simplifying and transforming the data. This step includes the researcher's choices of what data to code, which data to extract, and which segments of data yield patterns. *Data display* is a spatial representation of the data which helps to organize the data into understandable formats, view large amounts of data and establish the framework for drawing and verifying conclusions. Finally, *conclusion drawing* refers to the process of

inferring substantive meaning from the data. Similarly, McMillan and Schumacher (1997) describe qualitative data analysis as entailing **four, cyclical** phases:

- continuous discovery, especially in the field but also throughout the entire study, to identify tentative patterns;
- categorizing and ordering of data, typically after data collection;
- qualitatively assessing the trustworthiness of data, to *refine* the patterns;
- writing synthesis of themes and/or concepts.

#### *Transcription of Taped Interviews*

Fourteen interviews that comprised part of the study's data generated approximately 12.5 hours of tape. The researcher required between 5 and 6 hours for transcribing for every one hour of tape-recorded interview. Transcription time increased in those instances complicated by background noise; or when the interviewee spoke with a faint voice or where words were muttered or garbled.

Several steps characterized efforts to promote quality and consistency of transcription in this study. First, the researcher transcribed the interview within two days of the interview. Second, the researcher himself transcribed the interviews. Thirdly, the researcher recorded testimony verbatim, including incomplete sentences, and indicated laughter, and indiscernible words with brackets, and loud or emphasized words or phrases were capitalized. Finally, I consulted with my colleagues in advance of any transcription to ensure that transcripts were produced in a format consistent with the software package (NUD\*IST 4.0) chosen to support analytic functions.

### *Coding of Interviews, Field Notes and Documents*

Coding represents one form of data reduction which is defined by Miles and Huberman (1994) as “the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in transcriptions, field notes and documents (p.10). Coding is the process of dividing data into parts by a classification system. Researchers develop a classification system by using one of three strategies:

- segmenting the data into units of meaning called topics and grouping the topics into larger clusters to form categories; or
- starting with predetermined categories and breaking each category into smaller subcategories; or
- combining the strategies, using some predetermined categories and adding discovered new categories (p.509).

The third strategy of using predetermined categories and adding newly discovered categories characterized the coding scheme for this research. The conceptual (accessibility) framework guided the coding of interview transcripts, field notes and documents. A computer software program called NUD\*IST 4.0, an acronym for Nonnumerical Unstructured Data Indexing, Searching and Theorizing, supported data analysis of interview data and field notes.

Several steps characterized the coding process of interviews and field notes undertaken in this study. First, the accessibility framework was incorporated into NUD\*IST, and all themes and dimensions that comprise the framework were assigned a numerical address or code. This generated a coding scheme comprised of 70 numerical codes organized under 8 major code categories (see Appendix H for the initial coding

scheme). With a coding scheme in place, copies of interview and field notes transcripts were generated where transcript text was organized into text units (paragraphs) so that NUD\*IST generated numerical codes that could be attached. The researcher carefully reviewed each transcript and made judgments as to which NUD\*IST generated numerical code (representing the various themes and dimensions) would be assigned to which chunks of data (text units). As recommended by McMillan and Schumacher (1997), I asked myself, 'What is this about?' At this phase, I did not ask myself 'What is said?' which identifies the meaning of the segment.

Text units were copied to more than one NUD\*IST address when a particular chunk of data related to multiple framework themes or dimensions. Further, text units considered important by the researcher, but which did not "fit" into any of the established codes were grouped into new categories and assigned new codes (see Appendix I for final coding scheme). In this way, important data which did not match the original framework was not lost or ignored; rather it was integrated into the coding scheme for consideration during detailed analysis to take place at a later time. Computer entry of codes from each transcript signaled the end of the coding process for that particular transcript.

Document coding underwent a similar process as interview and field notes, whereby the framework guided the coding effort. Documents, however, were not integrated into NUD\*IST. Rather, each source document received several NUD\*IST address codes where notations were made as to (a) its title, (b) text that related to the themes and dimensions of the access framework, (c) text that included any "new and emerging themes/dimensions," (d) and the page numbers where relevant data could be located.

Like the transcription process, the coding process was labour-intensive. Generally, transcript coding ranged from 2 to 4 hours (depending on length of transcript). Time dedicated to source document coding varied widely, based on length, overall relevance and type of material. The entire coding process spanned several months, and was incorporated with data collection and transcription since all three activities lasted between three and four months.

#### *Detailed Data Analysis and Write-Up*

The themes and dimensions of the accessibility framework, and the new themes generated during the coding process, initially guided the detailed data analysis and write-up of findings. I did not rely exclusively on theoretical categories imposed from the theory and my interpretation (framework), but sought “to understand categories and theoretical dimensions from the perspective of the informants’ experience” (Palys, p.19).

The data analysis technique can be characterized broadly as thematic analysis, which involved a systematic review of the data, theme-by-theme. According to Ryan and Bernard (2000) “themes are abstract (and often fuzzy) constructs that investigators identify before, during, and after data collection. Literature reviews are rich sources for themes, as are investigators’ own experiences with subject matter. More often than not, however, researchers induce themes from the text itself” (p.780). The data was combed through several times – the first time for familiarity, and to establish repetition/duplication of text units among different codes since some text units (paragraphs) were coded to more than one code (theme). I compared the topics for duplication and overlapping meanings making notes of similar topics (McMillan & Schumacher, 1997). I then examined whether some of them were actually subtopics.

During the subsequent readings, I checked for consistencies, similarities, and contradictions of participant responses; summarized key testimony related to each theme; and flagged potential quotes that exemplified certain perceptions, phenomena, or ways of thinking. Specifically, thematic analysis allowed the researcher to (a) comprehensively review the data associated with each theme of the accessibility framework; (b) assess participant perceptions on which factors were the most influential and which factors challenged accessibility; (c) consider the “fit” between the accessibility framework and the situation of gay men; and (d) generate hypotheses related to future research and practice. Write-up of study findings flowed from the research questions and major themes. It involved writing descriptively how each theme played out in the Three Bridges Community Health Centre and I provided examples of each theme with quotations from the data.

### **Assessing the Quality of Qualitative (Case Study) Research**

Because the nature and purpose of the quantitative and qualitative traditions are different, it is erroneous to apply the same criteria of worthiness or merit (Krefting, 1991). The assessment of the merit of qualitative inquiry is typically referred to as trustworthiness. In 1981, Guba proposed a model for assessing the trustworthiness of qualitative data. Guba’s model is based on the identification of four aspects of trustworthiness that are relevant to qualitative research: (a) credibility, (b) transferability, or fittingness, (c) dependability, and (d) neutrality. Specific strategies were used throughout the research process to increase the trustworthiness of the data. Although some strategies (*e.g.*, triangulation and reflexivity) are useful for establishing more than one criterion, the strategies are defined under the criterion to which they are most frequently applied.

### *Credibility*

In quantitative research, internal validity is based on the assumption that there is a single tangible reality to be measured. In qualitative research, internal validity is replaced by credibility, which is based on the idea of multiple realities, and hence the researcher's job becomes one of representing those multiple realities as revealed by informants as adequately as possible.

An important strategy is "prolonged" (and varied) engagement which allows the researcher to check perspectives and allows the informants to become accustomed to the researcher, thereby decreasing the likelihood that data are based upon the social desirability of actions and responses to questions. A time sampling strategy determines if the researcher is sampling all possible situations, including times of the day and week, and interactions among different social groupings. Accordingly, participant observation occurred at various times and days of the week. Also, as discussed previously, a range of informants were interviewed.

Peer examination, wherein a researcher discusses the research process and findings with impartial colleagues who have experience in qualitative methods, is another technique to establish credibility. Since the thesis committee consisted of a research supervisor and three other highly-qualified researchers, plus an external examiner, the technique of peer examination was followed. Credibility of the data was also enhanced because the relationship between the study population and the researcher was not provider/client, but rather community researcher and community member (Schilder *et al.*, 2001).

To reiterate, reflexivity and triangulation are two strategies which are useful for establishing more than one criterion, and hence receive detailed discussion herein, and in qualitative methodologies in general.

### *Reflexivity*

Hall (1996) states:

reflexivity...begins with being self-conscious (to the extent that this possible) about how one's doing of the research as well what one brings to it (previous experience, knowledge, values, beliefs and a priori concepts) shapes the way the data are interpreted and treated. An account of researcher constitutiveness is completed when this awareness is incorporated in the research report (p.30).

In qualitative research, the researcher may become so immersed with the informants that he or she may have difficulty separating his or her own experience from that of the informants. Reflexivity refers to the assessment of the influence of the investigator's own background (personal history), perceptions and interests on the qualitative research process. This was included in Chapter One in the section "Autobiographically Situating the Researcher."

On entering a new culture, the researcher must continuously reflect on one's characteristics and examine how they influence data gathering and analysis. One of the ways that researchers can describe and interpret their own behaviour and experiences within the research process is to keep a field journal. Rather than a formal research journal, I kept: rough handwritten notes; emails to committee members, colleagues and friends expressing my frustrations; entries on my calendar; or entered notes directly into a Microsoft Word document. The daily schedule and logistics of the study were kept. Also, I recorded my thoughts, feelings, ideas, and hypotheses generated from contact with

informants, as well as questions, problems, and frustrations concerning the overall research process.

### *Triangulation*

The most common term used in connection with qualitative data collection, analysis and confirmation issues is triangulation. Triangulation is a strategy for enhancing qualitative research, particularly credibility. A general prescription has been to pick sources that have different biases, different strengths, so they can complement one another (Huberman and Miles, 1994, p.438). Triangulation is the use of multiple methods in order to obtain more thorough coverage of a subject by viewing it from different angles. This can be achieved in two ways: by using different methods for different questions about the same topic, or by using different methods to explore the same set of questions” (Ristock & Pennell, 1996, p.51). Lather states that “*triangulation* is critical in establishing data-trustworthiness, a triangulation expanded beyond the psychometric definition of multiple measures to include multiple data sources, methods, and theoretical schemes. The researcher must consciously utilize designs that allow counterpatterns as well as convergence if data are to be credible” (1986, p.270, italics in original). This minimizes distortion from a single data source or from a biased researcher (Krefting, 1991).

In this study, triangulation (the collection of data from different sources using different methods/strategies) was achieved by incorporating a literature review, document analysis, participant observation, and interviews from a variety of informants. Theoretical triangulation occurred in that diverse theories or bodies of knowledge were incorporated into the conceptual framework, including primary health care, health promotion, population health, accessibility and gay men’s health. Triangulation may also occur in a

study in which there is a research team, as opposed to a single researcher; however, in this case, one researcher was responsible for data collection and analysis, with other members of the research team providing input as necessary.

### *Transferability*

Transferability refers to circumstances when findings fit into contexts outside the study situation that are determined by the degree of similarity or goodness of fit between the two contexts. Lincoln and Guba (1985) note that transferability is more the responsibility of the person wanting to transfer the findings to another situation or population than that of the original researcher, and therefore, I provided substantial information about the informants and the setting to allow others to assess how transferable the findings are; however, Krefting (1991) argues that if an assumption is made at the beginning of the study that the findings are descriptive in nature, the transferability criterion may not be relevant. A key factor in the transferability of data is the representativeness of the informants for the particular group. One strategy to address transferability in sample selection is to use experts to help in the selection of informants, also known as nominated sampling. This was employed to some degree since the Health Centre's manager and lead physician suggested possible, highly knowledgeable informants. It is important to note that every community health centre has its own personality, even within the same jurisdiction, since the community health centre administers policies in different ways and to varying degrees.

### *Dependability*

In quantitative research, reliability is the criterion concerned with the stability, consistency and equivalence in the study; however, if one subscribes to multiple realities,

the notion of reliability is no longer relevant. In qualitative research, the key is to learn from informants rather to “control” them (as in randomised control trials). Qualitative methods are tailored to the research situation, and there are no methodological shorthand descriptions commonly used in quantitative studies. Thus, dependability is the concept that refers to the trackable variability that is expected in qualitative research.

Dependability is achieved by describing exact methods of data gathering, analysis and interpretation in qualitative research. Triangulation of methods (discussed earlier) also enhances dependability, as does peer examination. This is a shift in health care research which often focuses on randomised control trials/quantitative research.

### *Neutrality*

The fourth criterion of trustworthiness is neutrality, the freedom from bias in research procedures and results. Neutrality refers to the degree to which findings are the function solely of the informants and conditions of the research, and not of other biases, motivations and perspectives (Guba, 1981). Lincoln and Guba (1985) shifted emphasis of neutrality in qualitative research from the researcher to the data, so that rather than looking at the neutrality of the investigator, the neutrality of the data is considered. Guba (1981) described the audit strategy as the major technique for establishing neutrality. This strategy involves an external auditor attempting to follow through the natural progression of events in a project to try to understand how and why decisions were made. Auditability suggests that another researcher could arrive at comparable conclusions. This was similar to the review process by the research supervisor, three other thesis committee members and an external examiner. Triangulation and reflexivity are also useful in the establishment of neutrality (discussed previously).

## Summary

This chapter outlined the research design strategies and processes that guided this examination of how the Three Bridges Community Health Centre conceptualises and addresses accessibility for gay men. This research was located in an interpretivist paradigm with a critical perspective, and employed a case study research design. The research was descriptive and exploratory. The development of the conceptual (accessibility) framework was ongoing throughout the research process, and the final version incorporated literature from primary health care, health promotion/population health, accessibility, community health centres and gay men's health. The final framework was also based on the research question(s), the researcher's personal knowledge of the subject area, and the data itself.

The site selection and population sampling began by negotiating entry through informal introductions and meetings with champions of the research at Three Bridges Community Health Centre, notably Dr. Peter Granger. After a research proposal was accepted by the thesis committee, ethical approval was sought and received from the V/RHB and the University of British Columbia. The Three Bridges Community Health Centre was chosen because entry was possible; it provided a rich mix of processes, people (including gay clients), interactions and structures; and good relationships with participants was likely. This research used non-probabilistic (purposive and theoretical) sampling since the research was not meant to be generalizable, but rather to delve into a complex phenomena – accessibility for gay men at a community health centre.

The three data collection methods employed were archival materials (25 documents), participant observation (approximately 33 hours) and semi-structured

interviews (11 staff and 3 client interviews). Many documents were dated, particularly since the V/RHB was replaced by the VCHA. Participant observation was also limited because of the mostly one-on-one, treatment-oriented service delivery. The interviews provided the greatest data source.

After data collection, interviews were transcribed and entered into a qualitative software package – NUD\*IST 4.0. All data was coded initially by asking ‘What is this about?’ and text units that did not fit into the original coding scheme (conceptual framework) were given a new code. The data was then combed through several times to establish familiarity. Through subsequent reviews, the content (text units) under various themes were reviewed and revised, and codes were collapsed, shifted, expanded or deleted as appropriate. The trustworthiness of the data was established in various ways, including the collection of data from different sources using different methods/strategies (triangulation), and the use of a thesis committee and external examiner were consistent with notions of credibility and neutrality. (See Appendix J for a summary of major aspects of the research design.)

## **CHAPTER FOUR RESULTS**

### **Introduction**

In this chapter, I discuss the relevant components of accessibility for gay men as conceptualized and practiced at the Three Bridges Community Health Centre. For the sake of brevity, the Three Bridges Community Health Centre is occasionally referred to as “Three Bridges” or “the clinic.” For confidentiality, the names of informants are not given, but are identified by a number after quotes, such as [Staff 1] or [Client 2]. In this chapter, the term “informants” is used to encompass both staff and client interviewees. The term “staff” includes full-time, part-time and seconded providers or staff of the Vancouver Coastal Health Authority. When specific information is attributed to “clients,” it refers to the three gay male interviewees.

This chapter is organized around the framework of accessibility discussed in Chapter Three (see Figure 3.1). Each element of the framework corresponds to a major section in this chapter. These elements/sections include:

1. A Mission of Accessibility for Vulnerable Populations
2. Assessment of Gay Men’s Health Issues, Barriers and Needs
3. Utilization of the Clinic
4. Delivery of Appropriate Programs & Services
5. Available Providers With Appropriate Knowledge, Attitudes and Behaviour
6. Cultural Accessibility (Gay-Friendly Environment)
7. Geographic Accessibility (Location)
8. Physical Accessibility (Architecture)
9. Financial Accessibility (Affordability)
10. Functional Accessibility (Convenience)
11. Awareness (Marketing & Publicity)
12. Partners in Accessibility

The first three major sections provide the contextual background for the reader to assess the legitimacy of the subsequent strategies to address access for gay men at Three

Bridges. These three sections would also be prerequisites for any primary care setting about to embark upon an examination of how (well) it addresses access for gay men, and other vulnerable populations. The remainder of the chapter has nine major sections on how accessibility is conceptualized and practiced at the clinic. Each of the twelve major sections of this chapter details how Three Bridges addresses each of these elements (the strengths), the challenges in addressing these issues, as well as informants' suggestions for improving accessibility.

#### *Background of Three Bridges Community Health Centre*

The Three Bridges Community Health Centre actually began as the Downtown South Community Health Centre. The Downtown South Community Health Centre was opened on Seymour Street in December 1995. It was a partnership of the Vancouver Health Department, St. Paul's Hospital, Alcohol and Drug Services, Greater Vancouver Mental Health Society, and the Downtown Granville Tenants Association. A report released in 1990 had demonstrated that the majority of Downtown South residents were using St. Paul's Hospital emergency department as their primary health care provider, and that many clients did not have a family physician and/or did not feel welcome in a regular practice. The Downtown South Community Health Centre provided community-based, multi-disciplinary and integrated care to low-income residents on a drop-in basis. Physicians from St. Paul's Family Practice Unit were relocated to the Centre to not only bring services closer to residents, but also to reduce the inappropriate utilization of St. Paul's Emergency Department. During the provincial and regional health care restructuring of 1997, the Downtown South Community Health Centre joined the

Vancouver/Richmond Health Board (V/RHB). It operated for approximately three years before being relocated and reconfigured as the Three Bridges Community Health Centre.

*We simply opened the doors and thought we would develop programs... depending on who came to us.... We haven't really had a moment to breathe for six and a half years. Those of us who are gay on staff...hoped that we would have a big queer community involvement, and...that ended up being so. Had any of us been hired more in advance...I think we would have done clear outreach to the queer...community. [Staff 4]*

The Three Bridge Community Health Centre opened in late June 2000, and brought together staff and services of the former V/RHB that had been previously separated. It included staff and services of the former Downtown South Community Health Centre; community health services staff of the “Adult/Older Adult program” and the “Infant/Child/Youth program;” and staff of the community and public involvement committee of the V/RHB. The former V/RHB created the Three Bridges Community Health Centre with the expectation that they would serve residents living, and persons working, in the area. When the Downtown South Community Health Centre, and the subsequent Three Bridges Community Health Centre opened, they did not target their services to any specific populations beyond people living or working in the area.

### **Developing a Mission of Accessibility for Vulnerable Populations**

A Three Bridges’ orientation handout states, “Our mission is to provide high quality, comprehensive health care to the local population.” Although the Three Bridges Community Health Centre was unsure what marginalized populations it would serve in the beginning, it was sure it would be serving at-risk populations. Since its inception as the Downtown South Community Health Centre, the current Three Bridges Community

Health Centre has attempted to increase access for folks who have difficulty receiving health care in the mainstream system.

*Because our clinic is a free clinic...we're really set up here to provide care to people for whom there are...real, dramatic barriers meaning economic, racial and as well as homophobia. Most of the more well-heeled...gay men...are not really for us. [Staff 4]*

They purposefully target vulnerable or at-risk populations with multiple barriers to accessing services. This may include gay men who have trouble accessing the fee-for-service system.

*For high-functioning gay men, they enter the system here, but most of them will be happier in a regular physician practice which often helps with accessibility because it opens the door for other vulnerable populations to be seen. [Staff 7]*

By assisting some clients locate providers in private practice, this allows providers to see more marginalized populations, and also people not accessing the clinic may prefer a setting which does not have a focus on marginalized populations.

*I love encouraging people who haven't had a great beginning, and that's certainly most of the people that I see.... And here they are, miraculously still alive...and trying to find their way in the world.... I have never felt like I would be a counsellor for what...the worried-well. I'm not that interested in working with people who are well-educated, forgive me, well-funded, and who are whining. [Staff 4]*

Community health centres are often the safety net for people who fall through the cracks of the regular system, but as a staff member stated, “*if you throw a bunch of higher socio-economic gay, straight men, women into this soup, they're not going to feel comfortable, but I don't feel so bad...that's what we're here for*” [Staff 3]. Another informant cautioned, “*I don't think we can be all things to all people as much as we might like*” [Staff 1].

### **Assessment of Gay Men's Health Issues, Barriers and Needs**

Making community-based services accessible usually begins by identifying and assessing the needs of the population. In program planning theory, most organizations would assess the health issues and needs of the community first and develop a mission accordingly. Three Bridges continually assesses the community that they are serving and develops programs accordingly. Many of the mechanisms undertaken by the clinic to enhance access for gay men were developed, either formally or informally, by assessing the health issues and needs of this population around primary health care delivery. Therefore, before fully elucidating how the Three Bridges Community Health Centre conceptualizes and practices the notion of accessibility, it is important to characterize the gay male population of the clinic.

#### *Health Issues*

Informants identified the health issues/needs of gay men as information and treatment of drug problems, that is, substance abuse (*e.g.*, alcohol, heroin, cocaine, steroids, party drugs - crystal-methamphetamine and Ecstasy); smoking; mental health issues (*e.g.* depression); violence (hate crimes and domestic abuse); information, testing and treatment of sexually transmitted diseases (STDs) (*e.g.*, anal warts, HIV/AIDS, hepatitis A, B and C); information on safer sex practices; information or treatment on sexuality issues (*e.g.*, impotence, safer sex and sexual addiction); information on or access to complementary therapies; eating disorders and body image problems (*e.g.*, steroid use, starvation, over-exercising); self-esteem issues (*e.g.*, self-hatred, fear of loss of status, perfectionism); grief and loss; childhood sexual abuse; social isolation; and "coming out." These issues are, of course, in addition to "regular" men's health issues, whatever

their sexual orientation; however, in gay men's minds, the predominant health issue is HIV/AIDS. As one informant stated, "*You don't hear gay men talking about, do they have the same risks for heart disease as other men; do they have the same risk around this or that*" [Staff 8].

*I think that one of the issues for the gay men's population is that for quite some time health was focused on HIV and AIDS, and that there's a lot more to it than that, but that's...been the spotlight that's blinding people to everything else because it's been such a life and death issue.* [Staff 8]

The **relationship** between health issues was also noted by informants, such as the abuse of drugs with body image problems and HIV. Some informants felt that these issues were more common in the gay male clientele accessing services at Three Bridges than the gay male population seeking care elsewhere.

*I think one of our biggest concerns is that gay guys do not have good self-esteem, and that puts them at risk for a lot of things, STDs, HIV particularly, and substance use.* [Staff 9]

The only thing that all gay men have in common is their sexual orientation, and thus, "*gay culture fixates on sex*" [Staff 3]. Party drugs (e.g., crystal-methamphetamine, Ecstasy, and Viagra) and alcohol are widespread on the gay party scene. This culture reinforces substance misuse/abuse and makes gay men susceptible to illness and disease.

*I have friends who have substance abuse problems and...they don't want to be around other people and have that... thrown in their face. They only want to hang around other people that are doing the same thing that they are, so they'll avoid anybody whose going to confront them.* [Staff 10]

Other informants, particularly community developers, constructed health issues in terms of the "determinants of health" such as socio-economic status, housing, and access to culturally-sensitive services, but cautioned, "*when people think about gay men's health...they don't necessarily think about broad determinants of health*" [Staff 8]. A

client who was interviewed also noted the relationship between health and socio-economic status.

*I think all these issues are co-relating because poverty, if you take that as a core issue, you'll find that these [things] like...monetary, social and health, they're all interrelated. [Client 3]*

### *Internalized Homophobia*

Informants frequently noted the relationship between gay men's health issues and oppression. Internalized homophobia, heterosexism, and/or a lack of self-esteem were stated by informants to be related to the abuse of alcohol and drugs, unsafe sex practices and a lack of career direction among some clients. Employed, gay male clientele frequently conceal their sexual orientation from employers fearing discrimination.

*Gayness has always been a liability, especially in gay men's minds. Even the men I work with [counsel], they say... 'I won't get advanced,' and they'll sit here and talk about, 'what if people find out.' So rather than people finding [help], you go home and drug yourself to a stupor. [Staff 11]*

*Gay men don't believe they have a right to health.... I think so many gay men treat themselves so poorly 'cause they really do believe that internally that 'I'm not entitled to this. I won't ask. This won't be given to me.' The tenet of that is so strong in people's minds, still, even young people have that still. It's so hard to hear at times. [Staff 11]*

Some providers stated that homosexuality had affected gay men's psycho-social development and thus "*they have no career direction [and] they're out of focus*" [Staff 11].

### *Barriers in the Health System for Gay Men*

Systemic barriers to the access of health services may include race, sex, sexual orientation, age, housing, culture, religion, language, physical or mental disability, and socio-economic status. These factors may also affect a person's health status, and thus

making allowances for these factors is critical in providing access to services, health and health status. The barriers that the gay male clientele of Three Bridges face are related to their sexual orientation, as well as these other barriers, such as low socio-economic status. Accordingly, most of the clients have **multiple** barriers to accessing care, in addition to their sexual orientation. There was a perception by most informants that the health system was heterosexist and homophobic for gay clients and gay providers. This not only affected the quality of care that clients received, but also providers' ability to work in or create a gay-friendly environment. Many providers felt the other health care settings, particularly hospitals, were particularly homophobic and heterosexist. Three Bridges staff were asked their *perceptions* about barriers that gay men may face in accessing health services, as well as specific incidents/factors that clients may have mentioned to them.

#### *Fear of Homophobia and a Lack of Confidentiality*

Providers mentioned that some gay men do not feel comfortable disclosing their sexual orientation for fear of homophobia, fear of judgment, and fear of a lack of confidentiality. These fears and previous homophobic encounters with health professionals may lead gay men to edit their stories to sound heterosexual.

*I think it's very difficult for gay men to go and talk openly about who they are and what they do in terms of their sexual practices and how many partners they have, and whatever the realities of their life is, and feel like that's going to be okay, so access is an issue. [Staff 4]*

These fears were an issue, particularly for youth and gay men "coming out," because they feared their sexual orientation would be revealed.

*It's amazing how much coming out... can affect a person's comfort in the early stages in accessing health care and being open with their physician. So a lot of people are either, 'stop, don't talk about that aspect' or they*

*stop going to their doctors because there's that connection to their family.*  
[Staff 2]

*I can imagine for a young man who's questioning his sexuality or realizing he's gay, you've got a very vulnerable period there...and so having that kind of ability to support and educate someone at that stage of their life...is really critical...so that horrendous things don't happen to them at a stage where they just didn't have the information and education they needed.* [Staff 1]

Some gay men may not know how to introduce the subject of their sexual orientation with providers, or know how to ask questions about sexuality if their provider is unaware they are gay (or about things like safer sex, steroid use, party drugs). When some clients did disclose their sexual orientation, they felt lectured to if they received treatment for an STD, and/or the provider insisted the client have an HIV/AIDS test because of their sexual orientation. Providers at Three Bridges also mentioned that some gay clients felt that other providers did not respect gay men's partners, or they felt they were treated differently, or judged. Clients interviewed affirmed many of the barriers articulated by providers. They feared a lack of confidentiality.

*I [went to Three Bridges the first time because] I needed something treated...anal warts. I didn't want to go to my family physician because they code it for payment on MSP [Medical Services Plan], which would reveal the treatment, whereas Three Bridges does not bill MSP. I was afraid it would be revealed to my employer because my job requires a security check.* [Client 2]

Heterosexist intake forms that do not allow the option for a same-sex partner were also mentioned as a barrier. Homophobia was believed to be more pronounced for effeminate/androgynous gay men, or transgender gay men.

*Depending on how you present as a gay man...the way you speak, the way you walk, the way you talk, the clothes you wear - if it tends to be outside the norm, that in itself in the waiting room setting can create a barrier. If you are flamboyant and wear more feminine clothing, people in the*

*waiting room point and stare or ... people will label you as transsexual and it has nothing to do with that at all. [Staff 3]*

### *Providers' and Clients' Lack of Knowledge*

Lack of understanding of how the health system works or what services are available may also limit gay men's access to services. Other barriers identified were provider-based, such as providers' lack of knowledge of gay men's health issues.

*I think you [can] have a very open, friendly, wonderful family physician or walk-in clinic who is missing a whole proportion of things that only tend to occur in gay men, in terms of screening and prevention. [Staff 3]*

*I don't think clients should have to be put in the position...of necessarily being the educator. ...You want be able to get service, not to have to spend the time educating your provider. [Staff 1]*

Some gay men do not introduce their sexual orientation because they believe that their health care providers would not know about queer issues, or felt their sexual orientation was minimized.

*I found that doctors in the past have pretended that...[my sexual orientation] is not a big deal, like...there was a gay doctor, but that itself doesn't change [things], especially if they're in a private practice because you're still another number. [Client 3]*

The counsellors of Three Bridges mentioned their clients' previous experiences with psychiatry and counselling, often when the clients were teenagers and sent by parents. According to providers, some of their gay clients have either experienced "reparative therapy,"<sup>26</sup> did not disclose their sexual orientation to mental health professionals, or created a heterosexual persona. These experiences often have contributed to gay men's negative self-concepts, more than they have been helpful. The

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<sup>26</sup> Reparative therapy refers to any formal attempt to change a person's sexual orientation from homosexual to heterosexual.

health care providers may not have been aware of their clients' sexual orientation, or felt that by minimizing it, it would help their clients.

*The biggest complaint area I would say from gay men would be around psychiatry.... They got a lot of reassurance around 'Oh, I'm sure this is just a little pattern in your teens. It'll pass; we all go through it'. That kind of really dismissive [attitude], instead of looking a little deeper to see...really where this person is at. [Staff 4]*

*Ten years later, they're struggling with the same issue because they didn't address the issue, and... it just created...more psychological harm because...they created this whole other persona... unbeknownst to the therapist who probably was good intentioned. [Staff 11]*

Providers also believed that there was a greater difficulty accessing mental health services (i.e., counselling) than physician services because of financial barriers.

#### *Barriers with Gay Physicians*

There is often an expectation among gay men that they will receive better care if their health professional is also gay. However, providers at Three Bridges noted sometimes gay men do not want to reveal to their gay physician that they may have exposed themselves to, or contracted an STD.

*Oh, they're embarrassed to tell their gay physician that they have [an STD]. They're presenting themselves from their status, 'Oh, look at me, I've got this nice job. I'm not casual in my sexual relationships.' They're doing this because most of the gay physicians are high status when you look at them collectively as a group. [Staff 11]*

Things such as personality conflicts between providers and clients, or even abuse, were also attributed to gay men's poor experiences with gay providers.

*Another interesting group are the ones who feel, actually, that they have been abused in some way shape or form by other queer identifying health professionals...whether it's physical, emotional or sexual, but boy do the stories ever go round and round, and usually about the same two or three physicians. [Staff 3]*

Internalized homophobia was also reported to be prevalent among gay male providers, which resulted in these providers being “overachievers” and in a state of “burn-out.” This was deemed a poor model (of behaviour) to project to clients and other providers. There was also a concern that this taboo is not discussed or acknowledged among gay providers either in an informal (social support), casual, or professional context.

#### *Lack of Availability of “Out” Gay or Gay-Positive Physicians*

The lack of available gay providers was seen as a barrier for gay men accessing health services; a staff member commented, “ask me to name even 5 gay doctors, I can't do it.” It was believed to be especially acute for gay men seeking physicians, and even more problematic for transgender people.<sup>27</sup> Lesbian, gay and bisexual physicians who are closeted were seen as contributing to the difficulty of gay men accessing health services.

*If you were a gay man who actually was really comfortable with a woman and thought I could go see a dyke...and I'm actually more comfortable talking to women... 'cause that's so often true.... The gay men physicians are full, and the lesbians are not out 'cause they don't feel so safe. [Staff 4]*

Accordingly, there was a problem for clients identifying queer professionals. Internalized homophobia of providers was also attributed to providers not identifying as gay.

#### *Barriers Not (Directly) Related To Sexual Orientation*

Other barriers faced by some of the gay men that access services at Three Bridges were not *directly* related to their sexual orientation. These barriers include: lower socio-economic status, poor literacy skills, alcohol and drug problems, mental health issues, mental and physical disabilities (e.g., hearing impaired), race, barriers for immigrants and

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<sup>27</sup> A review of the 2001/2002 *Gay and Lesbian Business Association of Greater Vancouver Directory* revealed 1 physician; 17 counsellors/practices; 9 dentists/practices; and 7 opticians/optometrists' practices. These are “businesses who are gay and lesbian friendly” (p.10).

refugees (e.g. language), and barriers for male sex-trade workers or transsexual gay men.

Often these barriers are compounded by sexual orientation, and vice versa.

*One of the worst things...is care cards...because you're working with people who don't file their taxes, they have no money, they can't get through to the care card people on the phone, they don't have a computer to do it over the internet, and they can wait weeks and weeks.... And so they come to Three Bridges, they can't go see a doctor anywhere else, and even if they come to Three Bridges and then they get referred out, they can't go to the referral because they don't have a care card. [Staff 6]*

Two of the three clients interviewed spoke of barriers in their past health care experiences, such as doctors not taking their medical complaints seriously, or physicians not willing to complete paperwork for disability or food supplements. As "Client 3" stated, "as soon as they know that you're on disability...doctors don't treat you very well." These barriers were not necessarily due to their sexual orientation, but often related to their socio-economic status. For instance, a walk-in clinic required a fee for one client to transfer his file to Three Bridges.

*I'm tired of conventional clinic[s] where you're just treated as another number...they're just concerned about your wallet...or the very short time [of appointments], and they do not listen half the time, and they're not sensitive to my situation monetarily or otherwise, beyond my sexuality. [Client 3]*

The barriers identified by clients also related to the structure of the fee-for-service system, and its inability to accommodate a holistic approach to health. When asked to characterize his past health care experiences, one client responded, "they have displayed...insensitivity in the past with respect to sexual orientation, class, identity or even my status as a mental patient" [Client 3].

## Utilization

The Three Bridges Community Health Centre was created by the former V/RHB to serve the population that lives and works in the area. The clinic website lists the following populations as clients: seniors, families with young children, single professionals, gay and lesbian people, street youth, and individuals with addictions. The clinic population is quite diverse, and this creates tensions at times at the clinic, particularly in the waiting area, such as individuals feeling unsafe, unwelcome or that they do not belong.

*It's hard...because there's such a mixture of people who come here...from street kids who come in, and people who just want to do needle exchange and go out, and others who want to read something while they're sitting, and the girl who would bring her pet rat, and the mother who wouldn't want to come in with her child because she was there.... Serving a wide variety is very difficult. [Staff 5]*

The tensions of serving a wide variety of clients are further discussed in other sections.

All populations using the clinic have unique access issues, but some of these issues are not mutually exclusive. Given the clinic's diversity, it was somewhat difficult for the staff to characterize the gay male clientele, or even the general clinic clientele for that matter, since there are no limitations on who can access services there. Also, since there are different populations using multiple services at Three Bridges, different providers characterize the clientele differently.

A provider stated that the clinic had a clientele of 18,000. Estimates of the queer population range from 3,600 (20%) to 4,500 (25%) which predominately includes gay men and transgender folks. Although the clinic is queer-friendly, bisexuals and lesbians tend not to use Three Bridges because they often do not live in the area. No hard data exists as to the client composition, including sexual orientation and gender identity. As one provider stated, *"It's all anecdotal, and subjective because I'm just going by what I*

see, and what we think" [Staff 10]. Another provider noted, "*We don't track [sexual orientation], because being queer isn't a health problem*" [Staff 4].

Not surprisingly, the providers of Three Bridges CHC used terms and expressions like, "*diverse*," "*varied*" or "*running the gamut*" to describe the clinic's clientele, including gay men. The gay male clients of Three Bridges often had multiple barriers, and were believed to be more likely to be seeking care in the health care system after a period of no care, poor care, or previously having used their parents' providers.

*I think it's really complex how it works in people's minds. They get to a place where they... say 'Okay, oh my god, this is really killing me. I've got to see a doctor.' Then they say, 'Okay, what's it going to mean for me to go to a doctor.' And in a lot of cases, if it means more work because...it also means...getting their acts together...not just their health issues, but it means they have to look at financial issues. It means they have to look at actually getting to the appointment, so in a lot of cases we're seeing people who are in that stage.* [Staff 6]

Some gay men will delay seeking care because of the perceived or real barriers they might/will face, which may exacerbate their illness. Accordingly, by the time some of these clients access care at Three Bridges Community Health Centre, they may have numerous health issues that need to be addressed or have heightened illnesses. Many clients at Three Bridges, including gay men, often do not seek preventive medicine practices either. Many of the providers also described these men as leading "chaotic" or "unstructured" lives, meaning they may have had drug problems, unstable housing, unstable personal relationships, and low socio-economic status.

The staff generally characterized the gay male clientele as having a tendency "*to see more of a lower end, in terms of socio-economic status of the gay community.*" As in the general population, gay clients of the clinic were employed, underemployed,

unemployed (on employment assistance, social assistance, or had no financial assistance), on disability, or enrolled in secondary or post-secondary school.

The age of the clinic's clientele, including the gay male clientele, "*tends to be younger as opposed to older.*" The clinic, however, has clients at all ages. Most of the clinic's clientele, including gay men, are Caucasian. Other races mentioned included First Nations and Asian. Unstable/inadequate or no housing was identified as an issue for some gay men, and other clientele of the clinic. For instance, some clients live in hotels on Granville Street (two blocks from the clinic). Social support systems for gay men (partners, friends and family) and social connectedness to the gay community was also varied.

Some gay males seek care at Three Bridges CHC for only some health issues, such as STD testing or treatment, and choose to seek care with another primary care provider for other health issues.

*Some people come to us who are not out to their doc or who are not comfortable talking to their doc, or not enough knowledge from their regular doctor, so they just come here for sexual health issues or gay men's issues. [Staff 2]*

Although the "well-heeled" do attend Three Bridges, they tend to enter the system there, or seek care only on occasion. One staff member described these gay men as, "*a bit more bugged-eyed and freaked out when they come to the clinic because...they'll come and see the health nurse to get a screening, but we will not see them again... until they're in crisis and they don't want to go to their family doctor*" [Staff 6]. This sentiment was affirmed by another provider.

*Snotty gay men think that we are...a street-bound clinic so they don't want to come here, God forbid. Although they'll sneak in here to get STD testing*

*I've noticed. They're not shy to put on the glasses and the hat to get in here. [Staff 11]*

The staff also characterized gay males not typically accessing the clinic. They were characterized as being more educated, having a higher socio-economic status, and having better support systems. They may be seeing fee-for-service physicians or Spectrum.<sup>28</sup>

*I think a lot of...out, gay men who have resilience, strength, education, higher socio-economic can get over or pass barriers. Here we don't see a whole lot of that group; we see [people who] have another X on their forehead, or another major barrier-creating issue. [Staff 3]*

When it came to suggestions for improvement around various population groups, providers felt that they were addressing as many groups/clients as they could given their single location and current resources. Three population groups were singled out as needing health services: immigrants and refugees, street youth, and seniors, with the most concern for seniors because “*when you have a waiting room full of folks who are young, sometimes addicted, sometimes a little stressed out...that's not an atmosphere where a senior would necessarily feel comfortable*” [Staff 1]. The West End has a considerable population of senior citizens.

#### *A Profile of the Three Clients Interviewed*

Below are profiles of the three clients interviewed. Their stories not only helped to personalize the research, but confirmed the providers' characterizations of the clientele. The clients were aged 24, 34 and 39 at the time of the interviews. The three clients interviewed did not go to Three Bridges with any specific expectations about the kinds of

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<sup>28</sup> Spectrum Health, while offering a broad range of primary health care to families in the community, focuses on primary health care to patients with HIV/AIDS.

services or delivery. They based their expectations on previous experiences with traditional primary care delivery, and what they were told by the person referring them.

“Client 1” had been to Three Bridges “three or four times...over the past couple of months.” Before that, he lived in Manitoba with his family. He said that he moved to Vancouver “*because I felt very controlled, and I wanted to live my own life, make my own choices.*” He has no housing, and stays at Covenant House some nights.

*I was very abused, used and manipulated from a lot of people, not just my friends, but some family too. But I've made it through it all, right? And I can use it all for good, right? [Client 1]*

*I can [handle], or sometimes I'll go over to the Dufferin and I'll hang out there until I run into somebody, and do a date [for money] or whatever. But I've been pretty lucky when I go and do dates, right? I don't, I usually get paid for other people doing stuff to me, right? I was kinda of thinking about going to check that “Labour Ready” [a temporary employment agency] that's over by Broadway Skytrain. I was going to go check that out tomorrow if things work out. [Client 1]*

“Client 2” had been going to Three Bridges for 15 months for the treatment of anal warts. He sought care for other health issues from a fee-for-service physician. He had a good support system, was educated and employed, and had stable housing. He is South Asian (Indo-Canadian). Other than his current STD, he described himself as “very healthy.” He was active in the gay community with volunteer responsibilities at queer cultural events and AIDS organizations. Since he only used Three Bridges for treatment of an STD and was otherwise satisfied with the medical treatment he received elsewhere, he was less reflective on other aspects of accessibility; however, he represents an important component of the gay male clientele of the clinic.

“Client 3” had been going to Three Bridges for “*at least 6 months if not more.*” He was born in India, and has a university degree from there, but it is only recognized a

grade twelve equivalent in British Columbia. He has lived in B.C. for 16 years. He is on disability. He noted his friends were a source of social support, but not financial support. He lives in a hotel on Granville Street. Of the three clients interviewed, he was the most reflective of his current and past health care experiences, as well as barriers in the health system.

*As a person who has been politically active in the past through media or through lobbying...for changes to [the] human rights act or the criminal code, or to get that stupid panic defence thing out of the books. I keep myself very informed, and I keep in touch with different media that cater to our interests as...queer people.... I have five years of published work with respect to sexual orientation. [Client 3]*

### **Delivery of Appropriate Services & Programs**

As stated in the introduction, the first three sections of this chapter provide a contextual backdrop of the elements that frame the issue of accessibility. Now that the clinic's mission, its overall clientele and gay men's health issues, barriers and needs have been characterized, it begs the question, how does Three Bridges address issues of access for gay men? As one provider succinctly put it, *"Well they wouldn't be coming here if they had positive experiences elsewhere"* [Staff 3].

This section details the specific programs and services the clinic provides, in part to gay men, to address the issue of accessibility. The Three Bridges Community Health Centre provides a range of health services and programs that are appropriate for gay men. The services include primary care, alcohol and drug counselling, a methadone/harm reduction program, community counselling, community health services, research projects (Vanguard and HIV Vaccine Trial), youth services, "Boys R Us," and "Pride Health Services." Two programs – Boys R Us and Pride Health Services – are discussed in

greater detail because of the uniqueness of the programs. This section will also highlight challenges in providing these services, and suggestions for improving their current services and programs, as well as suggestions for new services and programs.

The programs at Three Bridges are mostly one-on-one therapeutic/treatment-oriented. The clinic services are arranged into three client streams: primary care; youth service; and addictions (all of which may be accessed by gay men as appropriate). The clinic also has several committees for professionals involved in methadone treatment, youth, and Pride Health Services to coordinate these services.

#### *Primary Care*

The primary care stream provides primary care services to clients who may not be able to be seen by a physician in a family practice. Several physicians are members of the primary care stream, many of whom work part-time at Three Bridges Community Health Centre (five full-time equivalents). Nurse clinicians are also part of the primary care team; these registered nurses work in an expanded nursing role to provide sexually-transmitted disease screening and treatment, wound care for ambulatory clients, and other specific, medically-delegated functions.

#### *Alcohol and Drug Counselling*

Three Bridges Community Health Centre provides alcohol and drug counselling services, which has a range of addictions clientele from persons wanting to quit smoking to persons with cocaine or heroin addiction. Acupuncture is also available for persons with addiction and substance abuse through a confidential, drop-in Monday to Friday from 4:45 to 6:45 pm. Clients can self-refer to the alcohol and drug counsellor, or they can be informally referred by providers within or outside the clinic. Most of the alcohol and drug

counselling is one-on-one, and for gay men this may entail exploring the underlying causes of their addictions, such as internalized homophobia, coming out, and low self-esteem.

*I...work from a...[place so] that they begin to understand how homophobia is playing out in their lives, and...influencing their choice making...and...to get them to become their own gay cheerleader.... These are people who don't self-promote because you can't self-promote homosexuality, so...they try to promote straight-acting/straight looking, and it, of course, gets them in trouble because their souls aren't straight-acting/straight-looking - their souls are gay. [Staff 11]*

#### *Methadone/ Harm Reduction Program*

Five health professionals run the methadone program, including a gay physician. It includes a needle exchange. All methadone patients are required to undergo either one-on-one or weekly group counselling which entails “*psycho-educational stuff...low level, low engagement 'cause the program is harm reduction in nature...so we're doing information about use, problems, and that kind of stuff*” [Staff 11].

#### *Community Counselling*

A community counsellor serves two roles – social work and counselling. To meet the immediate needs of clients, she stated I provide “*solution-focused, short-term...problem-solving counselling...not psychotherapy and not long-term therapeutic work, though I sometimes will see people over a five year period here and there as perhaps crises occur*” [Staff 4]. Typical counselling with clients lasts for one to three visits. If a gay man is in a fairly critical state, but can afford to pay for counselling or cannot be referred expediently, he will be provided interim care until a long-term option becomes available. Often, the counsellors at Three Bridges first have to address clients’ past negative

experiences with the health system or health providers, particularly other counsellors and psychiatrists.

*I kind of get them balanced. Also get them focused on what their issues really are...so that when they go to a kind of therapeutic resource that's going to be ongoing for them...then they're...a little less chaotic, hopefully a little less in crisis, and a little more focused on the work that they need to do. [Staff 4]*

*Our clients are frequently not parented very well, not educated much, many of whom are very multiple problemed, and have quite a bit of difficulty with comprehension sometimes even with reading and writing. I help pave those ways to try to explain the system enough to get them through it, and encourage them to not balk, even though balking is perfectly normal. [Staff 4]*

The community counsellor also helps clients manoeuvre the health care, legal and financial systems, such as welfare, disability and Employment Insurance.

### *Community Health Services*

The community health services division of Three Bridges Community Health Centre includes Adult/Older Adult and Infant/Child/Youth programs, and is housed on the 2<sup>nd</sup> floor of the clinic. The staff of the Adult/Older Adult program includes nurses, social workers, occupational therapists, physiotherapists, a nutritionist and program support staff. These staff liaise with hospital staff to arrange services for people being discharged from hospital. General practitioners, family members and others can refer individuals with chronic or acute health care needs. One team member of the program provides a holistic assessment for each eligible client, and a personalized care plan is developed with the client.

Staff of the Infant/Child/Youth program include community health nurses, a speech-language pathologist, a nutritionist and support staff. Programs include: home

visits to new parents and newborns; consultations and referrals with daycares, preschools, schools, community centres and community agencies regarding general health issues (speech, audiology, nutrition, and dental health); communicable disease control; and an on-call telephone information in response to any general health calls from the public, Monday-Friday. The Vancouver Coastal Health Authority recently decided to revamp Adult/Older Adult and Infant/Child/Youth programs into a configuration of promotion/prevention, treatment and rehabilitation. During the time of this research, it was unclear how this would affect the configuration of services offered at Three Bridges Community Health Centre.

*Research Projects – Vanguard & Vancouver HIV Vaccine Trial*

The B.C. Centre for Excellence in HIV/AIDS has two research projects located at Three Bridges Community Health Centre. A research nurse conducts the Vanguard Project, which is a longitudinal cohort study of young men between the ages of 15 to 35 who have sex with men. It examines the prevalence and risk factors for HIV transmission. A second research nurse conducts the Vancouver HIV Vaccine Trial which is a multi-centre study being conducted throughout North America and Europe to test an investigational vaccine to prevent HIV infection. The vaccine is synthetic, so there is no risk of contracting HIV. In Vancouver, there are 105 gay men volunteering in this historic clinical trial.

Many of the clients of Three Bridges initially seek primary care at the clinic, and later become involved in the Vanguard project, or vice versa. The Vanguard project is also linked with other physicians in the community as a means to recruit research subjects. It is also a vehicle for gay men to find a gay/gay-positive physician, since some of these physicians will also see subjects from the Vanguard project as ongoing patients.

### *Youth Services*

One of Three Bridges Community Health Centre client streams is for "at risk" youth (under 26 years of age). It runs several late-afternoons and evenings every week. There is a combination of booked appointments and drop-ins.

### *Boys R Us*

"Boys R Us" is a program for male sex trade workers, which includes some gay men. A staff informant noted, *"It's not a gay program, but by definition we get an awful lot of gay men here because they are sex trade workers, but estimates range from sort of 50 to 75% of sex trade workers are gay"* [Staff 10]. The Boys R Us program has three main components: a drop-in centre; an outreach program to where the "guys" (male sex trade workers) work; and an exit program for guys wishing to leave the "business."

The first component is a drop-in centre that operates out of the meeting room at the clinic from 7 to 9 p.m. Tuesday, Wednesday and Thursday. Hot meals are offered at seven o'clock with film videos shown weekly.

*Every other Thursday, we do a life skills cooking class where the grocery coordinator from AIDS Vancouver comes and anybody who wants to do the cooking can...choose what they want to cook. Ideally, they would go out with some assistance to buy everything, and then they come at 5 o'clock and...cook the meal with a little bit of help. Some weeks that works really well; some weeks, it's just too much.* [Staff 10]

Because the drop-in hours and the clinic hours partially overlap (for one hour each evening), it enhances the likelihood that clients of Boys R Us will access health services at the clinic. This connection to the clinic also facilitates awareness of its services, so they may seek health services at other times. The coordinator of the program assists clients to access services provided by the clinic, and also links clients to external services, and helps them access disability benefits or social assistance. The drop-in outreach

program seeks to provide a “very non-judgmental, friendly environment for male sex trade workers to come and just hang out and connect with each other” [Staff 10].

*People can come in that are cross-dressing, that are going out to work, or just basically, 'I'm wearing a dress today.' And nobody cares. And that's another thing the volunteers have to be very cool about. [Staff 10]*

The second component of Boys R Us includes an outreach program, in operation while the drop-in centre is open.

*Myself and one of the volunteers do an outreach down to the stroll where the boys are working on the street, and try to identify where they're working, and respectfully do a walk by, and let the new guys know about Boys R Us. The guys that we do know, just chat to them, make sure they've got everything that they need, whether that's condoms, lub, needles, whatever. We carry cards that tell them about the drop-in, and we do that depending on the number of volunteers, and if there's enough people to leave...then we'll go out. If there aren't enough people to leave here, then that doesn't get done. [Staff 10]*

The drop-in and outreach components are volunteer-driven, and volunteers from AIDS Vancouver were singled out as being particularly effective because of their training. The role of volunteers is also “very intense and some people...couldn't handle it” due to the nature of the clientele. Various community-based agencies provide volunteers (YouthCo AIDS Society, AIDS Vancouver, and BC Persons with AIDS). Volunteers help with organizing the meal and keeping “some semblance of order while they're arriving and eating because there's not a lot of manners” [Staff 10].

*I think it's probably really good for...[the guys] to sit and talk to somebody that's ...a bit more outside of what they do, but is still getting a lot of non-judgemental acceptance from this real mainstream man or woman. There's a lot of that that helps. [Staff 10]*

The third component of Boys R Us is an exit program that draws clients from the guys that are coming to the drop-in. As the name suggests, it is for guys that are interested in leaving the sex trade. The clients enter the exit program on a contractual

basis in which they agree to work with program coordinator on a project of their choosing which might entail the creation of a brochures on safer drug use, safer sex practices, or outreach services for Aboriginal youth.

The target audience for the projects that the clients develop is often other sex trade workers. They are paid \$15/hour, which includes outreach to the stroll to distribute brochures to guys that may need some health information, may be new to Vancouver, or new to the sex trade. Half of their salary is paid upfront as they need it, and the other half is saved until they finish the program. The participation rate for the exit program is steadily increasing. There were five participants at the time of this research. Most of the exit program participants are also accessing alcohol and drug counselling, although it is not mandatory.

*Most of the guys that are actually working on the streets have drug and alcohol issues, so mostly if they want to make a change it's, 'I don't want to work anymore' or 'I want to work less' and 'I don't want to do drugs anymore' or 'I want to be doing them less.' So it's a harm reduction approach to it, rather than saying 'You can't come here unless you're clean.' It's like 'You can come here, but let's work on that.'* [Staff 10]

The exit program is also flexible in terms of how quickly participants complete it.

### *Pride Health Services*

Pride Health Services is a drop-in program designed specifically for gay men, lesbians, bisexuals and transgender (LGBT) persons who have trouble accessing mainstream services for a plethora of reasons (as discussed in the section on barriers). It seeks to provide an open and safe transitional primary-care access point for sexual minorities. Some of these clients may be youth who have not received care outside of their family's physician, people struggling with sexuality issues, such as coming out and gender identity, people new to the region, or gay men without family physicians.

*Occasionally, people come in who are really quite...unstable or dysfunctional or having difficulty coming to grips with their sexuality, and they kind of bond to this [Pride] clinic, so we see them for a while, and then we sort of gradually help them to move into another space. [Staff 9]*

Pride Health Services takes place on Thursdays from 3-6 p.m., and regular clinic operations for the general public are run concurrently to Pride Health Services, so clients from the general public likely do not know that Pride Health Services is operating at those times. This is accomplished by using a separate entrance for Pride Health Services, which is marked by a Pride (rainbow) flag, a common symbol used among LGBT people.

*We chose the hours 3-6, thinking we could catch some people who are coming after school, or after work, others during the day who aren't working, or shifts as many are. [Staff 9]*

When clients enter the Pride Health Services office, a reception person, who is the youth worker at the (Gay and Lesbian) Centre or the coordinator of the gay men's health program from AIDS Vancouver, greets them.

*My role here is a youth worker...and...sometimes youth may not want feel comfortable coming into the [Lesbian and Gay] Centre, so by me being present [at Three Bridges], and introducing myself to them, they might feel a little bit more easier...[going to the Gay and Lesbian Centre] just because they would have a familiar face. [Staff 2]*

New clients are then taken to a private office, and informed of the range of services that are provided during Pride Health Services, which includes access to a physician, a nurse clinician, an alcohol and drug counsellor and a community counsellor (as mentioned previously). An intake worker completes an intake form that includes sections on: STD screening; HIV testing; vaccination; alcohol and drug issues; mental health concerns/psychiatric counselling; housing and finances; social support; violence/abuse; health access issues; and counselling.

*Usually people come in and say 'Oh, I just need to get a prescription refilled.' It's usually not just that; it's a whole [host of] other issues. [Staff 2]*

These health professionals are all regular staff at Three Bridges Community Health Centre; their time during Pride Health Services hours are used exclusively for Pride Health Services clientele, and appointments for regular clients are not taken for these services during that time. These staff are mostly queer-identifying professionals with the occasional straight, queer-friendly professional.

The management team of Pride Health Services is a partnership that includes the manager of Three Bridges Community Health Centre, the executive director of the Centre, and the director of programs and services from AIDS Vancouver. They are responsible for its development. Service providers also meet regularly to address pertinent issues related to Pride Health Services, and to coordinate the care of clients. The coordinator of Pride Health Services acts as a bridge between the management team and the service providers; he takes direction from the management team and applies changes to policy or procedure, and also takes input from the service providers about changes that are needed, and provides the necessary follow-up.

One informant described Pride Health Services as "*a fabulous partnership*" that also assists with furthering awareness of the clinic and its services among external providers and potential clients. During Pride Health Services, there is also a transgender support group, which is facilitated by a volunteer, and may include transgender gay men. At times, representatives from other community agencies, such as YouthCo AIDS Society, are also in attendance at Pride Health Services for youth who may be dealing with issues around HIV, so youth do not have to seek out external organizations. The

clients may also be informed about activities/groups at the (LGBT) Centre to reduce social isolation by forming connections to the LGBT “community.” The Pride Health Services program tries to facilitate cultural accessibility (gay-friendly) with functional accessibility (convenience).

At times, a lack of clients has been an issue at Pride Health Services. To increase awareness (an aspect of accessibility) of Pride Health Services, special marketing / publicity of the service is targeted at the queer community. Awareness is discussed in greater detail later.

*We advertise widely in the bars, and in the baths, and in Xtra West, and everywhere we could think of, the dance places, but we didn't have a lot of business. [Staff 9]*

Once clients feel comfortable and have addressed most or all of their health needs (depending on the issue) through Pride Health Services, they then begin a transition process of being referred to the regular Three Bridges clinic, where they will often be cared for by many of the same providers, or referred to external health providers. This transition allows for new clients to enter Pride Health Services since the purpose of the program is an access point and not to provide ongoing, continuing care.

*We are only available one half day a week, so we are clear upfront...that it's a...transitional service, in that we'll see people...for a month, three months, six months, but there is an expectation that...they will move unto another primary health care provider, and we'll help them find that provider because we're unable to sustain a practice.... It tends to be quite an easy transition because it's the same room in the same clinic; it's just a different door. [Staff 3]*

Some populations have more difficulty making the transition, specifically, the transgender clients, and those with severe mental health issues.

*Some people can appear ready, you can refer them out and they won't go back again...and then we see someone two years later and they haven't*

*seen anybody since, so it's sort of like trying to find the right timing. So I think we sort of err on the side of caution which is to wait longer. [Staff 6]*

The transgender clients seem more comfortable entering through Pride Health Services' separate entrance because of possible harassment in the waiting room of the regular clinic.

*People who are transsexual...don't feel comfortable in the waiting room, and the waiting room doesn't feel comfortable with them, so that creates a bit of tricky problem for transitioning people because...what do you do when they don't feel it's a safe space, and...two years later...they're still coming to Pride Health. We're still trying to deal with that. [Staff 3]*

Three Bridges' providers have been successful in establishing rapport with external agencies to whom they mutually refer, such as the (Gay and Lesbian) Centre or the Gender Dysphoria Program at the Centre for Sexuality, Gender Identity and Reproductive Health at Vancouver Hospital and Health Sciences Centre (hereafter referred to as the Gender Dysphoria Clinic). However, as revealed previously, the lack of queer or queer-friendly health providers also makes the referral process to external providers a major challenge. This is addressed, in part, by referring to other gay physicians at Three Bridges, or a physician who works part-time at Three Bridges and at a private practice.

*But the challenge...when we're referring out, is to who do we refer, because we aren't always confident that the people that we're referring out to are as sensitive, not only to LGBT...issues, but sometimes even whether their sensitive to health access issues...because we also see a lot of people who sometimes don't have health care cards. [Staff 6]*

### *Challenges*

A "challenge" of Pride Health Services revealed during the research was that the drug and alcohol counsellor was not being utilized as much as he could be during Pride Health Services. Another challenge mentioned by an informant was the issue of the LGBT model of service delivery of Pride Health Services, in which, all sexual minorities are

served by one program at the same time, and thus one sexual minority might deter another. Also, some queer clients may not be comfortable accessing services labelled as queer, or may feel their health issue must be queer-related. As one informant stated, *“Sometimes we define the people who are coming in to use our service as a queer health-related issue. I think that could deter some people from coming actually because how does a client define what a queer health issue is or isn't.”* [Staff 2]

Some staff were also uncertain about various aspects of Pride Health Services, and desired greater information about clients’ and potential clients’ thoughts on various issues of accessibility, such as the appropriateness of the location of Pride Health Services, the appropriateness of its hours, the appropriateness of community partners, and how better to reach potential clients (advertising).

*In Pride...we have set up an outcome evaluation framework and it does involve trying to get back to clients over time to see changes based on the service here. So in microscopic ways we're trying...but our program evaluation capacity is not what it probably should be.* [Staff 1]

### *Suggestions for Improvement*

Several staff mentioned expanding Pride Health Services within Three Bridges, as well as expanding programs like Pride Health Services to other locations, including beyond the West End of Vancouver since Pride Health Services *“was originally meant as a pilot project that would spread”* [Staff 8]. Also suggested to improve Pride Health Services was to serve different sexual minorities at different times.

*I'd like to see support for Pride Health Services being open more hours, at least a couple of times a week, and have events for the gay men's community held there, so that people who might not go there for service right now, might consider going there in the future when they're a bit more familiar/comfortable with the space.* [Staff 1]

### *Challenges and Strengths of Three Bridges' Programming for Gay Men*

Several staff suggested that with their current level of resources, personnel and space, the clinic could not take on much more in the area of gay men's programming, and/or felt that it was not necessarily their responsibility, or that they were "*probably way over represented in terms of the...type of programming that we have*" [Staff 3]. They also noted that their partnerships with community-based agencies were paramount in creating accessible programming for gay men.

*We've just gotten a fairly sizeable grant from the federal government [from the Department of Justice as an anti-crime promotion] for the Boys R Us program that allows us to have a co-ordinator on a full-time basis. Again, that came because... [AIDS Vancouver, the Centre and Three Bridges] came together and said let's put this proposal in together.... So I think there's a lot of power in that kind of partnership. Sure, everyone's budget is squeezed. I imagine the next two years will be pretty brutal, but again, if we can't hang in there together, then we're not going to get anything done.* [Staff 1]

Another suggestion to augment the current programming for gay men, was to improve outreach, particularly with the assistance of other community-based agencies.

Some staff informants also suggested that program development should be done in conjunction with the community, and not based upon the perceived needs by professionals. The range of programs at Three Bridges was deemed essential to facilitating access for gay men. Research projects such as the Vanguard Project and the Vaccine study were also noted as enhancing accessibility. The openness of the staff to access other modes of therapy was also reported as a strength of the clinic by both staff and clients.

*There was a woman in the waiting room doing energy work on a bed, and she's got candles and incense, and they've got acupuncture for addiction, it's great! It just seems to be an incredibly well used place, and they're not afraid to try new stuff.* [Staff 10]

### *Suggestions for Improvement of Three Bridges Programming for Gay Men*

Informants were asked “What kinds of programs or services should be available in a community health centre for gay men?” This question allowed informants to comment, in part, on gaps at Three Bridges Community Health Centre, as well as make suggestions for improvement. Four areas were frequently mentioned as gaps in programming for gay male clients of Three Bridges; they were **mental health counselling; referrals; health promotion for gay men; and information**. Staff felt only partially responsible to alleviate programming gaps related to mental health and referrals since these gaps were issues for many users of the health care system, and should therefore be addressed by other stakeholders, such as Government of British Columbia and the Vancouver Coastal Health Authority (VCHA), and other health professionals and primary care settings. As for gaps in programming related to health promotion and information, these issues were being addressed. Efforts were constrained, however, by a lack of time, finances and personnel.

#### *Mental Health Counselling*

Informants frequently mentioned a lack of mental health counselling services for all users of the health care system in British Columbia, including gay men. Gay men and other sexual minorities were singled out as having unique issues related to their sexual orientation that need to be addressed because “*coming out or realizing...they're gay throws them off their developmental wheels*” [Staff 3].

*Mental health is a big one, but we can't do it here, as well as we would like to. And it's really not done anywhere else, so not necessarily in the sense of a psychotic illness, but in the sense of counselling for stresses and that kind of thing. We do the best we can; we can't do that much in 10 minutes. So I'm trying actually to develop what's called a shared-care*

*program, which we have a psychiatrist and a mental health counsellor on site plus resident trainees who would provide that kind of care on an ongoing basis. It's probably the biggest gap that I see. That's not just with gay men though, that's with the population of BC generally.* [Staff 9]

One informant also mentioned the need for services for gay men with serious mental illnesses; specifically, he suggested, *“a day program...to engage them; there's so many isolated mentally ill gay men in this community”* [Staff 11]. Another informant mentioned enhancing alcohol and drug counselling services for Boys R Us participants.

*I think they would really...benefit from a roundtable group session running once a week just for male sex trade workers...not quite therapy, but to talk about what they do, and...basically share in a more formal sort of setting.... The only time they talk about it is when they're at the drop-in.* [Staff 10]

Two clients (not interviewed) suggested a specific gay detox program in Vancouver because, in the words of the provider, *“they were going to detox, and they were approaching all of these ‘Well, why are they using drugs? Were you abused as a child?’ And their whole point was, ‘I started doing mostly because I was gay’”* [Staff 10].

### *Information*

Many clients and staff mentioned information gaps for clients regarding services available at Three Bridges, as well as a lack of health information on pertinent issues. Informants believed these information gaps were relevant to a discussion of accessibility. A client interviewed who exchanged sex for money, and was not reached by the Boys R Us outreach, was unaware of the Boys R Us program, although he had used primary care services at the clinic. Since he did not “hang out on the stroll,” he is not reached by their outreach efforts. It was the objective of the former V/RHB for all community health centres to have health information centres, which would offer a wide range of

information on illness, treatments, prevention, staying healthy, health services, support groups, community resources, and many other topics (V/RHB, Summer 2001).

*The people...come into Three Bridges and there's...no pamphlet racks; there's no information on anything. You...have to ask. They didn't even know what was available in this Centre. [Staff 5]*

*If they displayed...more information as far as my sexual identity goes...as to how I could make myself feel more comfortable, or... any other issues that they might seem pertinent. [Client 3]*

Distributing a brochure about the clinic's services and relevant health issues for gay men at various gay men's events, and creating events to reduce social isolation while providing information were suggested as potential means to create awareness of the clinic and its services, and to provide gay men with health information. Staff also suggested redirecting or accentuating the communication and information services at the Vancouver Coastal Health Authority (VCHA) to improve awareness of the existing services at Three Bridges Community Health Centre among the local population.

*We put out a newsletter a couple of times a year; that's as much as we can do, but it doesn't get to everybody. We need to work at that a million times better so that people know where we are. [Staff 5]*

At the time of this research, the clinic had begun to address gaps in health information and information on the services the clinic provides. The community developer was in the process of organizing a pamphlet rack at the time of this research. Currently, it is at the providers' discretion whether to inform clients of available services.

#### *Health Promotion for Gay Men*

A frequently mentioned need for programming related to gay men's health was the creation of a wellness fair (on gay men's health) in the community which would provide an opportunity for gay men to socialize and receive health information simultaneously.

At the time of this research, some providers at Three Bridges and other agencies were discussing the possibility of putting on a wellness fair or gay men's health series, which would consist of a series of events to attract gay men. Most staff informants who suggested the need of such an approach reiterated the notion that success in launching such an event would likely be related to the number of community partners that could be included in its development; however, some informants also discussed frustration in connecting with and rallying support for such events from individuals who did not provide services, as well as creating events that would appeal to a broad spectrum of gay men.

Staff informants mentioned challenges in getting information about health and social events out in the community, as well as challenges in creating social events and decreasing social isolation in the gay community. There was a sense that many queer people did not feel part of a community, or know how to meet people in a meaningful manner (*i.e.*, beyond casual encounters). Identifying community groups/leaders, and forming and maintaining significant relationships were also challenges in creating community-based gay men's health events.

Staff informants also mentioned the need for more social support groups for gay men. Three current social support or group-based programs at Three Bridges include the Boys R Us program, a social-support transgender group that meets on Thursday afternoons during Pride Health Services, and a men's group for addiction care within the methadone program. However, none of these groups are for gay men exclusively, or would be considered gay men's spaces, although they may include gay men. Through a range of providers at the clinic, gay men receive education around safer sex, issues of

coming out, and self-esteem. A suggestion was the creation of programs or social support groups that reflects the diversity of the gay community living and working in the area. Suggested topics of programs and groups were career development, spiritual health, and personal development unique to the queer community, such as coming out or self-esteem.

*Health is not about my wound. Health is about how we are in the world.  
Are we safe? Are we well housed? Can we eat?* [Staff 4]

*One of the things that...is really needed is...some kind of social support group for, apart from people who are HIV positive, because there are groups for that, for gay men who have prostate cancer, for gay men who have diabetes.... There's...a whole group of gay men that we see [that] have MS, but there's no [group for them]. In the context of gay and sex and that, these present real [concerns], like for the diabetic gay men...impotence is a big issue...You can't really go to your straight diabetes group and say 'You know I can't get it up.'* [Staff 11]

There were efforts also underway to increase preventive medicine for queer clients by physicians and nurses using a "Palm Pilot" in which clients' age and sex would be entered, and a series of periodic medical exams and vaccinations would be suggested.

### **Available Providers With Appropriate Knowledge, Attitudes and Behaviour**

To fulfill the variety of duties, services and programs at Three Bridges Community Health Centre, there are a variety of full- and part-time health providers, support staff, seconded staff, volunteers, students and medical residents. Many of the physicians actually work part-time at Three Bridges Community Health Centre with other work responsibilities at the University of British Columbia (UBC) or in a group practice. Counselling and community health services staff are typically full-time, while seconded staff for Pride Health Services and Boys R Us are from community-based agencies, such as the Centre, or AIDS Vancouver. Some seconded staff are limited to approximately a half-day per week at Three Bridges Community Health Centre. This allows the clinic to

have the expertise when needed without the requisite resources if these people were full-time; however, some seconded staff noted that such a short amount of time at the clinic limited their ability to impact accessibility and programming for gay men. These part-time arrangements allow part-time staff and seconded staff to do outreach, or to combine both their academic work and medical practice. Their other duties at UBC, AIDS Vancouver or the Centre also allow many of the queer staff to further the issue of access for gay men and other sexual minorities when they are not working at Three Bridges Community Health Centre. Since most the services at Three Bridges are one-on-one treatment-oriented, there were few opportunities for volunteers. Two programs that have social support as a component (Pride Health Services' transgender support group and Boys R Us drop-in) use volunteers.

Some of the staff are relatively new, while others have been with clinic since it was the Downtown South Community Health Centre. The front-desk staff were deemed critical by most informants in supporting access for gay men because they are the first point of contact for all clientele. Sensitivity and respect by reception staff towards queer clientele, no matter how "alternative" they are, was considered essential for a setting to be gay-friendly. The three clients interviewed described the reception staff as "*really good*" or "*great.*" Approximately fifty percent of the staff (on the first floor at Three Bridges Community Health Centre) identified themselves as gay or lesbian. Queer staff work, to varying degrees, in all three client streams of primary care, youth service, and addictions.

### *Queer Providers' Experiences with Heterosexism and Homophobia*

Some queer providers at Three Bridges recalled personally experiencing homophobia or heterosexism, and therefore they could relate to their clients' previous barriers with the health system. As one staff informant frankly stated, *"the ideal would be to have, for me to go to any doctor, and not be treated like shit if I mention that I suck cock, but that doesn't happen"* [Staff 6]. Some queer providers also reported that they had experienced oppression working in other health care environments, particularly hospitals because they are more 'closeted' and highly bureaucratic environments. Some queer providers also felt that many managers of health and social service agencies still consider homosexuality a liability, particularly when working with youth.

*I can understand...what some of the barriers are...being a physician and being gay...and having dealt with...the oppressive nature of society related to the GLTB community, though I don't feel any of that now, and haven't for a long time, I'm sure I will at some point again. But in this context...I can give suggestions and...play a role in identifying what barriers are created and what we can do to overcome those, and...broaden those concepts...to youth, and addictions who also, as communities carry significant...barriers to primary health care.... Philosophically it's all...about oppression.* [Staff 3]

*People are really welcome here and that we love them. It's more than just being here because it's our job. Many of us [are queer] and...we're really concerned with our community. That we really get what the issues are, and the kind of barriers we're up against, that everybody is up against, and we know what's going on politically as well, and how those things can affect us.* [Staff 4]

Because of the discrimination that queer people have historically experienced, the staff can also identify with struggles that go beyond sexual orientation, such as oppression related to socio-economic status or race, and many want to work in settings like Three Bridges Community Health Centre because of its mission. The staff have become champions for not only queer causes but other causes seeking "equality for all."

*It's interesting that who is interested in urban downtown health are queer and lesbians; that's who we are - we're urbanites. We're interested in those realities, so I think that's why we gravitate to the work. [Staff 11]*

Straight staff at Three Bridges were more likely to have a more functional, and less personal attachment to the queer community. This is not to negate their compassion and concerns with equity, but straight staff have had different life experiences, and (most likely) have never experienced homophobia.

*Because gay men live and work in this community, then it's critical from my perspective that they have equal access to services here at Three Bridges Community Health Centre, as any other member of the population. [Staff 1]*

Since gay providers are more likely to understand the barriers and life experiences of their gay clients, and the role of homosexuality on one's health, gay clients routinely seek out "their own kind."

*People self-select.... They say 'Oh, my friend saw you, and he said I could come and talk to you.' PWA [Persons with AIDS] call me 'cause they know me, and say 'Can I come and see you?' They're selecting because they know who I am. And they have specific addiction concerns, so it fits...or I get referrals from people who know me, like physicians in the community. [Staff 11]*

Accordingly, the presence of "out" queer staff increases the likelihood that queer people will access health services at Three Bridges. It was also noted that the presence of queer health professionals creates positive role models for clients and other personnel. Creating a gay-friendly environment is not without its challenges for queer professionals at Three Bridges since they may receive criticism from other health professionals.

*I usually say to people that I'm more interested in having [gay clients]... so...I get flack from other practitioners saying 'Well, isn't that limiting? Aren't you suppose to serve everybody?' I say 'Well, I've served everybody for 30 years, and now I want to serve my own kind.' [Staff 11]*

### *Requisite Knowledge for Providers Serving Gay Men*

As discussed previously, gay men have health issues that are unique or somewhat unique from the general population. A physician noted that an understanding of the health issues of gay men was not only related to the treatment of illnesses, but also an understanding of risk factors, preventive health and screening. He also noted that health professionals treating gay men also need an understanding of health from "*sociological, anthropological and political aspects.*"

*You need to have an understanding of anal health - it's huge. I mean gay men have anal sex, so you got to look there, and...having a good understanding that it's not just the penis. [Staff 3]*

This also underscores that when patients conceal their sexual orientation their health may be compromised. Three Bridges' staff also emphasized the importance of differentiating between sexual orientation and sexual behaviour. This is important, not only for men who have sex with men (MSM) but do not identify as gay, but it may also be part of a gay man's "coming out" process.

### *Gaps in Providers' Training*

Many of the queer and straight professionals at Three Bridges felt that there were voids in their own education around queer health, and that it was their personal interest in the queer population that facilitated their self-directed education. Health professionals stated that they "*self-taught*" or "*learned on the job.*" Some informants also noted that issues of sexuality, in general, did not receive a lot of coverage in their education.

*I had very little education...on health issues for sexual minorities. We had "all day sex day"- I think that was it.... I basically learned on the job. [Staff 7]*

Not surprisingly, the staff spoke of their personal interests in community health, health promotion and community development that *"says community defines what their health issues are, and what would be helpful to them, and our responsibility is...to try and structure those [resources] in a way that works for the clients"* [Staff 1].

Some providers also mentioned that their education actually discouraged discussions of sex.

*I was trained in what they call professional distance which is you never say anything personal. You never absolutely touch somebody even if they were sobbing out of their mind, and their child had just died.... I was trained not to talk about sex unless it absolutely had to be discussed.* [Staff 4]

#### *Enhancing Accessibility by Recruiting Queer Staff*

Recruiting gay men, or other sexual minorities, was deemed to be very important in creating an accessible environment for queer people. It was recommended that for agencies trying to be queer-friendly, recruiting of sexual minorities was essential, and increasingly possible since more queer health providers are open about their sexual orientation. Sexual minorities who are well-connected to the queer community, and aware of other services in their community, also improve access for gay men. For straight staff, the presence of queer staff helps facilitate the educational process of learning about queer identity and health issues.

*When I'm hiring staff, I'm very clear with them about who our populations are...and you need to be able to be comfortable with serving those populations...and...you need to be prepared, if you don't already have the knowledge base, to get that, and they can get that...from our existing providers...[or] from doing courses.* [Staff 1]

*You...got...to do very careful screening of staff who are being selected to make sure that they're gay-positive and not just accepting. That's a little different.* [Staff 9]

*There's no question that because we have a number of gay/lesbian providers...that really promotes...an atmosphere of being gay-friendly. Even for our providers who are not gay or lesbian, working in this environment, having that resource basically right there, so that when they run into something they aren't sure or it's new information or whatever, it's very easy to get a good answer really quickly, and also some support around learning a new skill if that's what's required. [Staff 1]*

### *Enhancing Accessibility Beyond The Clinic*

Queer staff also advocate for queer-friendly changes in the health system. Many of the providers have been engaged in the community in queer health issues and cultural events for several years. The queer professionals at Three Bridges are open about their sexual orientation in other facets of their lives. Many physicians are also faculty members at the Faculty of Medicine at UBC where they have an opportunity to improve queer health through research and teaching. In a course, "Doctor, Patient and Society" first-year medical and dental students are exposed to queer health as one part of the course's curriculum. This is only one afternoon however.

*Every year a group of...[queer physicians] go into a panel discussion for first-year [medical and dental] students...and...talk about being gay...how it was to come out.... And then we have little tutorial groups with 8 students with their regular tutor, and then a tutor who is either gay or lesbian to talk about some of the issues. [Staff 9]*

Another interdisciplinary course on HIV/AIDS for health professionals also discusses, in part, gay men's sexuality. Many informants stated that although the education of health professionals is improving in post-secondary education, more education in medical schools/residency is needed.

### *Teaching Environment*

Another way the Three Bridges Community Health Centre addresses the lack of knowledge or understanding of queer health by physicians and other health professionals

is by welcoming family practice residents into their setting. Other professional students from medicine, nursing and social work are increasingly using the clinic as a venue for training.

*There are a number of gay students who are just drawn like flies to this place [Laughing]. I don't know how they know about it, from all across the country. I get a phone call and they tell me in code, usually. And so of course I do try to accommodate. It's an important experience for them.*  
[Staff 9]

This training not only exposes them to queer-related health, but other issues and populations that the clinic serves. Family practice residents are encouraged to learn about the various social services (food, housing, counselling and transportation) that are available to patients. Many of the current staff have actually been trained at Three Bridges Community Health Centre, or at the former Downtown South Community Health Centre. Students and residents seeking short-term exposure (one week) to the clinic are typically not permitted because it detracts from patient care.

*We graduate 50 [family practice residents] a year [from UBC], so...only ...15% of the UBC residents have experience or exposure to gay men's health issues[through Three Bridges], but it's a good start. We're pretty proud of that.* [Staff 3]

There was a concern raised about the effect of a large number of students/residents on the clinic. Such a practice affected the clientele's opportunity for continuity of care by the same provider. This was especially an issue for seniors.

*There was a big concern that we should make up our mind whether we're going to be a teaching clinic or clinic that teaches, and there's a distinct difference.... So we came down...that we should be a clinic that teaches, and so I was asked to try and draw up some guidelines as to what we would be prepared to do.* [Staff 9]

### *Challenges and Suggested Improvements in the Knowledge Base of Providers*

Although the clinic facilitates the learning of queer health issues and treatment, a lack of knowledge about queer life and queer health issues by some providers was deemed an issue at Three Bridges Community Health Centre. Reception staff, residents, nurses and physicians were all singled out by various informants as needing more education to make Three Bridges a gay-friendly environment.

*I think you have to have clinicians that are knowledgeable about queer health issues, and I can't say you necessarily [have that] here 100%, probably 50%. Even queer docs don't know what some of the queer health issues are.... That comes from training; thus one of my biases is teaching...queer health issues is getting that on the table, post-graduate educational level. [Staff 3]*

*I think that we would have to do a better introduction to our reception staff, as well, perhaps to our full staff around the realities of gay life.... A whole education process [so] that the residents who come [here] who aren't gay would have [as] part of their curriculum, sexual minorities care so that we don't have to do all that work when they get to the clinic. [Staff 4]*

Suggestions to improve this lack of knowledge included better in-house training, external training<sup>29</sup>, better training on queer health issues in the curriculum of health professionals.

A social support group for queer providers was suggested as a means to connect with other professionals *"because not only does it help people stay stronger and more resilient, it helps build the connections to serve the community better"* [Staff 8].

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<sup>29</sup> The Department of Psychology at Vancouver Hospital and Health Sciences Centre conducts a one-day workshop, "Sexual Orientation Issues in Healthcare: A Best Practices Workshop for Caregivers," which includes the following topics: the nature of sexual orientation; coming out issues; gay and lesbian culture 101; homophobia; sexual orientation and the law; health issues; interviewing strategy concerning sexual orientation issues; lifespan development; barriers to optimal care; and best practices for service provision.

### *Availability of Providers*

Since a lack of available providers is a barrier for gay men in accessing primary health care, the providers at Three Bridges articulated that a part of their mandate is to address a lack of gay-friendly providers. Many physicians in family practice frequently do not accept new patients; however, such a policy does not exist at Three Bridges. An informant stated, *“there are no doctors...but...if that is a barrier...then we do need to step up to the plate.* [Staff 3]

*We are not full. We are never full that is our official policy. We will not turn them away from Three Bridges clinic.* [Staff 7]

The providers noted the issue of availability is significant for the general population, and for gay men specifically. It therefore needs to be addressed from a system-wide level.

### **Cultural Accessibility (Gay-Friendly Environment)**

As detailed in the previous section, the staff are critical in creating a gay-friendly, culturally-accessible environment. This section further details attributes of the setting that enhance cultural accessibility. Informants articulated a variety of attributes that signify a gay-friendly environment: people feeling comfortable, safe and respected (non-threatening environment); confidentiality; comfort with asking questions; non-judgemental environment; availability of appropriate printed material; welcoming through visual cues; and being free of, and sensitive to, discrimination. Most of these attributes also apply to male sex trade workers or the clinic's harm reduction program for drug users. These attributes are matters of degree rather than simply being present or absent.

*I...inform gay men who come to see me...that their lives are welcomed here.... It doesn't matter whether they're as alternative as hell, that we do*

*have, not just me, but gay staff, I don't out them automatically...because I think that's over the line, but I do say that actually many of us were hired because of who we are, and that our clinic takes a very purposeful, open approach to caring for folks. [Staff 4]*

*So here we take things much more personally, much more kindly, we develop a relationship, we make trust, we build a rapport, we internally refer, we personally introduce where we can and it's kind for the patient, and it's reasonable for the provider. [Staff 4]*

When the clinic cannot fulfill all the needs of patients, providing queer-friendly referrals was another indicator of gay-friendliness according to informants. Informants also believed the clinic had a gay-friendly reputation, which was indicated by queer people returning for care, as well as clients recommending the clinic to their friends. Having clients feel comfortable enough to disclose personal information, which they might not disclose in another setting was a goal of Three Bridges' staff. Also, the ability to ask questions was deemed important. Since some gay men only used Three Bridges at times (e.g., STD testing), providers also contacted clients' regular providers to disclose their health issue, such as HIV diagnosis, if the client requested it.

*A lot of times, once you say that this is a...highly confidential space...they become really open about what they're there for, and so I think being open about...[their sexual orientation] makes it easier for them. [Staff 2]*

While providers wanted to create an inclusive environment, their efforts were not without challenges. A mix of gay and straight clients in the methadone program has created tensions. Providers also cited local examples of HIV programs that include gay men and injection drug users (IDUs). Providers were mixed in their opinions of whether a queer-only clinic was desirable; however, providers favoured programs within the clinic exclusively for gay men.

*Mixing communities is important 'cause that's the real world.... The clinic needs to act like the best real world, the real world that you'd like to have and see, and support that. [Staff 3]*

*We have enough history with HIV to show how disastrous that was to mix those [gay men and intravenous drug users] populations. The Dr. Peter Centre is an example. The PWA drop-in lounge became a horror story. So that community of people which are so damaged and hurt, are also so incredibly rigid in their thinking, and they don't move from those positions easily ... and you feel badly about yourself anyways; it just reinforces it. So it's a real dilemma, mixing those populations. [Staff 11]*

Some of the causes of these tensions are profound.

*Addicted people are the most homophobic people in the world. Drug addicts think homosexuals gave them HIV. Come on? That's how they talk. You know perverts. We're the perverts, and they're whatever. [Staff 11]*

This is complicated by the fact that Three Bridges has “a high percentage of young men and women who were sexually abused as children and they interpret that as being homosexual in nature...and you see those tensions here” [Staff 11].

These tensions were witnessed during my participant observation. I heard a client of the acupuncture program (for people with addictions) make disparaging remarks about male sex trade workers (calling them “whores”) while I was “hanging out” in the waiting area for Pride Health Services which is across the hall from where acupuncture takes place. Ironically, this area was deemed “safer” from discrimination by staff than the main waiting room.

### *Racial and Linguistic (Cultural) Accessibility*

Most queer staff (including seconded staff) at Three Bridges Community Health Centre are Caucasian. Some informants noted however that having a variety of staff with varied races and language abilities is desirable. The staff try to accommodate requests to address language barriers through either internal or external sources.

*We do have a few other languages, but not so much in our care providers, it tends to more in the front desk staff. [Staff 1]*

*If they come to me, and they say 'I don't want to talk to you. I'm sick of talking to white chicks.' I'll be... 'Okay, here's the people we have on staff here,' in terms of the languages that are spoken, 'You have a right to talk to who you want to talk to, and maybe someone at Native Health would be better, maybe somebody at. Maybe we need an interpreter, we'll call in Mosaic.'<sup>30</sup> So depending on the circumstances, I will just try to say, 'That's okay. Of course, you're upset about that.' [Staff 4]*

A suggestion for improvement was “*to be a little bit better at welcoming people.*” Some providers felt that although they thought they did a good job at being accessible for gay men, they had some ways to go before their aspirations of a gay-friendly clinic were realized. This was especially complicated by the fact that the clinic has a diverse group of clients. After describing a hypothetical, gay-friendly clinic, a provider stated, “*I don't see a clinic in Vancouver that looks like that.... I think that we do a good job, but I don't think that's us yet either.* [Staff 4]

### *Intake Forms and Procedures*

Creating a gay-friendly environment begins with a client's interactions with staff at the front desk, continues when he completes an intake form, through to meeting with the provider. On the intake forms at Three Bridges Community Health Centre, references to sexual orientation or gender identity have been deliberately omitted. Also, the intake form does not have a space for either partner or spouse.

*That front-end staff is critical because they're your first point of entry, and if you come in there and you are cross-dressing, and the little box says M or F for your sex, for your gender, add T for Trans...and in terms training and informing your front-end staff, that they're not going to be like 'Hi Timothy' when it's very obvious that they're Cassandra. So for example, we put people's alternate name, whether they're nicknames or whether they're trans names...right on the chart. [Staff 4]*

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<sup>30</sup> Mosaic is an organization in Vancouver that provides multi-cultural services, including interpreters.

As mentioned, intake procedures at Pride Health Services are more thorough since many of its clients may not have accessed health services for some time, or have special access issues.

### *Visual Cues*

Queer people have become adept at spotting visual cues or cultural signs (most often rainbow flags or stickers), often on an exterior door to signal that the establishment is queer or queer-friendly. In the waiting area, and on the clinic's main entrance, there were no rainbow (Pride) flags/stickers. Most staff informants repeatedly stated that symbolic invitation was an important mechanism to enhance access for gay men, but ironically several informants felt that Three Bridges did not have enough rainbow flags/stickers. Small rainbow stickers were placed on some office doors, but some had been removed; however, staff were uncertain who removed them or why. Some queer informants felt that some straight staff felt a Pride flag in the waiting area might deter some straight clientele.

*I think there needs to be more clear cultural signals...and we need a big Pride flag in the waiting room. It's not going to offend anyone else, and if it does... it can be a learning experience. [Staff 3]*

*We've put...[Pride flags] all over the doors here, they take them off which is so upsetting. Maybe something more permanently attached to the clinic like this. So I think visual reassurances are a tremendous first step, so that before they even get to a care provider, they get a clear message that that's cool. [Staff 4]*

On most occasions during participant observation, there was very little reading material (gay-related or neutral). Copies of *Xtra West*, a local queer paper, were visible/available, but only for the first few days after being dropped off (every second Thursday). Other than some queer community announcements posted on the wall next to

the entrance, there were no posters on the walls. A sign posted stated: "Three Bridges Community Health Centre, where you can: Get help / Help yourself / Help Each Other." The clinic was examining the possibility of putting a statement of inclusion / diversity statement in the waiting room.

Gay providers are also more likely to have more queer-identifying cues in their offices than straight staff, which signifies not only to the gay clientele that sexual diversity is welcome, it also suggests to the straight clientele that the environment welcomes and embraces gay people (clients and providers), and that tolerance on the part of straight clientele is expected.

*We need to be identified by...putting a rainbow sticker on my door, or...making sure that in my office are symbols of gayness. That's important as opposed to going into a neutral [office].... This is me, this is my office. I project my identity, and [if] 'you're not comfortable, there are other people you can see.' [Staff 11]*

#### *Feedback from Clients*

During the interviews, staff were asked to recall any feedback they had received from clients on matters pertaining to accessibility.

*I cannot recall...in two years having anyone come in and say... 'Your staff treated me poorly because I'm a gay man.' Never. Now...I don't make the inference that we're perfect because that hasn't happened. [Staff 1]*

*They tell me it's so refreshing to be able to talk about the things they've been wanting to talk about, and that they can be open about it, and that I understand it. [Staff 4]*

The clients interviewed also said they chose Three Bridges because they wanted sensitive and confidential treatment. Clients felt the Community Health Centre as a primary care setting was better than other settings because there was a greater sense of safety, personalized service, ownership and diversity.

*I also find that the doctors [at Three Bridges] are more receptive and listen. That is the main thing, which I was pleasantly surprised.... They are very easy to accommodate me, as far as schedules go...and they're very sensitive, and they treat [me] with respect and courtesy. [Client 3]*

One client said he chose Three Bridges because of its proactive and holistic approach, and believed he could attain a greater continuum and range of services there.

*I want to make sure my doctor or my nurse is comfortable with my sexuality and...not just treat me like another conventional heterosexual person because my needs may be different.... I just feel that clinics that have public funding, or they are reliant on community services and are accountable, are more prone to provide more sensitive and more holistic services to clients than your conventional private practice. [Client 3]*

He also noted that, “private practice...actually plays a bigger role [in the quality of care] than the sexual orientation of the physician or nurse” [Client 3]. Another client felt that when he received care at Three Bridges, the nurse was unfamiliar and uncomfortable with treating anal warts, which caused him to be uncomfortable in receiving the treatment.

*She looked for someone else to do it, but couldn't find anyone. I didn't go back for a couple of weeks for treatment after that even though I'm suppose to go back every week, and, for awhile, I started booking appointments two weeks in advance so I could be assured of receiving my regular nurse. [Client 2]*

He suggested that “people who work there should be comfortable with treating these issues” [Client 2].

### **Geographic Accessibility (Location)**

Thus far, the contextual background (*i.e.*, providers' assessment of gay men's health issues, barriers and needs, and utilization of the clinic) has been discussed. The variety of programs, attributes of providers, and the setting have also been discussed. The next three sections respectively address geographic, physical and financial aspects of accessibility.

As mentioned previously, the former Downtown South Community Health Centre was begun to alleviate pressures of St. Paul's Hospital's emergency department, and to provide integrated care to individuals in the geographic area who had difficulty accessing the fee-for-service system. When the clinic moved to 1292 Hornby Street (at Drake Street) and became Three Bridges Community Health Centre, the clientele largely remained the same, however the clinic was closer to the gay neighbourhood. Staff informants were generally mixed in their opinions of the appropriateness of the location of Three Bridges Community Health Centre to attract gay men, whereas client informants felt the location was appropriate. Staff generally felt that the location was appropriate for the gay men and other marginalized populations that they do serve, but not conducive to attracting a larger gay male clientele because of a lack of visibility.

Vancouver's West End is home to the city's largest population of gay men. Although the clinic is close to the gay neighbourhood, it is located one block from the West End boundary. It is also not located in an area with a lot of pedestrian traffic.

*In terms of gay health clinic...it has to be a place that people walk by. It has to be a place that people don't feel like they're leaving their community...and I know it's six blocks, but it's not necessarily in the community. [Staff 6]*

The Three Bridges Community Health Centre was created with the expectation that it would serve persons living and working in the geographic area of "Community Health Area 1" of the Vancouver Coastal Health Authority (downtown Vancouver, the West End, Yaletown and Fairview). Because of the clinic's unique services and gay-friendly providers, they also welcome clients from outside the designated geographic area. Most staff informants were concerned that Pride Health Services was the only service of its kind in the Vancouver region, and was not particularly accessible for gay

men and other sexual minorities outside the West End. The clinic is located approximately two blocks from major bus routes.

It is more likely that the reason more gay men do not use the clinic is not because of its location, but rather a lack of *awareness* of the clinic and/or its location. However, even if the clinic were located in a more visible area for gay men, it may still not attract gay men because it may be “too visible,” or it may have a stigma because of its association with people who are poor and/or use drugs. An informant noted, “*even if you opened a beautiful, new queer health clinic, they wouldn't go because there's a...street connection*” [Staff 6]. The clinic also serves male sex trade workers who often work and live just a few blocks away.

*It's beautifully located sort of right between the more mainstream West End, and then Granville Street and the stroll [where sex trade workers work]. It's close to where all the hotels are that a lot of them live in.... It's not right on a really, really busy street. The door opens onto that patio with trees [which] I think is really, really beautifully chosen because people will come out and there will be a safe little place.* [Staff 10]

All three clients interviewed described the location of the clinic as “convenient” and an important consideration of why they sought care there. One of the three clients lives in a hotel room on Granville Street, while another client lacks stable housing and “hangs out” in the area or uses Covenant House for housing which is located approximately three blocks from the clinic (Drake Street and Seymour Street). A third client stated, “*I think it's a good location. It's convenient. I work in Yaletown, and live in Burnaby, so I can go during lunchtime*” [Client 2].

Suggestions to improve geographic accessibility/visibility included outreach, and satellite clinics in other parts of Vancouver, such as Commercial Drive and the heart of the West End. Also suggested to improve geographic accessibility was holding special

events outside the West End to increase the familiarity of the clinic “ *to build up its reputation as being queer friendly*” [Staff 8]. More clinics like Pride Health Services in other community health centres were also suggested.

*There are some challenges...because...the lesbians as being in Kits or the Eastside. Where are gay guys? Downtown. So where do you put a clinic for everybody? So maybe it's having a clinic with satellite offices which creates a connection between the geographic areas where the populations are, and there's community connection in terms of the services that are provided.* [Staff 6]

*Those clinics have got to get up to speed on a variety of issues, including GLTB health, so I'm sort of the mindset that I don't want them all coming here. The CHA [community health area] clinics should be looking after people who are in their area.... They need to actually build a safe, overall space for any queer-identifying individuals. They also need to do that for addictions.* [Staff 3]

There was a concern that there were few places where queer folks could seek care other than the West End. Staff informants also wanted other community health centres and the VCHA to address health issues for LGBT people, or to at least examine the feasibility of enhancing accessibility. This would allow providers to steer gay men geographically for continuing care.

### **Physical Accessibility (Architecture)**

Often physical accessibility only refers to wheelchair access to entrances and washrooms for people with physical disabilities. While those features are addressed at Three Bridges Community Health Centre, in this study, physical accessibility refers to the physical features of the Three Bridges building that either improve or detract from access for gay men and other clients. These features also include aspects of the building that can help or hinder the workings of a multidisciplinary team since the more smoothly service providers work together the improved quality of care clients receive. A barrier expressed

for effective multidisciplinary work was the division of staff between the first and second floors. The first floor houses the primary care team, while community health services, such as physiotherapy and homecare, are located on the second floor.

*What doesn't help...is that the staff room, where you could go to eat lunch and communicate with people, holds about 10 people, and we have a hundred working in the building.... And it's up on the second floor way over in the corner.... People hardly use it. [Staff 5]*

While providers were grateful to have more space than when they were located on Seymour Street, including a larger waiting area, more clinical space, and more community rooms, some felt more restricted than other community health centres in Vancouver. Satellite offices were suggested as a means to alleviate a lack of space. A staff informant also mentioned the clinic's high ceilings and colourful décor as positive attributes of the building.

*We don't have the third floor of this building, if we did, we would probably have mental health services up there...and that would be another improvement to access for sure. [Staff 5]*

The building has four locked doors which require a staff pass key to open, and divide the clinic into five separate, restricted areas to prevent theft and to control the unsupervised movement of clients. People entering the clinic area from the waiting room have to pass through a locked door that a receptionist opens. Providers were mixed in their opinions of whether the locked doors were barriers. A provider who mentioned it as a barrier had not received any negative feedback from clients with respect to the locked doors. Another provider felt it improved privacy for support groups.

*The way that the clinic is constructed...you can't get from this area [community rooms] into the rest of the clinic unless you've got one of the pass keys. And so... nobody can get in there, and they [Boys R Us participants] are separated and given a degree of privacy. There aren't people sort of wandering through, peeking in. [Staff 10]*

A positive attribute of the building is a separate entrance and office for Pride Health Services. On the downside, the physician's office and the nurse's office "*could not be any farther away from*" the Pride Health Services waiting area [Staff 3].

The community development office is located in a corner of the building not publicly accessible, and also distant from providers because the building's layout was designed with only a general idea of how the space would be used. Not surprisingly, many providers were unfamiliar with the specific activities that the community developer was engaged in, and her distance from the public frustrated her.

*It's hard being over in this corner. I would like to be...front and center, in that door [entrance] when people walk in, and say 'Hi, how are you today? Need any information?' In fact, we're trying to get a volunteer to do that – someone who'll make it a much more pleasant place to be. It's so much like a clinic/doctor's office, and we have to try and make it a much more community-focused welcoming place. It isn't yet. [Staff 5]*

The former V/RHB recognized access to health information was a health issue, and thus when it created community health centres, it made allowances in the physical plans of community health centres for a health information area. Unfortunately, the health information area at Three Bridges is approximately one-fifth of some other community health centres; it had not been developed at the time of this research. It is a small area next to the main entrance that will eventually have a computer and other health resource material.

In a document released in June 2001 by the former V/RHB, it noted that some clients with physical disabilities often experience embarrassing and uncomfortable situations when physicians perform exams (*e.g.*, anal) without accessible exam tables.

Informants did not mention physical disability as a barrier to receiving quality care at Three Bridges.

### *Waiting Room*

The main waiting room of Three Bridges Community Health Centre has three, back-to-back areas for seating, which are divided by walls approximately four-feet high. There is also a children's play area in one corner. During participant observation, I observed notices of some of the clinic's programs or community events/programs posted next to the entrance. The waiting room area was particularly clean and well maintained. Clients waiting for appointments frequently chat about their health issues/life situations to one another (*e.g.*, welfare, housing, medications, treatments, and health issues), and clients were frequently accompanied by friends (who waited in the waiting area while clients were seen by providers). There were constant traffic flows, with some people only passing through for needle exchange/methadone treatments. As the clinic's website (<http://www.vcn.bc.ca/vrhb/chc1.htm>) states, the clientele were a mix of West End residents – homeless youth, seniors, gay men, professionals, drug users and parents with infants. Many of the clients have established a rapport with front desk staff and practitioners, calling them by their first names.

The physical feature of the building mostly frequently cited by staff informants as detracting from accessibility, which may deter some gay men (and seniors, parents with children and other populations) from using the clinic, was the waiting room. Staff noted that some clients felt unsafe or unwelcome, or had been verbally harassed. As mentioned, this was particularly a problem for transgender folks, which may include some gay men. Drug users, a significant portion of Three Bridges clientele, were usually cited as the

perpetrators of this harassment. Staff informants were not sure how frequent an occurrence this was. Aggressive or offensive behaviour is not tolerated, and clients displaying such behaviours are not seen by providers, but asked to return another time.

*We have profoundly addicted...and dysfunctional people...and they reflect our world. There's homophobic, ...racist...[and] transphobic comments...and it's very difficult to always squelch that. I mean we do what we can, but it's out of the mouth before we even know what's coming. And so I would say, safety issues, and respect issues, with other patients, is sometimes an issue here. [Staff 4]*

The difficulty for staff is that they have to hear the comments in order for them to take action. Some staff expressed a concern that some front desk staff may not be addressing the problem, but again, they were uncertain because the time providers spend in the waiting area is minimal. Furthermore, front desk staff are mostly occupied, and may simply not be paying attention to clients waiting for appointments.

*I've tried to talk to our front desk about, if they see something like that taking place, we need to address it, and if they are not comfortable addressing it, then they need to let one of us know...because this needs to be a place to feel safe for everyone. [Staff 4]*

It was believed that the more “gay-looking” (androgynous/feminine), or poor a client looked, the more susceptible to harassment they were.

*The people that get picked on are...not in very good shape, so guys from the stroll who are dressed as women, or who are transsexuals but who will never have the money to finally get all of that huge transitioning done.... The folks that get picked on the most...[are] the most vulnerable, although, they're tough some of them, but they're still vulnerable, because they're economically trapped. [Staff 4]*

The three clients interviewed did not express any discomfort about the waiting room. Two of clients were economically marginalized (unemployed and on disability). The third client (who is employed) noted, “*In the waiting room, I see people on methadone and stuff, but it doesn't bother me*” [Client 2].

## Financial Accessibility

Three Bridges Community Health Centre addresses financial accessibility in two main ways: 1) its services are free, and 2) people who can afford to pay for services are assisted with finding alternate care, which allows greater access for clients who cannot afford to pay for services. Clients do not need to have British Columbia Medical Services Plan (BC MSP) coverage to receive care at Three Bridges, or to obtain lab work and x-rays at St. Paul's Hospital.

### *Counselling Services*

Although counselling is free at Three Bridges, the prohibitive costs associated with clients receiving long-term counselling elsewhere were repeatedly cited as a barrier.

*Because I'm the only free counsellor, other than addictions counsellor, in the entire... Vancouver Coastal Health Authority, I have to be very careful to not spend my time with people who can afford to go somewhere else.... My job is still to lower the barriers, right? Even if they're not right for me, I want to find them someone that they can afford, and that will treat them with respect... so the folks that end up coming and spending any amount of time with me are usually have not a lot of income, often not a lot of education, often other problems like addiction and mental health problems, or emotional health problems because of their abuse histories.*  
[Staff 4]

Financial accessibility is especially an issue for counselling services because many mental health services are not covered under the British Columbia Medical Services Plan unless provided by a psychiatrist. Informants felt there were a sufficient number of counsellors in the region for gay men. The access issue associated with counsellors was not a lack of availability as with physicians, the problem was the exorbitant costs associated with counselling services, making them inaccessible for most people.

Another issue raised by informants around counselling and access was that many gay men do not realize that BC MSP does not cover counselling services. Accordingly,

counsellors at Three Bridges often spend time distinguishing between counselling and psychiatry, explaining coverage and counselling options available through their clinic.

### *Complementary Services and Dental Care*

Informants also felt that there were financial barriers to alternative/complementary services, such as massage. Three Bridges Community Health Centre provides free access to acupuncture for persons with addictions. Difficulties accessing dental care were also issues for some clients of Three Bridges because of the prohibitive costs. Since Three Bridges does not have a dental clinic, clients were referred to dental clinics at the University of British Columbia or at Reach Community Health Centre.

*Even to say 'Okay, you're going to have to pay \$45 for a dental exam.' They'll just look at me like, 'Are you crazy.' A lot of them either don't have the money or are just so accustomed to 'Well, whose going to pay that 'cause I'm not going to'. ...A free clinic providing everything free is more like what [they're accustomed to], that's part of the culture. Going and paying for something themselves, they just won't. [Staff 10]*

Providers and clients noted that financial accessibility was not only limited to whether people could afford to pay or not, but was also dependent on the *perceived* socio-economic status of clients by providers in other settings, usually based upon clients' appearance. Providers at Three Bridges repeatedly stated that they were there to alleviate these economic barriers.

*If I would dress casually or ...a little shabby, they [private clinics] would tell me that it's important to be hygienic, and be very condescending... which I was very appalled. But I didn't take [it] too much at heart, but it was subconsciously there. It made me feel uncomfortable, and less reliant to avail of those services. [Client 3]*

Some staff informants also noted that there is a false perception that most gay men are in high-income positions. They believed that gay men's income level were representative of the general population.

### **Functional Accessibility (Convenience)**

As discussed earlier, many of the clients of Three Bridges have multiple barriers (e.g., socio-economic, mental health issues, alcohol and drug dependencies) to accessing the fee-for-service system. Functional accessibility refers to aspects of a setting related to convenience, such as increased hours of operation beyond 9-5 Monday to Friday, drop-in appointments rather than scheduled appointments, and multiple services under one roof. Many of these features are implemented in community health centres because they frequently serve marginalized populations. Three Bridges Community Health Centre has taken into account the conditions under which their clients live, and have adapted their delivery of services accordingly. A (fee-for-service) solo or group practice may be appropriate for many gay men if they have fewer barriers.

#### *One-stop Shop*

The former Vancouver/Richmond Health Board created community health centres as “one-stop shops” for services (V/RHB, *Directional Plan 2002-2003*). One of the features that make community health centres more accessible for clientele is not only the services they offer, but also the integration of those services in the same location. This alleviates clients from having to try and identify multiple service providers themselves, and then travel to the various locations, and fill out the requisite paperwork each time. When new clients access services at Three Bridges CHC, they may be informed of the other services that are provided. Clients can be informally referred to other providers, and be actually introduced to the provider creating an immediate, personal connection.

*They can come to numerous providers under the same roof...and you get a chance to know the clinic and...how the clinic runs.... If you've got providers in four different spots in the city, then you're adjusting to each system in each place, and each of the systems are different. We have a*

*nicely coordinated kind of thing going on, so that part has got to be fabulous. [Staff 4]*

Clients also liked a more holistic approach in receiving care.

*They have a better approach than your conventional clinic or private practice. That means they are more receptive to your concerns.... Let's say if you have an addiction problem, they have...better coordination to get to your holistic approach, or the best approach to really remedy your situation. And other therapies are offered than your conventional office. It is a community centre type clinic, and not just a clinic. [Client 3]*

As mentioned previously, a way to improve the one-stop shop approach would be to have more space, so more services could be offered.

#### *Drop-in & Hours of Operation*

Clients of the clinic can drop-in to seek an appointment with a provider, however, for a whole host of reasons, an immediate appointment may not be available. Clients may have to wait for a few hours – often they book an appointment and return.

*They don't want an appointment. They can't make that kind of commitment.... Their lives are in chaos...meaning there is...perhaps unstable housing, unstable employment, unstable relationships, and so it makes it really difficult to focus on their health needs. [Staff 10]*

Having to wait for a period of time was seen as a deterrent for some clients in accessing care.

*Sometimes when they come on a full day...they have to wait a long time and so, 'forget this, I'm not coming back!' And so they either go untreated or they have to try and find treatment somewhere else, and a lot of people won't even try. [Staff 9]*

Two of the three clients interviewed frequently dropped in and found this to be convenient, and felt welcomed when they dropped in. Their decisions to seek medical care were often “*spur of the moment*,” but one client noted “*you want to have services when you need it, not at their disposal*” [Client 3]. The third client regularly scheduled

appointments because of a medical condition requiring weekly visits with the same provider.

There are also less likely to be repercussions for people who cannot keep appointments at Three Bridges. Often, clients at Three Bridges have a less structured life than people who use the fee-for-service system.

*They would have a hard time going anywhere else because most doctors and dentists...if you miss one appointment, then they're not as likely to want you to come back because they're in business. And so a place like this is...a little more flexible. [Staff 10]*

Another feature of Three Bridges Community Health Centre that makes it more accessible for its clientele is that it has extended hours of operation. It is open Monday to Friday from 9 a.m. to 8 p.m., and on Saturdays from 10 a.m. to 5 p.m.; however, the hours are not posted on the clinic doors. This also overlaps for an hour with the Boys R Us drop-in program, held three nights a week, so it allows those participants to access health services.

Suggestions for improvement included having the clinic stay open until 9 p.m. since Boys R Us participants may have difficulty accessing the clinic before 8 p.m. or providers are booked even if they arrive at the clinic before 8 p.m.

*[Male sex trade workers] will work all night or will party all night and sleep all day, and then by the time they come here for dinner, they're just getting going, so if they've got a health issue, they quite often won't show up until very late in the day, and so even though the clinic is open 'til eight...sometimes that's not even late enough. [Staff 10]*

Another suggestion for improvement was to study how many people did not schedule an appointment if they dropped-in, and to determine if or where they sought care instead.

### *Length of Appointments*

Because of the nature of the Three Bridges clientele, they often delay in seeking care, so when they do present, their conditions may be worse, or they may have several conditions that need to be addressed. Also, they are less likely to return regularly for follow-up appointments. More “high-functioning” patients can be accommodated in a regular practice since they are more likely to return for any required follow-up.

*Lack of continuity of care is an issue, but that's an issue for drop-ins and CHCs in general versus a traditional office. That is probably reflective of the population so when people come, you have to do as much as you can in that visit because they may not come back, which it helps that you can spend more time with people [here].... If clients want to make continuity of care for them, then they show up to appointments or wait for their regular provider. [Staff 7]*

In the fee-for-service system, physicians are remunerated for the number of patients they care for, and thus the more patients they see in a day, the more money they make.

Appointments in private practice are typically 10-15 minutes. The physicians at Three Bridges are paid per hour, and they stated that they have greater flexibility and time in assisting clients than in the fee-for-service system.

Being a salaried physician also had other benefits, which contributed to the quality of care clients received.

*Less energy spent on business related activities that one has to address in a private system - who your staff are, who are hiring, who are you firing, why, are you meeting the bottom line. I just come to work, and then I leave. In the end, I don't have to spend any energy on that. I can just spend it on addressing communities that have difficulty accessing primary care because communities take energy. As soon as you get into the low socio-economic and addictions, or people who have ego/developmental problems related to their sexual identity, you're talking high energy for the dollar. [Staff 3]*

### *Care Cards and Other Bureaucratic 'Nightmares'*

Another way that Three Bridges makes receiving health care more accessible is that they do not require "Care Cards" (BC MSP coverage) as is required when accessing services through the fee-for-service system. However, Care Cards are required when clients of Three Bridges are referred to service providers (e.g., specialists) outside of the clinic, or when obtaining medications. A lack of Care Cards was associated with the nature of the clientele and/or their often unstructured lives. For instance, youth may not have Care Cards because they were included in their family's coverage. Also, new residents of British Columbia, who have not completed the required paperwork to transfer their former province's medical coverage to the BC MSP, are not eligible for coverage from their former province after three months. Some clients have lost personal identification cards which also complicates accessing other health and social services. Three Bridges also helps its clients obtain Care Cards. Some reception staff and the community counsellor were mentioned as being particularly adept at helping clients work their way through a maze of bureaucratic paperwork.

Clients also have difficulty accessing other forms of social services (e.g., disability, social assistance) because of the complicated nature of the processes and their literacy abilities. Staff assist clients in these essential endeavours.

*Sometimes...these guys have really experienced trouble working with... whoever's on the other side of the counter, and sometimes just...a phone call from me, or...you hate to say it but...I can show up with my briefcase and...then all of a sudden, doors open a little bit more...and that's sort of what we're going to...do more of. [Staff 10]*

### *Outreach*

Another method used to make services more accessible (convenient) for clients, so they are more likely to use them, is to go to them rather than waiting for them to come to the clinic. As discussed previously, the Boys R Us has an outreach program for male sex trade workers. They're also about to begin an outreach program geared towards street youth.

*We're [going]...to put a resident in Dusk-to-Dawn<sup>31</sup> one evening a week, and a lot of street youth...are gay or bisexual. And so...the resident and staff doctor, who is a gay physician himself, will provide care, and then try to do the follow-up care at this clinic...and bring to them the message that we're here and we're welcoming. Also, working with the street nurses to let them know that these services are being included. [Staff 9]*

### *Multidisciplinary Team*

The efficiency with which providers work together as a multidisciplinary team is integral for the clients to receive integrated care, and also helps providers comprehensively address clients' needs. Providers at Three Bridges routinely coordinate care and share information about clients. Since the clinic has only existed for two years, they are still learning how to work together. The physical separation of service providers (on two floors) exacerbates this difficulty. Some providers have worked with each other since the clinic was located on Seymour Street, while others were moved to the site from multiple locations.

*I tried...to bring...service providers together...and it's like pulling teeth. It's really, REALLY difficult. ...It took us from June of 2000 to March of 2001 to get together enough that we could have an actual open house, and...people were talking to each other, and in the beginning it was like Greek. 'Oh, OH, is that what you do? I didn't know that.' 'Oh, you're upstairs, I don't know what's upstairs!' [Staff 5]*

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<sup>31</sup> A drop-in for street youth operated out of St. Paul's Hospital.

Although community health centres were created by the V/RHB to provide integrated care, a staff informant noted *"we're still not integrated, as a team, giving service to the total public. It's difficult, it's really difficult"* [Staff 5]. Trying to integrate as a team was also complicated by the recent "reforms" of the Vancouver Coastal Health Authority since *"they've changed ICYAOA [infant, child, youth, adult, older adult] program, and...now we're going to do promotion, prevention, rehab and treatment"* [Staff 5]. Staff were unsure what this new configuration would mean in terms of program delivery, however, some feared *"the new focus will be on treatment, not promotion or proactive health"* [Staff 11].

One of the suggestions to improve the workings of the multidisciplinary team was to have more opportunities to meet since time was frequently mentioned as an impediment to more effective coordination. The community developer could help facilitate this process.

*That's another reason why I would love to still see a community developer attached to the health centre. I mean that's the person who can begin to work on all of that.* [Staff 5]

Improving information systems was also suggested as a means to improve coordination of care for clients, and the sharing of information among community health centres around queer health issues and initiatives.

*I can't go to a computer here and type in a name of a client that...we're seeing in the clinic and know whether or not someone upstairs has seen that person...which is quite pathetic.... That's a very fundamental piece of...providing integrated care... 'cause...we're probably giving people ten hep A shots when they only need three because...many of our clients aren't [good historians] by virtue of co-existing problems.* [Staff 1]

*Many of us...are...doing some phenomenal stuff...but...we aren't talking to each other in terms of program development and accessibility issues, which is all related.... I don't know where that information goes...and why*

*we don't get it.... When that piece comes together, we're going to be able to do better things. [Staff 4]*

Staff were concerned however that with the downsizing of staff, such as the LGBT community developer for the LGBT Population Health Advisory Committee for the former V/RHB, and decreased budgets, networking and coordination of care capabilities would be adversely affected.

### **Awareness (Marketing & Publicity)**

Thus far, many aspects of accessibility have been elucidated; however, health services and programs are not accessible if gay men are unaware of them. Accordingly, Three Bridges Community Health Centre has publicized its services to increase community awareness. Since Pride Health Services is a program specifically created to increase the access of health services for sexual minorities, much of the clinic's efforts around publicizing services to gay men have been to increase awareness of Pride Health Services, however, staff were unsure if resources were actually seen or read.

Most of the providers felt that word-of-mouth has been their most effective means to reach their target population. Also mentioned as being effective was inter-organizational communication (*e.g.*, e-mail listserves and newsletters), and organizational word-of-mouth with community-based organizations that also serve the queer community, specifically, the Centre, AIDS Vancouver, British Columbia Persons With AIDS, and YouthCo AIDS Society. In a listing of community organizations in *Xtra West*, a local queer newspaper, both Pride Health Services and the Three Bridges Community Health Centre are listed in a mailbox that people can call for further information. At various times, they have also placed ads in *Xtra West*, as well as stuffed inserts into queer

papers. A booth during annual Pride festivities in August is also used to publicize Pride Health Services. Despite advertising widely, traditional marketing tools such as distributing handbills at bars and the baths have been less effective than word-of-mouth and organizational communication. Pride Health Services was also targeted to high school students during anti-homophobia workshops on the backs of distributed leaflets.

Providers were concerned that there were many potential clients of Pride Health Services that were unaware of its existence, and yet they were concerned that if they market too much, they would be overwhelmed. Fewer clients for alcohol and drug counselling during Pride Health Services warranted special advertising of that service as a means to alleviate the conundrum of suddenly having too many clients. There was also a fear that if it's too visible, then people might not want to come because it is known as a queer clinic.

Two of the three clients interviewed had heard about Three Bridges Community Health Centre through Covenant House and the Centre respectively, while the third client was told by a friend about the clinic. The clients had also recommended Three Bridges to their queer friends.

*Yes, I have [recommended Three Bridges to other people.] When people tell me that they've not been having a good time with their doctors...I just point them, saying go there, they are good people, and they're good listeners, and I'm sure they'll find some remedy to your situation. [Client 3]*

The marketing of the *overall* clinic, beyond Pride Health Services, was not as much of an issue for staff informants, yet a lack of awareness by gay men of the clinic and the services that it provides was repeatedly stated as a challenge. Word-of-mouth by individuals and organizations was again articulated as the most effective means to solicit

clientele. Internal clinic referrals, from the Vanguard Project, the AIDS vaccine project, and the Boys R Us program were also effective.

*I think there could be some more advertising around the fact that we do provide a lot of queer health services here, and a lot of queer individuals come here, and continue to come back. [Staff 3]*

One suggestion for improvement was for the VCHA to increase awareness of gay-friendly services among the queer community, and not just queer health professionals.

### **Partners in Accessibility**

At various times during the interviews, informants listed a variety of their partners in the issue of access for gay men's health. They included AIDS Vancouver, British Columbia Persons With AIDS, the Centre, the Gathering Place, Covenant House, YouthCo AIDS Society, Asian Society for the Intervention of AIDS (ASIA), Friends for Life, GayWest, Community-Based Research Centre, Gender Dysphoria Clinic, all of the population health advisory committees of the former Vancouver/Richmond Health Board, but particularly the LGBT PHAC, and social clubs (e.g., baseball, basketball, softball, bowling, swimming). These partners include organizations actively involved in Three Bridges' programs or community-based campaigns, events and initiatives, as well as sources of referrals to and from the clinic. Staff stated that to increase any programs, such as social support programs, at Three Bridges, partnerships were paramount. The challenges of building and maintaining partnerships were time, money, and personnel, as well as identifying potential partners.

Some Three Bridges' providers felt that other community-based organizations were more adept at advocacy. This position was echoed in a recent Vancouver/Richmond Health Board publication:

Many health care providers, researchers and services are not in a position where they can speak out about social issues to the media. Partnerships with community groups who have a passion for the issues at hand can facilitate advocacy (2001, p. 41).

Conversely, other staff and client informants thought that providers, particularly physicians, have a significant role in advocacy because of their privilege in society.

*I know...doctors could play a big role as far as lobbying...because all the social agencies are totally strapped for cash, and they do not have teeth as far as advancing needs go, and doctors can play more proactive role, or nurses for that matter from the clinic. [Client 3]*

Informants underscored the importance of multiple partners in enhancing access for gay men.

### Summary

This chapter examined how the Three Bridges Community Health Centre conceptualizes and addresses the issue of accessibility for gay men. The results are also summarized in a table in "Appendix K: Summary of Results." This chapter included perspectives from multiple informants and elucidates the multiplicity of elements essential in providing accessible care.

The first major theme of Chapter Four highlighted Three Bridges' **mission of accessibility for vulnerable populations**. The clinic has a reputation of serving at-risk populations who have difficulty accessing the mainstream system. Next, the chapter highlighted the **health issues of gay men** from socio-environmental (homophobia, heterosexism), lifestyle/behavioural, medical and personal development (low self-esteem, coming out) perspectives. Barriers in the health system that specifically related to gay men's sexual orientation included real and perceived heterosexism and homophobia, previous homophobic encounters, lack of confidentiality, difficulty or fear disclosing

their sexual orientation, fear of judgement/felt judged, homophobic front desk staff, lack of partner recognition, providers' lack of knowledge of gay men's health issues, and heterosexist intake forms. There were also barriers related to a lack of gay or gay-positive providers, particularly physicians, and financial barriers in accessing psychologists and other health services, such as dentists for gay men with a low income. Referrals to external providers were also complicated by cultural and financial barriers. Some gay men experienced barriers related to other factors which were compounded by sexual orientation and vice versa (*e.g.*, low socio-economic status, poor literacy skills, alcohol and drug problems, mental health issues, mental and physical disabilities, race, ethnic, language). Singled out as being particularly vulnerable were immigrants/refugees, male sex trade workers, transsexual gay men, seniors, street youth and effeminate/androgynous men.

The **utilization** of the clinic by a diverse clientele (*i.e.*, seniors, families with young children, single professionals, queer people, (street) youth, and individual with addictions) caused tensions at the clinic, particularly in waiting room, and some clientele felt unwelcome, unsafe or that that they do not belong. Providers estimated the queer clientele to range from 20 to 25% with included mostly gay men and transgender people. Some gay men only use the clinic for specific services, such as STD testing/treatment. Providers felt that for some gay men, the clinic's association with street youth, poor people and people with addictions deterred some gay men, and others, from accessing the clinic.

The fourth major section addressed the range of **programs and services** offered by the clinic. The clinic has three client streams – primary care, youth services and

addictions. Other services include community counselling, research projects (Vanguard & HIV vaccine trials), Boys R Us (a drop-in centre, an outreach program to the “stroll,” and an exit program), Pride Health Services, and community health services located on the 2<sup>nd</sup> floor. Services are mostly one-on-one therapeutic/treatment-oriented, and with the current level of resources (time, money, personnel), the clinic cannot take on much more in the area of gay men’s programming. Outreach and partnerships were deemed critical in current and future programming, and suggestions for improvement included expanding services like Pride Health Services beyond Three Bridges. Four areas frequently mentioned as gaps in programming for gay male clients were mental health, referrals, health promotion, and information; however, staff felt only partially responsible to alleviate these programming gaps, particularly related to mental health and referrals since these are issues for many users of the health care system, and should therefore be addressed by other stakeholders (*e.g.*, VCHA, Government of British Columbia). Health promotion and information issues were being addressed, but still challenging. Information gaps included clients’ lack of awareness of services available at the clinic, as well as a lack of health information on pertinent health issues. While some providers were involved in creating a gay men’s wellness fair, there were challenges in getting information about health and social events out in the community, as well as challenges in creating social events and decreasing social isolation in the gay community. Some providers also felt a need for more social support groups for gay men on a range of issues (*e.g.*, personal development – coming out, self-esteem, diseases/illnesses).

The fifth major theme included a discussion of **available providers with appropriate knowledge, attitudes and behaviour**. The clinic has a variety of full- and

part-time health providers, support staff, seconded staff, volunteers and students/residents. Front-desk staff were deemed critical in providing gay-friendly care. Approximately fifty percent of the staff (on the first floor at clinic) identify themselves as gay or lesbian. Queer providers at the clinic personally recalled experiences of homophobia or heterosexism. Straight staff at the clinic were more likely to have a more functional, and less personal attachment to the queer community. The presence of out, queer staff increased the likelihood that queer people will frequent the clinic (*i.e.*, clients search out queer providers). Staff felt education for health professionals around queer health was lacking, and providers' self-interest in the queer population facilitated their self-directed education. Recruiting queer staff was deemed to be very important in creating an accessible environment for queer people. Many queer providers had been engaged in community-based gay men's health issues for years. The clinic is also a venue for training family practice residents and medical, nursing and social work students. Some concerns were raised that this may affect continuity of care for patients, but it was also stated as critical in educating health students. Reception staff, residents, nurses and physicians were all singled out as needing more education to create a more, gay-friendly clinic. Suggestions to improve a lack of queer knowledge included better in-house training, external training, and improvements in the curriculum on queer health issues. Social support group for queer providers in the Vancouver region and better means of communication were suggested as improve connections with other professionals around queer health issues.

**Cultural accessibility** (*i.e.*, gay-friendly environment) was identified as having various attributes: people feeling comfortable, safe and respected (non-threatening

environment); confidentiality; comfort with asking questions; non-judgemental environment; availability of appropriate printed material; welcoming through visual cues; and being free of, and sensitive to, discrimination. Some staff informants wanted the clinic to be more welcoming. Intake forms (other than for Pride Health Services) did not mention sexual orientation/gender identity, and did not ask about a partner or spouse. In the waiting area, or on the clinic's main doors, there were no rainbow (Pride) flags, however, there were small rainbow flags on some office doors. Several staff suggested more Pride flags to enhance accessibility.

The sixth major theme was **geographic accessibility** (location). The clinic was created with the expectation that it would serve persons living and working in the geographic area (*i.e.*, downtown Vancouver, the West End, Yaletown *etc.*). Staff felt that the location was appropriate for the gay men and other marginalized populations that they do serve, but not conducive to attracting a larger gay male clientele because of a lack of visibility and awareness by gay men. However, if the clinic were located in a more visible area, it still may not attract gay men because it may be "too visible," or its association with people who are poor and/or use drugs. Client informants felt the location was appropriate. The clinic welcomes clients from outside the designated geographic area because of its unique services and gay-friendly providers. Suggestions to improve geographic accessibility/visibility included outreach, satellite clinics, holding special events outside the West End, and more clinics, like Pride Health Services, in other community health centres.

**Physical accessibility** (architecture) was the eighth theme. A barrier expressed for effective multidisciplinary work was the division between the first and second floors,

and distance among some providers on 1<sup>st</sup> floor. Some staff felt restricted because of lack of space, although the clinic has more space than in former Downtown South clinic. Locked doors that divide the clinic into four, separate restricted areas were thought to be a potential barrier, but necessary. The locked doors also improved privacy for support groups. A strength of the building were multiple entrances and waiting areas (especially for Pride Health Services). The community development (office) is located away from most other staff and the public. The clinic has a small health information area available, but it was not yet developed. The waiting room was problematic because of the mixed clientele. A suggestion to improve the waiting area for queer folks was to make the waiting room more queer friendly by displaying a rainbow (Pride) flag, but concern was also expressed that this might alienate straight clientele.

The clinic address **financial accessibility** (affordability) since its services are free. People who *can* afford to pay for services are assisted with finding alternate care, which allows greater accessibility for clients who cannot afford to pay for services. Clients do not need to have B.C. Medical Services Plan coverage to receive care at Three Bridges, or to obtain lab work and x-rays at St. Paul's Hospital.

**Functional accessibility** refers to aspects of the clinic related to convenience, such as increased hours of operation until 8 p.m. and on Saturdays, drop-in appointments, multiple services under one roof (one-stop shop), greater flexibility in the length of appointments, and salaried physicians. Suggestions for improvement included having the clinic stay open later since Boys R Us participants may have difficulty accessing the clinic before 8 p.m. Suggestions to improve the workings of the multidisciplinary team included more opportunities to meet. Improving information systems/technology was also

suggested as a means to improve coordination of care, and the sharing of information among community health centres around queer health issues and initiatives.

**Awareness** (marketing and publicity) of the clinic mostly centred around the clinic's efforts around publicizing Pride Health Services to gay men. Word-of-mouth among clients and organizations, and inter-organizational communication were their most effective means to reach their target population. Providers were concerned that there were many potential clients of Pride Health Services that were unaware of its existence, and yet they were concerned that if they market too much, they would be overwhelmed with clients.

The final theme addressed **partners in accessibility**. Staff spoke positively of former V/RHB. The VCHA only recently appointed at the time this research was conducted. Numerous community-based partners were involved in programs and initiatives at the clinic. Fostering client participation at the clinic was thought to be more difficult or unnecessary.

The next, and final, chapter are my reflections upon the issues raised in this chapter.

## **CHAPTER FIVE DISCUSSION**

### **Introduction**

This research was motivated by a lack of published literature on the issue of how gay men's access to health (services and auxiliary resources) is conceptualized and addressed through community health centres. The goal of this study was to contribute to this literature through an in-depth documentation of how the Three Bridges Community Health Centre conceptualizes and practices the notion of accessibility for gay men. This final chapter has five objectives. The first is to provide a discussion about the results of this project, and to note the strengths and limitations of each of the twelve major themes of accessibility for gay men as discussed in Chapter Four. Secondly, implications of the research for policymakers/board members, the providers and the setting, and the clients are discussed. The third objective is to provide a discussion of the contribution and significance of this research. The fourth objective is to elucidate limitations and challenges of the research. Finally, the potential for future research around accessibility for gay men (and other sexual minorities) is discussed.

### **Results - Elements of Accessibility**

This study revealed extensive efforts by the Three Bridges Community Health Centre to address and enhance accessibility. Many of their efforts were accomplished by their partnerships with community-based agencies. The queer staff were also integral in facilitating accessibility, both at the clinic, in their other careers/jobs, as well as their daily lives. Some of the challenges reported within this study reflect the limitations of community health centres to address health issues given their limitations of time, money

and personnel. Another challenge for community-based settings is reaching the larger (gay) community, including gay men and community leaders. These issues are not unique to the present study or population.

For organizational purposes, the elements of accessibility (*i.e.*, themes) were each discussed separately in Chapter Four; however, the results revealed just how interrelated and multi-directional all the elements are. For instance, the programs were affected by the staff and by the utilization of clients, and the staff affected the utilization of clients and the programs. In turn, the staff and clients each affect cultural accessibility (gay-friendliness). Financial, geographic and functional accessibility enhance the likelihood that vulnerable clientele will utilize the clinic. In order for primary health care to be accessible, all of these elements and their interactions must be examined and addressed. The individual elements of the framework are not easily isolated. The Three Bridges Community Health Centre has developed a practice whereby they tweak program aspects to enhance the multiple components of accessibility depending upon availability of resources and utilization by clientele. The impact of the clinic on the health of the clientele is also tempered by many factors beyond its control. Issues of inadequate resources (*i.e.*, time, money, personnel) are a common refrain in our health care system.

#### *Developing a Mission of Accessibility for Vulnerable Populations*

Before a community health centre attempts to address accessibility, it conducts a formal or informal assessment of the community, and develops a mission or mandate accordingly. As described in the literature review, the health status of gay men in Vancouver is considerably poorer than that of the general population in this country. Furthermore, with the typical gay client of the clinic being more marginalized than many

gay men in Vancouver, they have further barriers in accessibility. The Three Bridges Community Health Centre is different from many community health centres. It was not started from the 'grassroots' but rather by the former V/RHB. The Board configured the clinic's staff, its basic programs and its physical site. The clinic began with no real target populations, except for those underserved. As with many CHCs, they serve marginalized populations, particularly those socio-economically disadvantaged. This research underscored the difficulty in serving a diverse clientele, as well as the potential pros and cons of operating a community health centre inclusive of queer people.

#### *Assessment of Gay Men's Health Issues, Needs and Barriers*

Developing accessible primary health care means examining and enhancing factors that may prevent clients from accessing those services. The providers characterized the health issues broadly and located them within their socio-historical context. This is crucial since these underlying causes of ill health also need to be addressed (*e.g.*, poverty, homophobia, heterosexism, and coming out). Providers had a profound understanding of the barriers that their clients have faced or may endure in the traditional health system, with psychiatry and counselling being cited as being particularly inaccessible for gay men. Again, this is highly significant because they can then (attempt to) address these barriers by improving the clinic.

#### *Utilization*

The clientele of the Three Bridges Community Health Centre are highly diverse, and includes parents with children, gay men and transgender folks, professionals living and working in the area, people with addictions and street youth, to name a few. The diversity of populations using the clinic compromised accessibility. This demonstrates that even

among relatively marginalized populations (queer, poor, addictions, sex trade workers), there is an unhealthy hierarchy. Given that these populations have no other comparable venue to access services, many populations have few likely alternatives to seek care elsewhere. Although it is not a given, the Three Bridges Community Health Centre is an example that when services are adapted to be more accessible, vulnerable populations will utilize them, but that utilization may be uneven across sub-groups. The clinic is also taking steps to address three particularly vulnerable populations: street youth, male sex trade workers and transgender people. Given its current resources, it has not addressed the geriatric population.

#### *Delivery of Appropriate Programs and Services*

Given the nature of the clinic's population, the services they provide are appropriate. Within the current level of resources, programs have been tailored to the specific groups that encompass the clientele, and fit with their needs. Community counselling, Pride Health Services and Boys R Us are especially unique. They are important for the populations that they serve, yet they do not disrupt or impose upon other services provided at the clinic. The clinic is continually seeking to improve these services by adapting current programs, and providing outreach or linking with other services. To reiterate, the four areas mentioned as needing improvements in gay men's health programming were mental health/counselling, referrals, health promotion for gay men (events, social support and preventive medicine), and information. Information needs to be addressed for the clinic in general (access to health information, and awareness of available services).

This research begs the question, should there be a separate clinic for queer people? There is no right or wrong answer to this question. A separate clinic would likely enhance accessibility for some queer people, but it might deter others who do not want to be identified with such a clinic. By incorporating all sexual orientations under one roof, clinics like Three Bridges seek to create an equitable health care system that is open and embraces all people, whatever their sexual orientation. Within our current (homophobic and heterosexist) society and given the health issues of gay men, special programming is necessary in community-based primary care settings.

*Available Providers with Appropriate Knowledge, Attitudes and Behaviours*

The staff at Three Bridges Community Health Centre are genuinely concerned about the clients they serve, they are aware of their health issues and needs, and highly predisposed to enhancing accessibility. The providers are tremendous assets in providing the services of the clinic, however, some informants noted that enhancing an understanding of cultural accessibility for gay men for straight staff is warranted. They are all dedicated to the populations they serve, and to the queer community in general. Their links to the queer community and to educational institutions are also paramount in making health care more accessible for gay men. The efforts of the staff at Three Bridges around accessibility for gay men and other vulnerable populations should be reinforced, particularly by the Vancouver Coastal Health Authority.

*Cultural Accessibility (Gay-Friendly)*

Queer-friendliness is a matter of degree. Given that the Three Bridges Community Health Centre is not a queer clinic, it has to balance cultural accessibility for queer and straight clientele. At Three Bridges Community Health Centre, there is a concern, by some, that if

the clinic is “too queer,” it will alienate other clientele. This is a legitimate point, but what they have done, in the waiting room in particular, is actually make it a very sterile environment, void of artefacts that appeal to any clientele. Displaying posters, for example, that reflect all of the clinic’s clientele, including queer people, would enhance cultural accessibility. Posters displaying parents and children, youth, seniors are also warranted.

Intake forms at Three Bridges do not ask for sexual orientation (except for Pride Health Services intake form) with the rationale that since sexual orientation is not a health problem, it need not be asked. However, gender and age are not health problems but are still routinely asked on intake forms. Accordingly, the intake forms do not allow for easy disclosure of sexual orientation. Before such a question is routine on intake forms within the health care system, health professionals need to be able to take into consideration (but not treat) sexual orientation in their prevention, treatment and diagnosis of various health issues, just as they do with a person’s age and sex.

#### *Geographic Accessibility (Location)*

For the vast majority of West Enders, including gay men, the Three Bridges Community Health Centre is unknown to them because of its location. However, given that the clinic is already busy and is targeting underserved populations, that is not an issue. The clinic is known and geographically accessible for the populations that it does serve. An issue repeatedly raised by staff was the absence of queer-friendly services at other community health centres in the region, even in areas with significant queer populations, such as Commercial Drive in Vancouver, and in North Vancouver.

### *Physical Accessibility (Architecture)*

The physical architecture of the building has already been established, and there are no easy solutions to remedying the issues around physical accessibility. As mentioned previously, to make the waiting area a more comfortable environment, posters that reflect the diversity of the entire clientele should be displayed.

### *Financial Accessibility (Affordability)*

Clients are most prohibited from accessing those services outside of the clinic in which there are fees associated, namely dental care and mental health counselling. Health services at the clinic are financially accessible because there is no charge associated with services.

### *Functional Accessibility (Convenience)*

The attributes of Three Bridges Community Health Centre that make it functionally accessible are its multiple services and providers in one location; its drop-in appointments and hours of operation; flexibility in length of appointments; the non-requirement of Care Cards; and its outreach. Improvements in these areas could include extending these attributes, such as hours of operation. It would also help clients if hours of operation were listed on the front doors.

### *Awareness (Marketing and Publicity)*

In the highly sexualized gay culture, marketing efforts for any community service may not garner much attention. Potential clients, like most citizens, are inundated with advertising, and may not notice “less catchy” ads. Furthermore, given that many potential clients may not contemplate accessing health services much in advance, the timing and frequency of ads is also important. Not surprisingly, word-of-mouth has been the most

successful mechanism for marketing at Three Bridges. The issue of marketing may be a moot issue since they may not be able to accommodate an increased number of clients. Given the populations and the highly specialized services, word-of-mouth is also appropriate. Displaying information on available services in the waiting area may also prove effective in reaching populations needing services.

#### *Partners in Accessibility*

Other stakeholders impact on the degree to which the clinic can address accessibility issues, including the clients, the VCHA, the health system, governments, and the larger social context (including the gay community). The success of Three Bridges in addressing accessibility is linked to its partnerships with other community-based agencies. For the clinic to thrive, it needs to maintain and enhance partnerships since they remain key to many initiatives. Given the decreased role of community and public involvement in the Vancouver Coastal Health Authority, and the fact that the clinic does not have a community board of directors, it is also incumbent upon the clinic to maintain a program advisory committee. This would also likely help in their dealings with the new VCHA since community members offer a different perspective than staff in dealing with Boards.

Creating a safe space for healthy social participation by providing venues where gay men can share experiences and knowledge on a variety of issues and topics would also be beneficial. Community participation builds community capacity – the ability of individuals and groups to identify common problems or concerns, take action to effect change within the community, and improve the quality of life for all community members (V/RHB, June 2001).

## **Implications**

This research has potential implications for a variety of stakeholders. This discussion will concentrate on those parties most closely aligned to the issue of accessibility at Three Bridges Community Health Centre. A significant portion of this research was concerned with informants identifying challenges and suggesting possible improvements. In effect, some of the stakeholders have already identified the implications. Accordingly, simply reiterating their ideas is unwarranted.

### *Policymakers and Other Settings*

Many of the challenges raised by staff need to be addressed at a policy, region-wide level. The VHCA needs to encourage gay providers, especially physicians, to identify and market themselves as being gay-friendly and accessible. It should continue to include LGBT people in employment equity initiatives. Also, given that the LGBT Population Health Advisory Committee was dissolved, the VCHA needs to develop a mechanism to ensure queer health issues are being addressed, and that sharing of information of relevant community events and conferences previously undertaken by the community developer are maintained. It should also continue to raise awareness among providers and the queer community regarding initiatives dealing with patient-provider relations. This may encourage individuals who are experiencing barriers in the health system to voice their concerns.

The VCHA also needs to address queer health issues across the entire region. Providers were concerned that queer people in other areas of Vancouver and the surrounding region did not have access to queer-friendly services. Even within the West End, a lack of queer/queer-friendly providers and accessible services were raised as

barriers. The VCHA also needs to embark upon an educational process of queer health issues for all staff, and enhance marketing of queer health services. The VCHA should also include information about queer health at health information centres within community health centres across the region. The VCHA also needs to ensure that health promotion and disease prevention initiatives for gay men are maintained and enhanced. Efforts to make all intake forms and processes queer-friendly within the VCHA must be undertaken.

As mentioned, the staff informants frequently mentioned the lack of queer-friendly services in other jurisdictions. It is incumbent upon other primary health care settings, particularly community health centres in the region, to address this issue. Given that the Three Bridges Community Health Centre had only existed for two years when this research was conducted, and that it serves a diverse population, it is feasible for other community health centres to begin to create more accessible environments for queer people, particularly in areas with large queer populations. Other community health centres and health care settings do not need to wait for the impetus to create an accessible environment for LGBT people to come from the VCHA. This research thoroughly discusses the relevant elements to create such an environment.

#### *Service Providers and Three Bridges Community Health Centre*

Most of the challenges identified by the providers (*i.e.*, lack of time, money and personnel) are not easily remedied. Given that the clinic's staff are most intimately knowledgeable of the strengths, challenges and most feasible suggestions for improvement, and strongly participated in this research, it is most appropriate if they set priorities for issues raised in this research that warrant attention. As part of the

dissemination plan for this research, a presentation (likely during a staff meeting) of challenges and suggestions for improvement will be given to interested parties at Three Bridges Community Health Centre. It will allow staff to review pertinent issues, and prioritize these issues accordingly. The staff should be commended for their efforts in addressing accessibility both at the clinic, and in their other career roles and in the community in general.

### *Clients*

Providers were realistic about the level of involvement at the clinic desired by the vast majority of clientele. Most clients are likely only interested in participating in something that will have a direct effect on the service they receive. Sporadic involvement in program evaluation through surveys is the most probable manner in which clients wish to be involved. Some clients may be interested in activities related to program planning through a program advisory committee, but such involvement, especially over extended periods of time with no remuneration, is unlikely to be attractive to most clientele. Also, given that most service delivery at the clinic is mostly one-on-one treatment oriented, opportunities for involvement are minimized.

### **Contribution and Significance**

This research has elucidated the mechanisms used by a unique organization, the Three Bridges Community Health Centre, to address and enhance accessibility for gay men. The results of this study will help decision makers to understand the multiplicity and complexity of factors that are pertinent in addressing accessibility for gay men, particularly those most marginalized. These factors or elements are also applicable to other vulnerable populations in which accessibility is an issue. Detailed within this report

are the key elements of accessibility and contextual nuances that were integral to the issue of accessibility. This research provides new insight into three previously unlinked variables, namely, accessibility, community health centres and gay men.

Not only will this research contribute insight into how these are linked, but also at a broader level, these results will contribute to these three bodies of knowledge. First, the contents of this study will add to the overall picture of accessibility; that is, it will contribute to an increased understanding of elements of accessibility, and their potential indicators. Second, it helps us to comprehend these issues through a 'rainbow' lens, in that, this research underscores the tremendous impact that homophobia and heterosexism have on gay men's health and their barriers in accessing primary care. Third, this research provides in-depth insight into a community health centre, its programs, providers, and some strengths and limitations of its day-to-day operations.

The results of this report hold significance for a number of reasons. First, the foci of this study correspond to two of the three priority areas identified by the former Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee of the Vancouver/Richmond Health Board – increased research into issues affecting the LGBT population of the Vancouver region, and a better understanding of issues of access for LGBT populations. Queer, community-based groups will also be interested in these results since it reveals the barriers queer people endure, and mechanisms to alleviate those barriers. It also holds significance by providing a discussion of the challenges of accessibility within Vancouver's current health system for queer people, as well as suggestions for improvement. The issues, barriers and elements of accessibility discussed herein are also relevant to various groups, such as seniors and women, whatever their

sexual orientation. Many groups in our society face barriers in accessing health care, and this begins to explore these pertinent issues. And finally, this research was significant in what it revealed about research with vulnerable populations, and conducting research in a highly confidential environment.

### **Limitations and Challenges of the Study**

This research is limited, in part, because of the sexual minorities that it excludes. The lesbian, gay male, bisexual, and transgender population is extremely diverse. It includes a range of sexual orientations (homosexual, heterosexual, bisexual), sexes (male, female) and gender identities (male, female). Consequently, there is a need for research that is tailored to the specific issues of the various sub-populations. This research excluded members of the LGBT population who were not gay men as a means to put boundaries around the research topic.

The health research issues of other members of the LGBT population are similar in many ways, but also unique. For instance, the rate of HIV infection is high in gay men as compared to lesbian populations. Much of the research on gay men's health has been subsumed by HIV infection and prevention. Similarly, other research has focused solely on lesbian health issues (Roberts & Sorenson, 1995). For instance, lesbians are at a higher risk for breast cancer due to the presence of risk factors. While some health issues are identical or similar for all LGBT populations, some issues are unique.

There are also political reasons for making research specific to subsets of the LGBT population. A report of a survey of gay men in Vancouver noted that queer health initiatives had only weak participation by gay men because the "sexual minorities

framework,” which encompasses all LGBT people, was employed, and it was not specific to gay men. A report by the Community-Based Research Centre (2000) noted:

We learned in focus groups, for example, that gay men had little time for tensions amongst subgroups competing for political turf. So we began GHV [Gay Health Vancouver] by hypothesizing that we would achieve stronger participation if we developed a community intervention intended exclusively for gay men. Although only speculative at the time, our hypothesis turns out to have been overwhelmingly confirmed. (pp. 1-2)

While this research examined how accessibility for gay men is addressed at the Three Bridges Community Health Centre, many implications are transferable to all LGBT people.

Limitations in qualitative research often derive from the conceptual framework and from the research design (Marshall & Rossman, 1999). Several sections in Chapter Four indicated limitations associated with this study. Strengths and limitations of the various data collection methods (participant observation, source documents, and semi-structured interviews) were discussed previously. There was also a discussion of benefits and limitations of the sample, and difficulties negotiating entry and securing client interviews.

Excluding individuals or groups who did not support the notion that accessibility for gay men is a legitimate concern of the health system in general, or the Three Bridges Community Health Centre, in particular, may have biased this study. There are individuals who believe that programs or services geared towards gay men or other sexual minorities is special treatment, and thus inherently wrong because it may exclude others. However, as stated previously, the purpose of the study was to determine how accessibility is conceptualized and addressed rather than to determine if it is necessary. This research is premised on the notion that it is necessary.

Although no qualitative studies are generalizable in the statistical sense, their findings may be transferable (Marshall & Rossman, 1999). The study is bounded and situated in a specific context, and therefore, the reader can make decisions about the study's usefulness for other settings. Although efforts were made to have informants behave and speak openly, informants could have inadvertently or intentionally behaved differently or withheld comments that they would normally share because they were aware their actions and thoughts were being scrutinized and recorded. Conversely, in their enthusiasm to share their views and experiences, informants may have portrayed themselves or the setting in a more favourable light. Despite its limitations, the study design adopted for this inquiry is compatible with its purpose and objectives.

The study was challenging in the amount of time (almost 6 months) required for ethical approval from the University of British Columbia and the former Vancouver / Richmond Health Board. Because of this protracted process, there was insufficient time to later amend the ethics agreement to make the research design protocol less challenging. In hindsight, I would have included in my research proposal/ethics the *possibility* of staff conducting the interviews, and the *possibility* of a focus group at Three Bridges Community Health Centre for the "Boys R Us" group.

The research was also complicated by the transition from the former Vancouver/Richmond Health Board to the Vancouver Coastal Health Authority. Despite this however, staff were extremely receptive to the research. Challenges relating to the clientele occurred because gay men are "invisible" population, that is, not easily identifiable. Also, many of the clientele of Three Bridges are marginalized in society which decreases their likelihood of participation. With respect to the male sex trade

workers in the Boys R Us program, a provider summarized their feelings toward research.

*Generally, they're really jaded about the whole thing, and it's like 'Well, how much are they offering?' 'If they're going to give me 10 bucks to sit and talk to them for 15 minutes, maybe that's okay.'* [Staff 10]

Given the richness of the setting, staff are also inundated with requests for participant observation which understandably makes staff protective over their clientele.

*I've had so many requests of people wanting to come and just observe, and...I...try to be polite, but they're not monkeys in the zoo. 'What do you mean observe?' This [space] is like their living room; you don't just go and sit in somebody's living room and just look, and that's how I have to keep it. [I've had] requests from doctors, students, bureaucrats from Health Canada and the [Health] Board. I was being a little bit like den mother because...this is their little spot.* [Staff 10]

Although I am gay and have lived in Vancouver for eight years, I had no significant previous experience on gay men's health issues or research in Vancouver, and therefore, I had no supportive networks which may have facilitated the process.

Initiatives for gay men's health and HIV prevention are at best "underdeveloped and under-resourced" (Marchand, 2001a). Researchers involved in gay men's health are overburdened, and funding for programs and services for queer people are in constant jeopardy. While gaining access to the setting, staff and clientele would have been easier for people more closely aligned with Three Bridges Community Health Centre, many of those people do not have the time to conduct research, or their research interests while related may not fall under the rubric of accessibility.

### **Future Research**

This report provides substantive documentation on a topic that had not previously been studied in depth. This investigation also generates a number of issues and questions for

further consideration. One is to investigate the degree that other primary care settings, particularly community health centres in Canada and elsewhere, employ the mechanisms elucidated in this research. Another question is the degree of applicability or transferability of the mechanisms used at Three Bridges Community Health Centre to other settings, particularly other community health centres. Also, the literature review revealed community health centres (in the United States) that were established specifically for lesbian, gay, bisexual and transgender people. This begs two further questions. How do they address accessibility that is different than Three Bridges? Are there aspects of those community health centres that can accentuate accessibility at Three Bridges and other community health centres which do not cater solely to LGBT people?

This research was exploratory and descriptive, that is, qualitative in nature. This research could serve as a backdrop into an exploration into clients' feeling and perceptions of how Three Bridges is addressing accessibility now that pertinent elements and indicators have been revealed. Given the research was broad in its conceptualization of accessibility, such a survey could be extended to the entire clinic population with questions about sexual orientation/gender identity. A survey examining gay men's experiences with the health system, barriers that they have experienced, and the importance of factors associated with creating an accessible environment would reveal the need, or lack thereof, of accessible services. Given that providers at the clinic already know how they address accessibility (although it may not have been done in such a systematic manner), they would probably be more interested in quantitative research that measures clients' perceptions and feelings, whereas this research only began to identify pertinent issues.

Also, given that this research examined accessibility from a gay male perspective, although elements examined are relevant to a large number of vulnerable populations, it did not substantively investigate accessibility as it relates to bisexual, lesbian or transgender people.

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**Appendix A:**  
**Listing of LGBT Community Health Centres in the United States**

**Callen-Lorde Community Health Center**

<http://www.callen-lorde.org/>

Serving the New York City LGBT communities.

**Chase Brexton Health Services**

<http://www.chasebrexton.org>

Serving Baltimore, MD's LGBT communities.

**Fenway Community Health**

<http://www.fenwayhealth.org/>

Serving Boston's LGBT communities.

**Hartford Gay and Lesbian Health Collective**

<http://www.hglhc.org>

Serving Hartford's, CT LGBT communities.

**Howard Brown Health Center**

<http://www.howardbrown.org/>

Serving Chicago's LGBT communities.

**Lambda Medical Group**

<http://www.laglc.org/~lambda/index.html>

Serving the Los Angeles LGBT communities.

**Montrose Clinic**

<http://www.montroseclinic.org>

Serving Houston, Texas' LGBT communities.

**Outer Cape Health Services**

No website listed.

Serving Provincetown, MA's LGBT communities.

**Whitman-Walker Clinic**

<http://www.wwc.org>

Serving the Washington, D.C. metropolitan area GLBT communities.

**Appendix B:**  
**Leaflet Soliciting Client Interviewees**

**Appendix C:**  
**Letter of Initial Contact with Staff (Soliciting Interviewees)**

[Letterhead from: Institute of Health Promotion Research, UBC]

**Accessibility to Health Services for Gay Men  
Vis-à-vis the Three Bridges Community Health Centre**

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

You are invited to participate in a research project on "Accessibility to Health Services for Gay Men vis-à-vis the Three Bridges Community Health Centre." This project is in partial fulfillment for a Master of Arts degree at the University of British Columbia.

The purpose of this research is to examine stakeholders' perspectives (**board members, policy makers, service providers and clients**) on the accessibility to health services for gay men as practiced at the Three Bridges Community Health Centre. It will reveal perceived and real barriers and opportunities for gay men in accessing health services, and will also provide insight into the Three Bridges Community Health Centre's delivery of primary health care to gay men. It will highlight the challenges, needs and successes of providing care to a population that is not easily identifiable with a full continuum of primary health services (promotive, preventive, primary curative, rehabilitative, and community support).

You have been selected as an important informant having specialized knowledge or impact on the delivery of health services for gay men. Your involvement would include a face-to-face interview between 30 minutes and 1 hour.

There is no direct remuneration for participating in this project. Your responses will remain confidential. Only the researchers involved in this research project will have access to information obtained from your responses. Information will be identified by a code number and kept in a locked filing cabinet. You will not be identified by name in any reports or publications related to the completed project.

Taking part in the study is voluntary and you may freely withdraw from the study at any time; withdrawal or refusal to participate will not jeopardize your employment or position.

**Appendix D:  
List of Staff Interview Questions**

**[Thanks for participating / Consent form / Some questions may be repetitive]**

1. Can you tell me a bit about your role at Three Bridges?
2. Can you tell me a bit about your program at Three Bridges?  
(target population, hours per week)
3. What do you see as your role regarding accessibility to health services for gay men?
4. How would you describe the gay male clientele of Three Bridges CHC?  
(age, race, income, education, health issues, social support, housing)
5. Do these gay men face any barriers in accessing health services?  
(fear of or outright discrimination; inappropriate or substandard treatment; providers confusing sexual orientation and sexual behaviour; lack of partner/relationship recognition; lack of appropriate providers)
6. Have clients of Three Bridges CHC articulated these barriers with previous providers to you?
7. How does the Three Bridges CHC address these barriers?
8. If you were to construct a framework of accessibility for gay men, what are the key features?  
(geographic, linguistic, financial, cultural)
9. What features of the CHC enhance the likelihood that gay men will access health services here rather than somewhere else?
10. What kinds of programs and services should be available in a CHC for gay men?
11. Have you received feedback from gay men who use the Three Bridges CHC?  
What do they say?
12. Are there features of the CHC that might deter gay men from accessing health services here?
13. What improvements would you like to make to enhance accessibility (new

- programs, hours, more personnel)?
14. What are the challenges in promoting health for gay men within the CHC?  
(space, resources, time)
15. How are the programs for gay men informed by policy of the Vancouver Coastal Health Authority?

#### Availability & Use

16. Are there a sufficient number of accessible providers for gay men in Vancouver?
17. Who do you see as being the stakeholders in the issue of accessibility for health services for gay men vis-à-vis the Three Bridges Community Health Centre?
18. What are the mechanisms for collaboration with other stakeholders? How successful are these methods? (Multidisciplinary team) How does the V/RHB work with other stakeholders (health professionals, PHAC, consumers) to facilitate accessibility for gay men? How are activities of the Community Advisory Committees, the LGBT PHAC, and the CHCs collaborated? (Intersectoral Collaboration)
19. Are gay male clients involved in planning, decision-making, evaluation or service delivery? How?
20. How do you market/publicize the CHC and its programs to gay men?
21. That's all the questions that I have for you, do you think that I've omitted any relevant matters of accessibility for gay men, or is there anything else you would like to say?

**Appendix E:**  
**Interview Questions for Gay Male Clients**

**[Thanks for participating / Consent form & Honorarium / Some questions may be repetitive]**

1. So how long have you been going to Three Bridges? So about how often do you go there?
2. And where did you go before you went to Three Bridges?
3. How did you hear about Three Bridges? And what did they say about it?
4. The first time you went to Three Bridges, why did you go there rather than somewhere else (like emergency, doctor's office, walk-in clinic)?
5. What did you expect to find the first time you went to Three Bridges?
6. What were your first impressions of Three Bridges?
7. Did your impressions of Three Bridges change over time?
8. So are there any improvements you would suggest for Three Bridges?
9. What do you think of the location?
10. What do you think of the staff?
11. Do you have trouble accessing any health or social services elsewhere?
12. What do you look for in a health care provider?
13. So what did you like about Three Bridges?
14. Is there anything you didn't like?
15. So what services or programs do you use at Three Bridges?
16. The Three Bridges CHC caters to other groups in the community; how does this affect your experiences there?
17. Can you tell me a bit about your past health care system experiences?

18. So have you recommended Three Bridges to other people?
19. So can you tell me a bit about yourself (housing, social support system, education, employment)?
20. How would you characterize your past health care experiences?
21. The Three Bridges Community Health Centre serves other groups in the community, I'm wondering how that affects your experiences there?
22. Those are all the questions that I have regarding the issue of accessibility for gay men or queer people at Three Bridges Community Health Centre, I'm just wondering if there is anything that we haven't talked about, that you think might be relevant?
23. How would you describe how your sexual orientation or sexual identity comes into play in health care you receive?
24. How would you describe your experiences in the past around your sexual orientation with health care providers?

All information is strictly confidential; there will be no identification of me personally on any records. Confidentiality will be achieved by the researchers using a code number on any printed or computer documents, and by storing this information in a locked filing cabinet, or under a password if kept on a computer hard drive.

Any concerns about my rights or treatment in this study may be forwarded to Dr. K. D. Srivastava, Acting Director of the UBC Office of Research Services and Administration at 604-822-8598.

I have read and understood the content, and received a copy of this consent form for my own records. My signature below may be taken as evidence of my consent to participate in the "Accessibility to Health Services for Gay Men" project.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_, 2002

I will receive a copy of the research findings if I provide a mailing address (below).

All information is strictly confidential; there will be no identification of me personally on any records. Confidentiality will be achieved by the researchers using a code number on any printed or computer documents, and by storing this information in a locked filing cabinet, or under a password if kept on a computer hard drive.

Any concerns about my rights or treatment in this study may be forwarded to Dr. K. D. Srivastava, Acting Director of the UBC Office of Research Services and Administration at 604-822-8598.

I have read and understood the content, and received a copy of this consent form for my own records. My signature below may be taken as evidence of my consent to participate in the "Accessibility to Health Services for Gay Men" project.

Legal Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_, 2002

Date of Birth (yy/mm/dd):    /    /

Mailing address (if requesting a copy of research findings):

## Appendix H: Initial Coding Scheme (prior to coding data)

Q.S.R. NUD.IST Power version, revision 4.0.

PROJECT: Access Project, User Glen Moulton, 7:33 pm, May 9, 2002.

- (1) **Clients**
- (1 1) Clients/Gay Clients
- (1 1 1) Clients/Gay Clients/Characterization
- (1 1 2) Clients/Gay Clients/Health Issues
- (1 1 3) Clients/Gay Clients/Barriers in the Health System
- (1 1 3 1) Clients/Gay Clients/Barriers in the Health System/Articulation of Barriers
- (1 1 4) Clients/Gay Clients/Risk Behaviours
- (1 1 5) Clients/Gay Clients/Internalized Homophobia
- (1 1 6) Clients/Gay Clients/Feedback to Staff
- (1 1 7) Clients/Gay Clients/Participation
- (1 2) Clients/Non-Gay Clients
- (2) **Staff**
- (2 1) Staff/Roles at 3B CHC
- (2 2) Staff/Role in Accessibility
- (2 3) Staff/Gay Service Providers
- (2 4) Staff/Training
- (2 5) Staff/Other Jobs
- (3) **3B CHC**
- (3 1) 3B CHC/Architecture
- (3 2) 3B CHC/Location
- (3 3) 3B CHC/Current Programs at 3B CHC
- (3 3 1) 3B CHC/Current Programs at 3B CHC/Pride Health
- (3 3 2) 3B CHC/Current Programs at 3B CHC/Boys R Us
- (3 3 3) 3B CHC/Current Programs at 3B CHC/Alcohol and Drug
- (3 3 4) 3B CHC/Current Programs at 3B CHC/Community Counselling
- (3 3 5) 3B CHC/Current Programs at 3B CHC/Physician Services
- (3 3 6) 3B CHC/Current Programs at 3B CHC/Nurse
- (3 3 7) 3B CHC/Current Programs at 3B CHC/Vanguard
- (3 4) 3B CHC/Gay-Friendly Environment
- (3 5) 3B CHC/Waiting Room
- (3 6) 3B CHC/Marketing & Publicity
- (3 7) 3B CHC/Governance
- (3 8) 3B CHC/Deterrents to Accessibility
- (3 9) 3B CHC/Features to Attract Gay Men
- (3 10) 3B CHC/How 3B's Addresses Barriers
- (3 11) 3B CHC/Challenges in Facilitating Accessibility
- (3 12) 3B CHC/Suggestions for Improvement
- (3 13) 3B CHC/Hypothetical Programs & Services in a CHC

- (3 14) 3B CHC/Vision of a CHC
- (3 15) 3B CHC/Partnerships & Collaboration
- (4) **VCHA**
- (4 1) VCHA/LGBT PHAC
- (4 2) VCHA/CHA 1
- (4 3) VCHA/Community Developers
- (4 4) VCHA/Opinions of Staff towards VCHA
- (4 5) VCHA/Restructuring
- (4 5 1) VCHA/Restructuring/Pre-reform
- (4 5 2) VCHA/Restructuring/"Reform"
- (4 6) VCHA/Role of Policy in Service Delivery
- (5) **Health System**
- (5 1) Health System/Other Primary Care Settings
- (5 2) Health System/Hospitals
- (5 3) Health System/Heterosexism
- (6) **Community**
- (6 1) Community/Gay Community
- (6 2) Community/Non-Gay Community
- (7) **Accessibility**
- (7 1) Accessibility/Financial Access
- (7 2) Accessibility/Geographic Access
- (7 3) Accessibility/Cultural Accessibility
- (7 4) Accessibility/Functional
- (7 5) Accessibility/Framework Elements
- (7 6) Accessibility/Stakeholders
- (7 7) Accessibility/Availability of Providers
- (8) **Methodology**
- (8 1) Methodology/Interviews
- (8 2) Methodology/Participant Observation
- (8 3) Methodology/Document Analysis
- (8 4) Methodology/3B's Intake Forms
- (8 5) Methodology/Challenges or Limitations
- (8 6) Methodology/Negotiating Entry

# **Appendix I:** **Final Coding Scheme (after coding data)**

Q.S.R. NUD.IST Power version, revision 4.0.

PROJECT: Access Project, User Glen Moulton, 12:00 pm, Jun 18, 2002.

- (1) **Clients**
- (1 1) Clients/Gay Clients
- (1 1 1) Clients/Gay Clients/Characterization
- (1 1 2) Clients/Gay Clients/Health Issues
- (1 1 3) Clients/Gay Clients/Barriers in the Health System
- (1 1 3 1) Clients/Gay Clients/Barriers in the Health System/Articulation of Barriers
- (1 1 4) Clients/Gay Clients/Risk Behaviours
- (1 1 5) Clients/Gay Clients/Internalized Homophobia
- (1 1 6) Clients/Gay Clients/Feedback to Staff
- (1 1 7) Clients/Gay Clients/Participation
- (1 1 8) Clients/Gay Clients/Social Isolation
- (1 1 9) Clients/Gay Clients/Information Seeking
- (1 1 10) Clients/Gay Clients/Sub-populations
- (1 1 11) Clients/Gay Clients/Expectations of 3B's
- (1 2) Clients/Non-Gay Clients
- (1 3) Clients/Mixing Clients
- (2) **Staff**
- (2 1) Staff/Roles at 3B CHC
- (2 2) Staff/Role in Accessibility
- (2 3) Staff/Gay Service Providers
- (2 4) Staff/Training & Life Histories
- (2 5) Staff/Other Jobs
- (2 6) Staff/Disclosing Sexuality
- (3) **3B CHC**
- (3 1) 3B CHC/Architecture
- (3 2) 3B CHC/Location
- (3 3) 3B CHC/Current Programs at 3B CHC
- (3 3 1) 3B CHC/Current Programs at 3B CHC/Pride Health
- (3 3 2) 3B CHC/Current Programs at 3B CHC/Boys R Us
- (3 3 3) 3B CHC/Current Programs at 3B CHC/Alcohol and Drug
- (3 3 4) 3B CHC/Current Programs at 3B CHC/Community Counselling
- (3 3 5) 3B CHC/Current Programs at 3B CHC/Physician Services
- (3 3 6) 3B CHC/Current Programs at 3B CHC/Nurse
- (3 3 7) 3B CHC/Current Programs at 3B CHC/Vanguard
- (3 3 8) 3B CHC/Current Programs at 3B CHC/Youth Program
- (3 4) 3B CHC/Gay-Friendly Environment
- (3 4 1) 3B CHC/Gay-Friendly Environment/Confidentiality
- (3 4 2) 3B CHC/Gay-Friendly Environment/Harm Reduction Approach

- (3 4 3) 3B CHC/Gay-Friendly Environment/Non-judgemental
- (3 4 4) 3B CHC/Gay-Friendly Environment/Respectful
- (3 4 5) 3B CHC/Gay-Friendly Environment/Underlying Philosophies
- (3 5) 3B CHC/Front Desk & Waiting Room
- (3 6) 3B CHC/Marketing & Publicity
- (3 7) 3B CHC/Governance
- (3 8) 3B CHC/Deterrents to Accessibility
- (3 9) 3B CHC/Features to Attract Gay Men
- (3 9 1) 3B CHC/Features to Attract Gay Men/One-Stop Shop
- (3 10) 3B CHC/How 3B's Addresses Barriers
- (3 11) 3B CHC/Challenges in Facilitating Accessibility
- (3 12) 3B CHC/Suggestions for Improvement
- (3 13) 3B CHC/Hypothetical Programs & Services in a CHC
- (3 14) 3B CHC/Vision of a CHC
- (3 15) 3B CHC/Partnerships & Collaboration
- (3 16) 3B CHC/Outreach
- (3 17) 3B CHC/Intake Forms
- (3 18) 3B CHC/Teaching Environment
- (3 19) 3B CHC/Referrals
- (3 20) 3B CHC/Stigma of Clinic
- (3 21) 3B CHC/Information Gaps
- (3 22) 3B CHC/Volunteers
- (3 23) 3B CHC/Care Cards
- (4) **VCHA**
- (4 1) VCHA/LGBT PHAC
- (4 1 1) VCHA/LGBT PHAC/Community Participation
- (4 2) VCHA/CHA 1
- (4 3) VCHA/Community Developers
- (4 4) VCHA/Opinions of Staff towards VCHA
- (4 5) VCHA/Restructuring
- (4 5 1) VCHA/Restructuring/Pre-reform
- (4 5 2) VCHA/Restructuring/"Reform"
- (4 5 3) VCHA/Restructuring/Transition Phase
- (4 6) VCHA/Role of Policy in Service Delivery
- (4 7) VCHA/Comm & Pub Involve
- (5) **Health System**
- (5 1) Health System/Other Primary Care Settings
- (5 2) Health System/Hospitals
- (5 3) Health System/Heterosexism
- (5 4) Health System/Service Providers
- (6) **Community**
- (6 1) Community/Gay Community
- (6 1 1) Community/Gay Community/Capacity Building
- (6 2) Community/Non-Gay Community
- (7) **Accessibility**
- (7 1) Accessibility/Financial Access

- (7 2) Accessibility/Geographic Access
- (7 3) Accessibility/Cultural Accessibility
- (7 4) Accessibility/Functional
- (7 5) Accessibility/Framework Elements
- (7 6) Accessibility/Stakeholders
- (7 7) Accessibility/Availability of Providers
- (7 8) Accessibility/Availability of Services
- (7 9) Accessibility/Appropriateness
- (8) **Methodology**
- (8 1) Methodology/Interviews
- (8 2) Methodology/Participant Observation
- (8 3) Methodology/Document Analysis
- (8 4) Methodology/3B's Intake Forms
- (8 5) Methodology/Challenges or Limitations
- (8 6) Methodology/Negotiating Entry
- (8 7) Methodology/Sample
- (8 8) Methodology/Research Purpose
- (F) **Free Nodes**
- (F 1) Free Nodes/Clients
- (F 1 1) Free Nodes/Clients/Resolving Conflict
- (F 1 2) Free Nodes/Clients/Trans Clients
- (F 1 3) Free Nodes/Clients/Hierarchy among Clients
- (F 2) Free Nodes/Staff
- (F 2 1) Free Nodes/Staff/Multidisciplinary Team
- (F 3) Free Nodes/3B CHC
- (F 3 1) Free Nodes/3B CHC/Financial Resources
- (F 3 2) Free Nodes/3B CHC/Can't Do it All
- (F 3 3) Free Nodes/3B CHC/Safe Environment

## Appendix J: Summary of Research Design

<b>Research Paradigm and Research Design</b>
<ul style="list-style-type: none"> <li>➤ interpretive/constructivist paradigm with a critical perspective</li> <li>➤ qualitative research – “how” research question – descriptive and exploratory</li> <li>➤ case study research design</li> </ul>
<b>Development of the Conceptual Framework</b>
<ul style="list-style-type: none"> <li>➤ incorporated literature (primary health care, health promotion/population health, accessibility, and gay men’s health), research question(s), researcher’s personal knowledge, and the data itself</li> </ul>
<b>Site Selection and Population Sampling</b>
<ul style="list-style-type: none"> <li>➤ negotiating entry included informal introductions with Lead Physician, ethical approval from the University of British Columbia, and approval from the Vancouver Coastal Health Authority</li> <li>➤ Three Bridges Community Health Centre – site selected because entry was possible; rich mix of processes, people, programs, interactions and structures; good relationships with participants likely</li> <li>➤ non-probabilistic sample – purposive and theoretical sampling – not meant to generalize, but chosen to delve into complex phenomena</li> <li>➤ sample was chosen because it was believed they would represent the key, salient perspectives of various stakeholders since their power and roles varied (see semi-structured interviews section below).</li> </ul>
<b>Archival Materials (Documents)</b>
<ul style="list-style-type: none"> <li>➤ 25 documents were reviewed ranging from 1 to 104 pages (with a mean of 16 pages, and a total of 398 pages)</li> <li>➤ documents collected were mostly of the former Vancouver/Richmond Health Board, and not the Vancouver Coastal Health Authority (VCHA), and were thus used sparingly since the future policies of the VCHA may not be represented in documents produced by the V/RHB</li> <li>➤ documents from the Three Bridges Community Health Centre were also somewhat dated</li> </ul>
<b>Participant Observation</b>
<ul style="list-style-type: none"> <li>➤ included the systematic noting and recording of events, behaviours, and objects in the setting, mostly in the waiting room, but also attended a Pride Health meeting, and related community meetings</li> <li>➤ cumulatively, participant observation lasted for approximately 33 hours</li> <li>➤ because the clinic’s programs are mostly one-on-one, my role mostly as an observer</li> </ul>
<b>Semi-Structure Interviews</b>
<ul style="list-style-type: none"> <li>➤ community developers of the Population Health Advisory Committee for Lesbian, Gay, Bisexual and Transgender People and Community Health Area 1 (N=2); (b) senior staff at the Three Bridges Community Health Centre (N=2); (c) program staff (N=4); (d) seconded staff (N=3); and, (e) gay male clientele (N=3)</li> <li>➤ VCHA board members or senior staff at VCHA were not approached or interviewed because of major internal restructuring</li> </ul>

➤ non-clients solicited through letters; clients solicited through leaflet displayed at clinic and distributed by providers at clinic
<b>Data Analysis Strategy</b>
<ul style="list-style-type: none"> <li>➤ interviews were transcribed and entered into a qualitative software package - NUD*IST 4.0.</li> <li>➤ data was coded (asked 'What is this about?') using initial coding scheme; text units that did not fit into existing coding schemes were given a new code.</li> <li>➤ the data was combed through several times – the first time for familiarity, and to establish repetition/duplication of text units among different codes since some text units (paragraphs) were coded to more than one code (theme). Content under various themes / text units were reviewed and revised, and codes were then collapsed, shifted or expanded as required.</li> </ul>
<b>Assessing the Quality of Case Study Research (Trustworthiness Features)</b>
<ul style="list-style-type: none"> <li>➤ triangulation (the collection of data from different sources using different methods/strategies) was achieved by incorporating a literature review, document analysis, participant observation, and interviews from a variety of informants. Theoretical triangulation occurred in that diverse theories or bodies of knowledge were incorporated into the conceptual framework, including primary health care, health promotion, population health, accessibility and gay men's health.</li> </ul>

## Appendix K: Summary of Results

<b>A Mission of Accessibility for Vulnerable Populations</b>
<ul style="list-style-type: none"> <li>➤ clinic serves at-risk populations who have difficulty accessing the mainstream system</li> <li>➤ clinic doesn't encourage clients with few or no barriers</li> </ul>
<b>Assessment of Gay Men's Health Issues, Barriers and Needs</b>
<ul style="list-style-type: none"> <li>➤ gay men have numerous health issues which need to be understood from socio-environmental (homophobia, heterosexism), lifestyle/behavioural, medical and personal development perspectives (low self-esteem, coming out).</li> <li>➤ barriers in the health system (related to sexual orientation – real and perceived heterosexism and homophobia, previous homophobic encounters, lack of confidentiality, difficulty or fear of disclosing sexual orientation, fear of judgement/felt judged; homophobic front desk staff; heterosexist intake forms</li> <li>➤ providers' lack of knowledge of gay men's health issues, and clients' lack of knowledge of how the health system works and health issues</li> <li>➤ psychiatry and counselling singled out as being particularly homophobic/heterosexist</li> <li>➤ financial barrier for counselling services</li> <li>➤ barriers also exist with gay physicians/providers – clients do not want to disclose unhealthy behaviours</li> <li>➤ lack of available 'out' gay or gay-positive physicians or difficulty identifying them for clients</li> <li>➤ client referrals to external providers difficult because of the lack of queer-friendly providers, and/or a difficulty in identifying other queer-friendly providers</li> <li>➤ referrals for mental health counselling difficult because of financial barriers</li> <li>➤ other barriers compounded by sexual orientation and vice versa (low socio-economic status, poor literacy skills, alcohol and drug problems, mental health issues, mental and physical disabilities, race, ethnic (e.g. language)</li> <li>➤ particularly vulnerable sub-groups – immigrants/refugees, male sex trade workers, transsexual gay men, street youth, effeminate/androgynous men</li> </ul>
<b>Utilization</b>
<ul style="list-style-type: none"> <li>➤ clinic serves people who live and work in the area (seniors, families with young children, single professionals, GLBT people, street/youth, individual with addictions)</li> <li>➤ clientele are diverse which causes tensions, particularly in waiting room; hierarchy among clientele, some clientele feel unwelcome, unsafe or that they do not belong</li> <li>➤ clientele's access issues/barriers are not mutually exclusive</li> <li>➤ estimate of queer clientele – 20 to 25%; mostly gay men and transgender people</li> <li>➤ difficult to characterize the gay male or general clinic clientele (anecdotally described as lower socio-economic, younger, mostly Caucasian, poorer health status than general population)</li> <li>➤ some gay men only use Three Bridges for STD testing/treatment</li> <li>➤ some partial or non-users (including gay men) do not like clinic's street/poverty connection (tend to be more affluent)</li> <li>➤ seniors, street youth and refugees and immigrants singled out as needing additional services, although not necessarily at Three Bridges – outreach, satellite clinics</li> </ul>

suggested
<b>Delivery of Appropriate Programs &amp; Services</b>
<ul style="list-style-type: none"> <li>➤ three client streams: primary care; youth services; and addictions (alcohol and drug counselling, methadone/harm reduction program)</li> <li>➤ other services: community counselling, research projects (Vanguard &amp; HIV vaccine trials), Boys R Us (a drop-in centre, an outreach program to the 'stroll,' and an exit program), Pride Health, and community health services (2<sup>nd</sup> floor)</li> <li>➤ services mostly one-on-one therapeutic/treatment-oriented</li> <li>➤ with current level of resources (time, money, personnel), the clinic cannot take on much more in the area of gay men's programming</li> <li>➤ outreach and partnerships deemed critical in current and future programming</li> <li>➤ suggestions for improvement - expand Pride Health Services and other services beyond Three Bridges</li> <li>➤ four areas frequently mentioned as gaps in programming for gay male clients - mental health; referrals; health promotion; and information.</li> <li>➤ staff feel only partially responsible to alleviate programming gaps related to mental health and referrals since they are issues for many users of the health care system, and should therefore be addressed by other stakeholders (e.g. VCHA, Gov't of B.C.)</li> <li>➤ health promotion and information, these issues were being addressed, but still challenging</li> <li>➤ information gaps for clients about services available services at clinic, as well as a lack of health information on pertinent health issues</li> <li>➤ some providers at clinic and other agencies were organizing a wellness fair or gay men's health series, which would consist of an event or events to attract gay men.</li> <li>➤ challenges in getting information about health and social events out in the community, as well as challenges in creating social events and decreasing social isolation in the gay community.</li> <li>➤ need for more social support groups for gay men on a range of issues (e.g. personal development – coming out, self-esteem, diseases/illnesses)</li> </ul>
<b>Available Providers With Appropriate Knowledge, Attitudes and Behaviour</b>
<ul style="list-style-type: none"> <li>➤ variety of full- and part-time health providers, support staff, seconded staff, volunteers and students/residents</li> <li>➤ front-desk staff deemed critical in providing gay-friendly care</li> <li>➤ approximately fifty percent of the staff (on the first floor at clinic) are gay or lesbian</li> <li>➤ queer providers at clinic recalled experiencing homophobia or heterosexism</li> <li>➤ straight staff at clinic more likely to have a more functional, and less personal attachment to the queer community</li> <li>➤ the presence of out, queer staff increases the likelihood that queer people will frequent clinic (i.e., clients search out queer providers)</li> <li>➤ staff felt education for health professionals around queer health was lacking</li> <li>➤ providers' self-interest in the queer population facilitated their self-directed education</li> <li>➤ recruiting queer staff was deemed to be very important in creating an accessible environment for queer people</li> <li>➤ many queer providers engaged community-based gay men's health issues for years</li> <li>➤ clinic is a venue for training family practice residents and medical, nursing and social work students. This may affect continuity of care for patients.</li> </ul>

<ul style="list-style-type: none"> <li>➤ reception staff, residents, nurses and physicians were all singled out as needing more education to create a more, gay-friendly clinic</li> <li>➤ suggestions to improve lack of knowledge included better in-house training, external training, and improvements in the curriculum for on queer health issues</li> <li>➤ social support group for queer providers or better means of communication were suggested as a means to connect with other professionals around queer health issues</li> </ul>
<b>Cultural Accessibility (Gay-Friendly Environment)</b>
<ul style="list-style-type: none"> <li>➤ attributes that signify a gay-friendly environment: people feeling comfortable, safe and respected (non-threatening environment); confidentiality; comfort with asking questions; non-judgemental environment; availability of appropriate printed material; welcoming through visual cues; and being free of, and sensitive to, discrimination.</li> <li>➤ wanted clinic to be more welcoming</li> <li>➤ intake forms (other than for Pride Health Services) do not mention sexual orientation/gender identity, but do have partner rather than spouse</li> <li>➤ in the waiting area, or on the clinic's main doors, there were no rainbow (Pride) flags</li> <li>➤ clients felt a greater sense of safety, personalized service, ownership and diversity</li> </ul>
<b>Geographic Accessibility (Location)</b>
<ul style="list-style-type: none"> <li>➤ the clinic was created with the expectation that it would serve persons living and working in the geographic area (downtown Vancouver, the West End, Yaletown etc.)</li> <li>➤ staff felt that the location was appropriate for the gay men and other marginalized populations that they do serve, but not conducive to attracting a larger gay male clientele because of a lack of visibility and awareness by gay men</li> <li>➤ client informants felt the location was appropriate</li> <li>➤ clinic welcomes clients from outside the designated geographic area because of its unique services and gay-friendly providers</li> <li>➤ if the clinic were located in a more visible area, it may not attract gay men because it may be "too visible," or its association with people who are poor and/or use drugs</li> <li>➤ suggestions to improve geographic accessibility/visibility included outreach, satellite clinics, holding special events outside the West End, and more clinics, like Pride Health Services, in other community health centres</li> </ul>
<b>Physical Accessibility (Architecture)</b>
<ul style="list-style-type: none"> <li>➤ a barrier expressed for effective multidisciplinary work was the division between the first and second floors, and distance among some providers on 1<sup>st</sup> floor</li> <li>➤ some staff felt restricted because of lack of space, although more than in former clinic</li> <li>➤ locked doors which divide the clinic into four, separate restricted areas thought to be a potential barrier, but necessary; locked doors improved privacy for support groups</li> <li>➤ a strength of the building were multiple entrances and waiting areas (especially for Pride Health Services)</li> <li>➤ community developer (office) located away from most other staff and the public</li> <li>➤ small health information area available, but not yet developed</li> <li>➤ waiting room problematic because of mixed clientele</li> <li>➤ a suggestion to improve the waiting area for queer folks was to make the waiting room more queer friendly by displaying a rainbow (Pride) flag, but concern expressed this might alienate straight clientele</li> </ul>
<b>Financial Accessibility (Affordability)</b>
<ul style="list-style-type: none"> <li>➤ services are free</li> </ul>

<ul style="list-style-type: none"> <li>➤ people who <i>can</i> afford to pay for services are assisted with finding alternate care, which allows greater accessibility for clients who cannot afford to pay for services</li> <li>➤ clients do not need to have B.C. Medical Services Plan coverage to receive care at Three Bridges, or to obtain lab work and x-rays at St. Paul's Hospital</li> </ul>
<b>Functional Accessibility (Convenience)</b>
<ul style="list-style-type: none"> <li>➤ refers to aspects of the clinic related to convenience, such as increased hours of operation until 8 p.m. and open on Saturday's, drop-in appointments, multiple services under one roof (one-stop shop), length of appointments, salaried physicians</li> <li>➤ suggestions for improvement included having the clinic stay open later. Boys R Us participants may have difficulty accessing the clinic before 8pm</li> <li>➤ suggestions to improve the workings of the multidisciplinary team with more opportunities to meet</li> <li>➤ improving information systems/technology was also suggested as a means to improve coordination of care, and the sharing of information among community health centres around queer health issues and initiatives</li> </ul>
<b>Awareness (Marketing &amp; Publicity)</b>
<ul style="list-style-type: none"> <li>➤ much of the clinic's efforts around publicizing to gay men have been to increase awareness of Pride Health Services</li> <li>➤ word-of-mouth among clients and organizations, and inter-organizational communication were their most effective means to reach their target population</li> <li>➤ providers were concerned that there were many potential clients of Pride Health Services that were unaware of its existence, and yet they were concerned that if they market too much, they would be overwhelmed with clients</li> </ul>
<b>Partners in Accessibility</b>
<ul style="list-style-type: none"> <li>➤ staff spoke positively of former V/RHB</li> <li>➤ VCHA only recently appointed at the time this research was conducted</li> <li>➤ numerous partners involved in programs and initiatives at the clinic</li> <li>➤ fostering clients' participation at the clinic was thought to be more difficult or unnecessary</li> </ul>