

Planned Parenthood of Toronto



# WOMEN'S NEEDS ASSESSMENT PROJECT

**Final Report - September 2002**

Prepared by:  
Women's Needs Assessment Committee  
Planned Parenthood of Toronto

**Forty years ago we began advocating for women's health and rights. This process and report are evidence that we remember our roots, our global connections and our values and commitment to women.**  
**- Hazelle Palmer, Executive Director**

The Women's Needs Assessment Committee members:

Rose Gutierrez  
Andrea Joyce  
Bridget McFarthing  
Leslie Molnar  
Mary O'Campo

Planned Parenthood of Toronto gratefully acknowledges the contributions of the following individuals in the preparation of this needs assessment report:

Key Informants

Focus Group Participants

Brian Hyndman

Sabrina Zollo

Xiaoming Hu

Nan Peacocke

Consultant

Literature Review

Literature Review

Editor

## **TABLE OF CONTENTS**

Executive Summary	5 - 7
Introduction	8 - 11
Process	12 - 13
Key Informant Findings	14 - 30
Focus Groups	31 - 39
Conclusions and Recommendations	40 - 44
References	45 - 46
<b>Appendix</b>	

## EXECUTIVE SUMMARY

The Women's Needs Assessment Project is an initiative of Planned Parenthood of Toronto (PPT) that involved a series of consultations with diverse women communities in Toronto to determine their opinions on the existing health care systems. In particular, the assessment would provide opportunities for women to state what challenges they face, what barriers to access exist and how effectively current health care services address their sexual and reproductive needs. The report's conclusions are unambiguous on the political, social and economic determinants that shape and mis-shape women's sexual and reproductive health and on the difficulties women encounter in accessing effective, preventative services that are free of cultural bias. Its twelve recommendations specifically address a health, rights and empowerment framework for moving forward.

The Project emerges within a tradition of innovative sexual reproductive health programming by Planned Parenthood of Toronto. PPT's broad and comparatively long (40 years) experience places the WNA in a beneficial position with regard to local, national and international affiliations and perhaps most significantly, affords the Project a history of commitment to values that are client-oriented, non-judgemental, sex-positive and pro-choice. Indeed, the adoption some four years ago of a community development framework as the philosophical basis and model for building upon its work signalled the agency's readiness to deepen its capacity to negotiate the complex and changing demographics and sexual cultures of Toronto.

Reviewing PPT's programming in the context of its commitment to women's health and confident of the agency's expertise in this field, staff began raising a series of questions for the purpose of determining what would further its partnerships in making women's health a priority in PPT programming. With the help of a Communications consultant, the five-person WNA Committee designed a strategy and workplan for a needs assessment. It would draw on interviews with 23 Key Informants from among community volunteers, health professionals and business. Four Focus Groups included participants living at a women's shelter, a pre-established mid-life group, a client focus group, and a general women's group. Women reflected diversity of dis/ability, age, ethno-cultural and sexual identity.

Selections from the literature review are effectively integrated in the text of the report, substantiating issues raised from the ground, so to speak, with scholarly research and offering useful insights and suggestions.

The Key Informants represented a mix of professional and voluntary services including information provision, peer counselling, referral, housing, food banks, medical and legal support. Their programs serve a range of communities including women and children with disabilities, street involved youth, lesbians and gays, transgendered women, divorced and widowed women, women and children living in shelters, women immigrating to Canada, prostitutes, women in or released from provincial and federal prisons, and HIV and Hepatitis C positive women. The Key Informants work with women of all ages in a wide range of sexual health services that encompass homelessness, relationships, partner and child abuse, addiction, and depression associated with sexual orientation, bereavement and mid-life

sexuality. The Key Informants, like the clients they serve, come from diverse ethno-cultural communities. Many emphasize preventative, holistic and sex-positive approaches in their work.

The WNA determined from interviews with Key Informants that while agencies attempt to address the complex personal, social and cultural designations of women's sexual health, their mandates were often defined by entirely arbitrary funding restrictions such as age. The most vulnerable in society, already female and socio/economically disadvantaged, were further marginalized by the judgmental attitudes and assumptions of the dominant society. This attitudinal access was singled out as one of the foremost barriers to the delivery of primary sexual health and is reinforced in the WNA's report with references to current research on the inadequate education of physicians. Such research proposed the incorporation of gender and sexual reproductive issues in the training of medical practitioners to better enable communication and more usefully to assess their patients' sexual history. Complementing this, Key Informants underscored the value of workshops in areas related to sexuality for women with disabilities. They stressed that self-esteem is a critical feature of personal empowerment in the practitioner/client relation and in the negotiating of safe sex between sexual partners.

The Key Informants reported a diminishing referral base to general physicians and specialists. They associated this decline with the increasing significance of economic and cultural barriers to sexual health delivery. As attitudes and beliefs about sexuality and disability change across a widening base of communities, systems of care must respond. Alternative methods, the informants advised, must review the sexual health priorities of women living the contemporary realities of city life. Services must take account of physical access in the design of clinics, but communication formats are just as important to accessibility by clients constrained by loss of language, literacy, or by disabilities such as visual and hearing impairment.

Telephone hotlines, printed material and the Internet were the resources deemed most useful for accessing sexual health information by Focus Group members. Participants of these groups shared with Key Informants a view of medical doctors as operating within a structure that is inadequate to women's experienced needs. The report notes an alarming tendency by clients to defer sexual health checks, compounding negative implications for the overall health of women already produced by a dominantly reactive (rather than preventative) medical model. Again, research findings proposing appropriate educational interventions, public health policy and strategies for clinical management substantiate suggestions discussed in the WNA Project and are helpfully referenced in the report.

Consistent with PPT's method of interrelating community, concept, and consultation, the WNA's report identifies the social, environmental and political determinants of health as most influential on the status of women's sexual health. The categorizations that class, race, immigration status, etc. impose on citizens have long been understood by vulnerable clients and by health workers to determine trends in health status. However, the growing barriers and gaps this report makes evident in the relationship between emotional and physical health signal this

situation as a matter of urgency.

WNA Recommendations are a comprehensive distillation of a broad based and well researched discussion. They speak to changing trends, conditions and priorities in social and health environments and to popular influences on health promotion programming. Maintaining PPT's commitment to respecting community, to advocacy and partnerships, the initiatives proposed seek to investigate, extend and integrate services and programs with a wider capacity to respond to women's sexual health needs in consultation with diverse groups and organizations. They address the contradictions between women's sexual health needs in contemporary society and socially dominant assumptions that currently dictate policy and profoundly affect women's well being.

The report urges funding of peer-based, mobile, and flexible models of access that are more sensitive to ageing, disability, and a changing sexual culture and less driven by "medicalization" and therefore more effective in delivery. Interagency relationships advocating and building holistic, women-centred models of health care particularly address the ethno-cultural character of city communities. The report attests that, if recognized and developed today, an overarching comprehension of the broad determinants of health offer the best fundamentals for a health care system that has the potential to meet the interrelated sexual health needs of women in the future.

## INTRODUCTION

*Planned Parenthood of Toronto (PPT) is a community-based, pro-choice agency committed to the principles of equity and to providing accessible and inclusive services which promote healthy sexuality and informed decision making to the people of the City of Toronto.*

Since 1961, PPT has been providing sexual health counselling and information services to Toronto residents. While our focus has been on sexual and reproductive health, the past fifteen years has seen our programming expand to include clinical primary care services, mental health counselling, violence prevention programs, health promotion and prevention programs, and anti-homophobia education.

This unique range of programming has enabled the agency to reach and work with diverse communities across the city and to form strong partnerships that are aimed at reducing and eliminating barriers to accessing sexual and other health services.

PPT has built a strong reputation in the area of sexual and reproductive health. Our unique approach to addressing sexual health issues is influenced by our agency's history, our affiliations, and our values. PPT was established in 1961 by George and Barbara Cadbury who were astonished to learn that dissemination of birth control was, at that time, illegal in Canada. Rallying a group of committed volunteers, the Cadburys spent years lobbying provincial and federal levels of government to change Sect. 51 of the Criminal code. Finally, in 1969 the law was changed and this significant development ushered in the beginnings of a sexual revolution that would change women's choices to this day.

Our affiliation with Planned Parenthood Federation of Canada and International Planned Parenthood Federation enhances the work we do locally, and keeps us connected to national and international issues effecting sexual, reproductive and human rights.

Finally, it is our values that have sustained the agency for the past 40 years. We believe in a client-centred, non-judgmental, sex-positive and a pro-choice approach to providing sexual health services and programming. This approach leads the individual to informed decision-making.

### **The Programs**

PPT operates seven unique and innovative programs. They are:

#### ***The Volunteer Opportunities Program***

Volunteers play a key role in PPT's activity. Approximately 200 volunteers currently work in a variety of agency capacities. The most popular volunteer program recruits and trains people to work as sexual health education counsellors either in clinics (The House and Bay Centre for Birth Control) or by phone. Volunteers are also critical to the Board of Directors, community outreach initiatives, fundraising events, speaking events and administrative tasks. PPT's volunteer pool is culturally and socially diverse and representative of Metropolitan Toronto.

### ***The Teen Sex Information Program***

The Teen Sex Information Program (TSIP) offers information, peer counselling and health promotion outreach activities 7 days a week to youth aged 13 to 16 who live in the city of Toronto. The program trains and supports youth to provide services to their peers in three distinct ways. On the phone through the Teen Sex InfoLine, a telephone counselling service, through outreach activities in middle schools and at youth health fairs and events, and on the Internet through a new youth-based web site called spiderbytes.ca. The TSIP is contacted by 250 to 300 youth per month.

### ***The House Community Health Centre***

The House is a community health centre specially geared towards adolescents and young adults. This clinic, which specializes in services for healthy sexuality and on issues of birth control and STIs, is a multi-disciplinary environment incorporating both medical staff and trained volunteers. The House sees approximately 6,000 young people annually.

### ***PPT at The Bay Centre for Birth Control***

The Bay Centre for Birth Control (BCBC) is the largest birth control clinic in Canada, offering services for 2,000 women monthly. PPT's program at the BCBC provides trained lay counsellors who in turn provide women-centred support and information to other women on birth control, pregnancy, STIs, interpersonal relationships and pregnancy options. Our program at the BCBC is PPT's only women's specific program.

### ***Community Health Promotion***

Our Community Health Promotion (CHP) outreach program works with high schools, groups and agencies to promote healthy sexuality and answer questions about reproductive and sexual health. Activities include health fairs, workshops, networking, community development and promoting PPT services. CHP recently launched the Sex ED In The City series, an annual 2-day training for professionals working with youth, at-risk and marginalized communities, in the area of sexual and reproductive health.

### ***T.E.A.C.H.— Teens Educating and Confronting Homophobia***

This program recruits and trains youth volunteers to go into high schools and talk with their peers about sexual orientation, the need for acceptance and the painful impact of homophobia. To date, the T.E.A.C.H. program has conducted 425 workshops and currently has 18 teen volunteers.

### ***SexAbility***

SexAbility is an exciting initiative designed to meet the diverse sexual and reproductive health needs of youth and young adults with mobility disabilities. This program is intended to provide information on issues of sex and sexual health faced by youth and young adults, through peer counselling, workshops and resources. PPT has partnered with The Anne Johnston Health Station, a community health centre in North York to offer this program.

## **Responding to Community Need**

Health promotion and prevention programs have always been influenced by emerging trends, peaks in infection rates, and reactions to social conditions and priorities. PPT's health promotion and prevention programming is also influenced by these factors. Many of the programs we operate are youth-focussed because youth face many barriers accessing unbiased sexual health information. Statistics that show rates of unplanned pregnancy and infection transmission demonstrate the need for youth to have early access to sex education. We believe we can create an environment for informed decision making by providing youth with information, access to services and non-judgmental counselling *when* they have questions and *when* they need it. Further, we believe this approach to service delivery, along with increased availability and methods of birth control options and emergency contraception, has yielded significant results. Teenage pregnancy rates hit a recent 10-year low and have been declining steadily since 1994 (*The Daily, Statistics Canada*, October 2000). Yet while we have seen a decrease in teenage pregnancy, sexually transmitted infection rates, particularly chlamydia, gonorrhoea and HIV, have been slowly increasing since 1997 (*Canadian STD Surveillance Report, Health Canada*, 1999) and continue to be of concern to teenagers and young adults.

In general, the focus of sexual health programming is also influenced by popular culture. Sex, sex information, reproductive health issues, and safer sex are often geared towards and associated with youth populations. That is, youth are having sex, youth need to have information about sex, and youth need to be "warned" about being safe when having sex. Ironically, youth still confront many barriers to accessing clear and unbiased information on sexual health issues when they require it.

The sexual health needs of young women to the age of 25 are often generalized or categorised among youth issues. Women are still predominately seen to be responsible for birth control protection. This responsibility carries with it the assumption that women have been able to easily access ways to learn about birth control methods, that they've exercised choice, and that they have a clear understanding of any contradictions to their health or lifestyle. In particular, women over the age of 25 are assumed to be "educated" about their sexual health, at a "child bearing age" or within a monogamous heterosexual relationship where knowing birth control options or safer sex methods is either routine or a lesser priority.

### **Why a Women's Needs Assessment**

When PPT began four decades ago we fought for women's right to choose and have access to services. Our 27-year-old partnership with the Bay Centre for Birth Control represents a long-standing commitment by PPT to make women's health a priority and central to our programming. Our experience in sexual health has resulted in unique expertise in this broad area, but do we still know how women's sexual health priorities are changing? How do the social determinants of health influence overall health and well-being? What are the challenges for women with disabilities, women of colour, newcomer women to Canada, refugee women, lesbians, or bisexual women? How different and similar are women's health needs as they age? Moreover, how does the way in which PPT works with women communities meet those diverse needs? We had more questions than answers. A women's needs assessment was timely and crucial to attaining those responses.

Four years ago, PPT adopted a community development framework as the model through which we would identify community needs, design programming, monitor outcomes and forge partnerships in the community; and to be the philosophical basis for proceeding with a women's needs assessment. We hope that what we learn from the women participating in this needs assessment will help us to shape programming across our agency so that it demonstrates our fundamental commitment to making women's sexual health a priority.

Hazelle Palmer  
Executive Director

## PROCESS

This section provides an overview of the developments and process in the design and implementation of the Women's Needs Assessment.

A Women's Needs Assessment Committee was struck early in the year. The committee was comprised of a Mental Health Counsellor, two Program Co-ordinators, a Health Promoter and a Manager. As members of the staff at Planned Parenthood of Toronto (PPT), they represented different program areas and worked more specifically with women. The Committee guided the needs assessment process through the levels of planning, implementation and analysis. Terms of Reference were developed and are attached to this report (see Appendix #1).

The Committee engaged the expertise of an external consultant, Brian Hyndman from the Health Communication Unit at the Centre for Health Promotion – University of Toronto, consulting with him in the early stages of the project. Brian, whose mandate is to provide community resource consultation, assisted in guiding the Committee in the design strategy and workplan and provided helpful information and feedback regarding the use of Key Informants, Focus Groups and a literature review. He briefly reviewed and gave feedback on target group, survey questions and group set-up.

In selecting the target group, the Committee worked hard at narrowing the focus for the assessment. Having determined early in the process to address the project exclusively to women, the Committee decided to focus on 18 years and over as it was generally an age spectrum identified in other PPT programs. Recognising the importance of inclusiveness and diversity in the gathering of data, the Committee identified women across a number of communities, namely: older women, youth, women with disabilities, lesbian, bisexual, and transgendered women, women of colour and women in conflict with the law.

In choosing Key Informants to interview, the committee relied on the community contacts they had already established. There was an effort to strengthen the links with our community partners and utilise the knowledge of our informed partners in the area of sexual health. A total of 23 Key Informants were contacted (see Appendix #2).

The key informant questions developed were based on the project goals. The Committee was focused on ensuring that the sexual health needs of women were identified and a sense of the work that was already being done in the sexual health community was recorded (see appendix #3).

The Committee identified 3 – 4 focus groups as adequate for gathering the information required with 10 – 12 participants as an optimum number per group. The Committee spent considerable time developing the focus group questions and gathering feedback from other sources. Questions were set up in a way to elicit responses from the participants by firstly addressing their general health needs and then, their sexual health needs (see appendix #4). The 4 groups held included:

1. General women's group
2. Client group
3. Women living in a shelter
4. Post-menopausal group

In presenting this final report the Committee acknowledges that this unfunded needs assessment process was not as comprehensive as it could have been. In stating this, the Committee recognises that the process was restricted by a number of limiting factors. Firstly, two attempts made early in the process to secure a funding source for the project failed. The lack of dollars limited the number of women attending our focus groups because we were only able to provide a restricted honorarium. This in turn restrained the Committee's ability to engage additional human resources in the work of the project. Secondly, the limited staff resources and time further limited the number of sources that information was gathered from. For example, the Committee was unable to include a satisfactory sample representation of women who do not benefit from the services of Planned Parenthood of Toronto.

Despite the above stated limitations, the needs assessment process was a positive experience with significant outcomes. Committee members felt that the connection with the Key Informants and community partners was very beneficial to the work of the project. The focus group exercises gave women who participated an opportunity to voice their own general and sexual health needs.

## **KEY INFORMANT FINDINGS**

This report draws from 23 Key Informant interviews. All Key Informants spoke about their work in different capacities with women including: women in conflict with the law, youth, HIV+ women from Africa and Caribbean countries, transgendered, and women with disabilities. This section examines their reflections of women's needs within their respective communities.

### **The Key Informants and Their Work with Women**

The Manager at the David Kelley Lesbian and Gay Community Counselling Program provided information on their mandate. They provide short to medium term individual, couple and group counselling for lesbians, gay men and related populations dealing with coming out, sexuality and identity, isolation, discrimination, relationship issues, parenting, self-esteem, violence, and other issues.

The Program Manager at New Directions noted that their program assists separated, divorced or widowed women by providing free information, referral, befriending, peer support, and widow's drop-in. This is a gay positive environment that includes a resource centre, lending library and a free weekly legal clinic.

A worker with Maggie's: Toronto Prostitutes Community Service Project was contacted. Their program provides a peer resource centre and drop-in, support for victims of violence or sexual assault, information on legal issues surrounding sex trade, promotion of safer sex practices and materials, and referrals to legal and other community services. It is staffed by working prostitutes and offers peer volunteer opportunities and information on HIV/AIDS prevention.

A Social Worker at the Shout Clinic provides individual counselling to street involved youth under 25 years old. She focuses holistically on client needs – from housing and food banks, to emotional and physical needs.

The women's project coordinator at Prisoners with AIDS Support Action Network (PASAN) provides individual and group counselling to women while incarcerated in provincial or federal prisons. She also provides ongoing support to women once they return to the community. Most of her clients are HIV positive or Hep C positive. 40% of PASAN's clients are aboriginal.

The Support worker at BlackCap (an AIDS service organisation) provides support to mainly African and Caribbean women.

The Counsellor at the AIDS Committee of Toronto provides individual and group counselling to HIV positive women of all ages.

The Executive Director of Choice in Health Clinic provides services to women aged 15-45. The clinic is an abortion provider.

The co-ordinator of Meal Trans, which is a drop in centre for Transgendered/ Transsexual women and men, provides resource and referral, food bank, clothing

services, and peer support counselling. They provide drop in on 3 days of the week and serve transgendered women of all ages. They also offer a drop in for transgendered youth on Wednesdays.

Good For Her, a store in Toronto caters to women's sexual health and sexual pleasure needs. The owner stated that the women they see are mostly 28 - 55 years of age with disposable income. The store has a focus on product sales, such as books and video's on sexual techniques and pleasure. Workshops are also offered on a wide range of sex education topics.

A Co-ordinator at Education Wife Assault (EWA) works with women aged 16 years and over, and occasionally with school-age children. EWA is responsible for education and training regarding women abuse and community development with disabled/deaf women on training initiatives on violence. EWA also provides program development on violence against women with marginalized groups.

The Co-ordinator of the Women's Sexual Assault and Domestic Violence Program at Sunnybrook and Women's College Health Science Centre works with women 14 years of age and up. Most of their clients range between 18 – 30 years. They provide emergency medical and emotional services for women needing post sexual assault or domestic violence care. They offer legal system advice and referral and 16 sessions of counselling on sexual assault issues in addition to outreach and education on sexual assault and domestic violence issues.

Contact was made with a Sexual Health Counsellor at Hassle Free Clinic, a sexual health clinic located in downtown Toronto. Hassle Free Clinic provides counselling and medical services for birth control and sexually transmitted infection.

A Registered Nurse and Manager were contacted at the Bay Centre for Birth Control (BCBC), a sexual health clinic for women. The BCBC provides general sexual health and clinical care such as pelvic exams, birth control fittings and sexual transmitted infection testing. A large part of these services involve short term counselling on sexual health issues including birth control and pregnancy options, abortion decision making, relationship and sexuality issues.

The Sexual Health Worker at the Immigrant Women's Health Centre (IWHC) was contacted. The IWHC is a sexual health centre providing medical and counselling services for immigrant communities. They also provide workshops for "hard to reach" women working in factories, churches and English as a Second Language (ESL) classes. Many of their services are available in various languages.

Women's Health in Women's Hands Community Health Centre (WHIWH) is a community health clinic that offers medical and sexual health services for Black women, immigrant women and women of colour. A Community Health Worker/Research Assistant at WHIWH provided information on her work providing HIV and AIDS workshops for service providers around cultural awareness and sensitivity. She also gives HIV and AIDS workshops for Black women and women of colour.

The Program Co-ordinator for the Menopause and Mid-life Program at The Regional Women's Health Centre works with women 40 - 65 years of age. The program provides individual and group counselling on issues such as menopause, mid-life sexuality, spirituality, empty-nest and isolation, living alone, retirement and nutrition.

The Prevention Education Co-ordinator for Alliance for South Asian AIDS Prevention (ASAP) an AIDS service organisation for South Asian communities offered information on its counselling, referrals, support groups and materials on HIV and AIDS to South Asian communities. As well ASAP provides HIV and AIDS prevention workshops in ESL classes and schools.

A Support Worker at Voices of Positive Women, an AIDS service organisation focussing on working with women, gave information about services to women living with HIV/AIDS. It includes the Treatment Access Program, information and referrals, skill development and health promotion workshops, peer support network and counselling.

An HIV/AIDS and Sexual Health Consultant to Toronto Public Health provides support to front line workers organizing community projects dealing with issues that affect women's sexual health. Her involvement includes the Female Condom Project, the HIV/AIDS and Pregnancy Project, the Condom Distribution Project and most recently the Exotic Dancers Outreach Project.

A Psychotherapist doing individual and group counselling at The Anne Johnston Health Station, a community health centre was contacted. She focuses on a full range of physical, mental and emotional health issues as they are impacted by disability. She works in collaboration with another person to offer a peer mentorship and workshop at the Regional Women's Health Centre. Due to funding mandates, both people work exclusively with women over the age of 18.

A Social Worker at Bloorview Macmillan Children's Centre, an agency for children with disabilities, provided input. She works with ages 13 – 21 years, carrying out psychosocial assessments and intervention with individuals and families. She also does group work addressing life skills with youth and young adults with disabilities.

The co-owner of the sex store Come As You Are is also a Sexual Health Educator who delivers workshops on sexual pleasure to women with disabilities and professionals. He works with adults over the age of 18 years, as influenced by the mandates set by the groups with whom he works.

It is not uncommon that services in the field of sexuality and sexual health do not recognise the need to address issues surrounding disability, and if they do, they are not aware of how to deliver sexual health services to women with disabilities. It was recognised that there is a big philosophical divide between work being done in the sexual health field and in the disability field. This is reflected in a tendency for sexual health agencies to impose their philosophies without consideration of the issues faced by women with disabilities. For a partnership between sexual health and disability agencies to address these issues and needs in a relevant way, the collaboration must work to ensure that the input of stakeholders from the disability

field be fully recognised. The Sexual Health

Educator from Come As You Are is an example of someone who does relevantly address disability in the context of providing sexual health education. His workshops and products inclusively incorporate the perspective of, and sensitively consider the issues surrounding, disability.

## Primary Sexual Health Needs

Key Informants noted that powerlessness is a central emotional issue influencing a woman's ability to address her sexual health needs. Her sense of powerlessness may come from low self esteem due to HIV diagnosis, being homeless or under housed, being transgendered, or because she is in conflict with the law. Women may form relationships with abusive partners that they hope will take care of them. Once designated as "outside the norm of society", women are further isolated and have trouble negotiating safer sex. All Key Informants spoke about the link between low self-esteem and high-risk sexual behaviour. As one said, "Every part of me makes me who I am, dealing with a disease focus for my health, does not heal all of me. Treating a disease and not the person does not change sexual behaviour".

For women in the transgendered community sexual health education is often not relevant to the reality they face. Transgendered women with a constantly shifting body image are exposed to different sexual risks. All Key Informants stressed the need to not assume the "cookie cutter approach" in dealing with women's sexual health. When delivering information and services on sexual health, this means that service providers need to adjust our approach to marginalized women, women from diverse communities, women in conflict with the law, transgendered women and HIV positive women. Sensitive and supportive professionals and staff who are knowledgeable about disability issues demonstrate attitudinal access. Environments must create a safe, non-judgmental space for people seeking women health services. Among Key Informants that work with disabilities it was unanimously noted that primary sexual health care needs for women with disabilities are related to two main areas: access and education. A worker from EWA put it this way, "Services need to be both physically and attitudinally accessible."

All Key Informants noted attitudinal access as a key issue. Many marginalized women do not access basic health services for fear of judgement from the medical and front line staff. Two Key Informants observed that while the women they work with are involved in the sex trade for survival, most materials targeted to women in the sex trade are about how to get out of the sex trade. As one key informant said, "There is a big move to stop prostitution, rather than help women be safe". **While most of the literature aimed at helping professionals to deal with sexual issues focuses on the medical side of sex history, Maurice (1999) recommends a "client-centred" approach to sexual therapy.**

All agencies identified a lack of knowledge and information that is specific to their target group. For example, there is a lack of knowledgeable staff to provide information that is appropriate and that addresses the specific needs of lesbians as well as information regarding the risk factors in unprotected sex. One agency

identified access to care that is assured to be inclusive and non-homophobic as a need for the women it serves.

On the priority of education, responses ranged from the need to provide general information on raising the level of awareness on women's health in general as well as basic body function. Also, the need for women to explore and gain the ability to express themselves about what gives them emotional and sexual pleasure was noted by several of the informants. **Findings from the Canadian Contraception Study (Fisher, Boroditsky, & Bridges, 1999) suggest that educational and clinical counselling regarding sexual and reproductive health is lacking due to misperceptions of contraceptive choices among women as well as lack of knowledge of their own sexual health and reproductive needs. Clinicians need to expand their efforts in order to effectively educate women about their contraceptive options, explain the importance of preventive behaviour, ask about sexual/reproductive health concerns and promote safer sex behaviours.**

However, according to a key informant at EWA a lack of information and much misinformation on birth control, abortion and sexually transmitted infections persists. This is particularly true for deaf women. Women with disabilities face a range of barriers, both physical and attitudinal. These women are at increased risk of STIs and pregnancy and are further marginalized as a result. Education must be relevant to disability and sensitive to the issues that women with disabilities face. **As a woman with a disability, it is not easy to obtain reproductive health care services from physicians. Barriers exist such as: physicians' attitudes that dehumanise women with disabilities and treat them as asexual; women with disabilities' lack of knowledge about sexuality and reproduction; and physicians' unfamiliarity in treating women with disabilities (Grabois, 2001).**

**Women with developmental disabilities encounter numerous barriers that prevent sexual expression. These include inadequate access to health care, limited choices regarding reproductive issues and lack of sex education. The values and beliefs of support staff also pose barriers. Survey findings showed that the majority of staff serving individuals with developmental disabilities felt comfortable supporting women in expressing their sexuality, but few were trained to do so (Christian, Stinson & Dotson, 2001).**

On a high priority level, education needs to be relevant to disability. "How can a woman who does not have control or strength in her hands and fingers benefit from pamphlets that instruct on breast self-exams?" asks the Worker from EWA, for instance. "Or how does a woman, who does not have feeling in her genitals, know that she has an STI? And what are the contraceptive options for a woman who cannot use the birth control pill because it contraindicates with other medications she is taking for her condition and who has physical limitations that prevent her from using barrier methods?" Other educational topics include sexual reproduction, sexual health, privacy, use of attendants, social skills, self-esteem, self-pleasuring, relationships, violence and abuse, myths about sexuality and disability, etc. Sexual health information that does not account for disability is useless for women in this group.

An overarching sexual health need for women with disabilities is an education focus

on attitudinal change about sexuality and disability. This is the precursor for all other needs (mentioned above) to be recognised and met. For women with disabilities, this means a validation of the need to be sexual. In a society that does not acknowledge the sexual nature of people with disabilities, this attitude is often internalized. A shift in attitude is also needed among parents, community, service providers and health professionals, since these individuals often serve as gateways of information to women with disabilities. Sexual health education should always include information about and accounting for disability, whether or not people with disabilities are included in the student group. This would be an effective vehicle towards the normalization of the sexuality of people with disabilities, for people with disabilities themselves and for the rest of society.

In addition, education must “demedicalize” the body. For the most part, people with disabilities learn about their bodies in very medical terms, more often than not, as it relates to their disability.

Physical access to services requires offices and clinics to have structures and equipment that allow for wheelchair access, such as ramps, elevators, accessible washrooms, examination tables, etc. The provision of attendant care is also important, allowing for the physical use of facilities and for the person to receive services independently of parents or caregivers. This is important because some women with disabilities do not have the same opportunity (i.e., freedom, privacy, means) as other women to seek out health services that they do not want other people in their personal life to know about.

Physical access also provides information that is relevant to disability and that is available in alternative formats. Methods that take into account learning disabilities (e.g., pictures, diagrams, hands-on activities), visual impairment (e.g. Braille, audio tape), hearing impairment (e.g., sign language, closed captioning), and communication limitations (e.g. knowledge of how to communicate with alternative and augmentative communication users) need to be implemented into the delivery of sexual health services to women with disabilities. Information that does not take into account these needs is inaccessible.

Key Informants at the AID Service organisations identified negotiating safer sex as a key issue for HIV positive women. They noted cultural barriers to talking about sex. As one provider said, “The women I work with don’t like to talk about sex. We spend a lot of time focusing on what you can do to enjoy your body”. Accessing basic needs such as good nutrition and healthy eating is a challenge for some women. A key informant made the point that. “Our women can’t even get basic needs met, so talking about sexual health is really difficult”. This was consistent for women in the prison system and transgendered women in Greater Toronto.

**Tepper (2000) notes that there seems to be a missing discourse of pleasure in the realm of sexuality and disability and makes a plea for inclusion of sexual pleasure in the disability studies agenda.**

Some Key Informants identified sexual pleasure as an area to be addressed. Rarely discussed in sex education or with visits to health care practitioners, little

programming is truly committed to sex-positive counselling and education. Women's bodies are medicalized and women's sexuality is often invisible. This is true particularly for older women and women with disabilities. One informant stated, "Older women face being trivialised by medical practitioners on all levels, particularly with sex". Two Key Informants observed that many sexual health programs leave out sexual pleasuring to emphasise birth control, sexually transmitted infections and pregnancy. Sex education needs to discuss not just the "how to" but the communication between partners and ways of talking about masturbation and pleasure. **Aggleton & Campbell (2000) present a human rights-based framework for sexual health promotion that addresses young people's needs and interests. This analysis is based on a positive definition of sexual health that focuses on sexual pleasure and which links sexuality to individual and collective needs and broader human rights and responsibilities. Such a framework might lead to the need for more appropriate information about sexual health and more accessible and integrated sexual health services. These authors also stress the need for measures to improve young people's confidence and to increase youth participation in decision making matters relating not only to their sexual health, but to the wider social and community environments that affect young people's sexuality.**

The Sexual Assault and Domestic Violence Program Key Informant stated that primary sexual health needs for women are not about sexual pleasure but about the prevention of assault and living a life free from violence. Access to emergency contraception, STI testing and treatment information is essential for women who have been assaulted. They need to access it immediately following an assault. Many women are not aware of where they can go to access such resources and do not have the means by which to get there.

According to the Mid-life/Menopausal key informant, the focus for older women is more on quality of relationship and companionship than sex. "Women often face a decreased libido due to hormone replacement therapies". It was discussed that sexual pleasure and masturbation take on a whole new meaning for women in mid-life when confronted with a potential new relationship or being on one's own. "How do women begin to think about love and sex outside of a marriage that they have been in for 40 years?" The medicalization of sexuality occurs for women during menopause and, as one key informant stated, "There is an expectation that if you are 'normal' you should be sexually active, except for this age group". Health care practitioners play a large role in the silencing of older women's sexual health needs.

In discussing the health needs of young women, many Key Informants identified that women, often in their teens or early twenties, must contend with depression and other mental health issues (such as bi-polar disorder or schizophrenia). Often times a crisis in a woman's health will trigger depression or other mental health issues.

All Key Informants were dealing with very similar issues affecting women's primary and sexual health. *One of the strongest messages expressed by the Key Informants is that women's sexual health needs are women's general health needs.* Birth control options, abortion, sexually transmitted infections, gynaecological care including irregular vaginal bleeding, fibroids, sexual reproductive cancers and infertility are the

most commonly cited as women's sexual health "illnesses". *It was strongly expressed that sexual health for women should mean more than "medical/ clinical" services.* Women served at these centres are in need of a holistic model/approach that addresses their sexual health needs. Beyond "medical/clinical" care needs, Key Informants believe there is a need for extended care including services that address the social structures that support and enhance women's sexual health. **The holistic approach to women's health is supported by Alexander, LaRosa & Bader (2001) who assert that historical, epidemiological, sociocultural and clinical issues affect women's health.**

A prominent theme throughout the interview process came through in discussions of relationship issues such as violence (emotional, physical and sexual) and building communication and negotiation skills in the context of relationship partnerships. Informants emphasised that many women are in great need of supports around mental health issues including supports for stress, depression, body image, low self-esteem and addictions.

The majority of informants claimed that the lack of awareness and access to general physician health care is a huge issue for the women who use their services. They have found that their referral base to general physician care and access to specialists has diminished over the years. A Community Health Worker from WHIWH stated, "All these needs, including education, must be met in a culturally sensitive and appropriate manner in order to be effective".

## **Social, Environmental & Political Determinants of Health: Barriers and Gaps**

The strongest factors identified by Key Informants as affecting women's sexual health are the social and political determinants of health. Class, race, culture, immigration status, language, housing, family and social support – these issues determine the quality of health in individual experience. The Sexual Health Counsellor from Hassle Free clinic reflected that "These determinants shape the quality of one's life. A woman is in a better place to look after her sexual health needs if all of the above is in good status". Her thoughts were echoed by the Prevention Education Co-ordinator from ASAP, "Often these form a vicious cycle of marginalization, which makes it difficult to access knowledge regarding one's sexual health. For example, if you are limited by your immigration status, which has impact on your access to employment, which may be hindered by language barriers, then your access to services and available materials that are relevant to you are limited". **A study on the impact of homelessness on women's health prepared by the Kappel Ramji Consulting Group (2002) found that homelessness impacts a women's emotional/mental, spiritual and physical health. This is an example of the need for a more holistic approach to health that considers the strong interrelationship between emotional and physical health.**

**Chrisler & Hemstreet (1995) examine issues in women's health to ascertain whether the diversity of women's needs is being met. They argue there is almost nothing written about the health needs of Native American, Asian American, and poor, rural women.**

**A paper by Maureen Jessop Orton addressing issues related to pregnancy prevention programs stresses the need for comprehensive sexual health education programs to be available for everyone regardless of cultural, religious and/or socio-economic background (Wong & Checkland, 1999).**

In the words of the support worker at BlackCap, “Race is a given barrier”. Many doctors have no cultural sensitivity around sexual health issues. “Most providers come from a North American ‘cookie cutter’ approach”. She offers an example: When giving sexual health information to a woman from Somalia, culturally appropriate questions are important. This may mean asking about female circumcision and the impact on her sexual and primary health. “Often times health issues are overlooked because providers don’t ask culturally relevant questions”.

Social determinants that impact the overall health of women who are marginalized due to immigration, abuse, HIV, conflict with the law, homelessness, and being transgendered include social prejudice towards “women outside the norm”. As one key informant said, “Society has a bigger problem with men dressed as women, than women dressed as men”. Meal Trans identified 60% of the women they serve as living below the poverty line. Choice in Health agrees: “Economic barriers make it difficult for women to get access to sexual health information as they are focused on survival”. The Shout clinic also observed that women who are homeless or under housed are vulnerable.

Social determinants that impact the overall health of women with disabilities include discrimination against people with disabilities in general. Stereotypes about the sexuality of disabled people are a specific barrier preventing women from accessing sexual health services. The mistaken view that people with disabilities are asexual persists. Service providers and health professionals who hold inaccurate preconceptions about the sexual health needs of women with disabilities cannot provide information accurately or with sensitivity. **A study by Milligan & Neufeldt (2001) evaluates social and empirical foundations to support the contention that people with disabilities (PWD) are viewed as asexual. The authors conclude that despite significant gains in biological and psychosocial understanding of sexuality and disability, much remains to be accomplished in the areas of professional practice, research, societal attitudes, and most importantly in the lives of PWD.**

Caregivers do not recognise the need for women with disabilities to have a sense of independence. It is an assumption that women cannot go out on their own to access information without the assistance of caregivers. Women in such situations begin to internalize stereotyped notions about sexuality and do not feel the need to formally address any sexual issues that they may have, causing perhaps the most profound barrier in access to sexual health services. The Social Worker at Bloorview Macmillan says, “This (discrimination) leads to lack of expectation (of needs), isolation, depression, rejection and possible abuse”.

Poverty is another social determinant that leads to lack of options for women on welfare or on Ontario Disability Support Program (ODSP) who are on fixed incomes.

Environmental determinants include lack of accessibility to health facilities and information, denying the basic right to access needed services and knowledge about one's own health. Women who use wheelchairs, scooters, or walkers face barriers to obtaining pap smears, breast exams, birth control and medications for STIs. Many health facilities cannot provide services, even if women can enter the building, as equipment also needs to be physically accessible. The worker at EWA observed a final difficulty that is present even when facilities and equipment are physically accessible. "Although people with disabilities go through the hospital system more, hospital staff are not willing to look at disability in a non-medical way. And service providers who are not knowledgeable about sexual health needs of people with disabilities often don't want to deal with it".

Environmental determinants include lack of access to basic human rights and services for women who are incarcerated as "security overrides health issues". The Co-ordinator of the Women's Project at PASAN, sites a court case where women, while in jail, have become drug resistant because their medications were not dispensed properly. She also refers to one institution that hired a doctor who had been convicted of sexually assaulting a woman patient. This case is being challenged in court. For transgendered women most services are geared towards men or women. One woman gives the example of going into a health clinic and using the washroom. She said, "I have to choose to go into the women's washroom and try to pass, or go in the men's washroom and risk assault". Women's services often discriminate against transgendered women, leaving them very few places to go. In fact the 519 Community Centre is the only agency that provides a transgendered women's program in Toronto. For highly marginalized women there is little or no access to sexual health services and information.

Related to the issue of accessibility is that information about sexual health is often not available in alternative formats. The standard format is not accessible to women who have learning or cognitive disabilities, who are blind or deaf, or who use augmentative and alternative communication, not to mention those who cannot read.

Three Key Informants noted location of organisations and inadequate transportation services as barriers to physical access. Confidentiality issues also compound transportation issues. This is in part due to people's particular disabilities and an inability to call Wheel-trans themselves but also to family members and/or care attendants who will accompany them everywhere they go. **There exist physical and architectural barriers for women with disabilities in obtaining reproductive health care services from physicians, including: physicians' offices that are inaccessible; and patients' difficulties in communicating with their physicians if they have a visual or hearing impairment (Grabois, 2001).**

Transportation is a barrier for women with disabilities going to appointments or educational sessions about sexuality, as WheelTrans does not provide sufficient or reliable service.

Political determinants impact the overall health of highly marginalized women. Services to transgendered women, women who are incarcerated, and HIV positive immigrant women, lack funding. Co-ordinator of the Women's Program at PASAN

observed that “The system cannot justify programming for women. It’s hard to make a case for 10 to 20 women receiving special programming”. All Key Informants referred to the rigidity in funding that allows agencies to provide sexual health information to mainstream women but does not reach marginalized women who require specific and tailored programs, education and information. These women are not getting basic health care needs such as paps, checkups and birth control information.

Another political determinant on the overall health of women with disabilities is the lack of priority to fund either women’s health or disability. “The political system is reactive and not focused on being proactive”, said the worker from EWA. On a broader scale, there is little political attention given to women’s health in general. Says a Sexual Health Educator, “Sexual health is the bottom rung of the ladder of work in health. It is the aspect that is often ignored”. A greater priority towards prevention and education in women’s health should also include sexual health.

It is clear that if the overall health needs of women with disabilities are to be addressed; a great attitudinal shift toward the needs of individuals in this group is required. This shift must focus on the full inclusion of people with disabilities into society and must be demonstrated by attitudinal accessibility – the recognition and acceptance of people with disabilities by individuals in the community and social institutions (media, etc). Environmentally, this shift is manifested in buildings and equipment accessible to wheelchairs, scooters, walker users, and in information that is given in alternative formats and relevant to disability issues. In the political arena, greater priority must be placed on women’s health and on prevention and education.

Determinants of this kind increase the isolation of women already marginalized by homelessness, immigration, HIV, incarceration or being transgendered. Resulting low self-esteem and increased vulnerability to abusive relationships further perpetrate feelings of powerlessness. These determinants decrease access to information, putting highly marginalized women at greater risk of sexually transmitted infections and unplanned pregnancies. “When these women become pregnant, often the abusive partner wants to keep the child and have further control of them. The relationship breaks down and we have a lot of single parents. We have a lot of children who were part of the foster children’s system due to abuse and have babies born back into this system” noted a key informant from the Shout Clinic.

BlackCap identified women who are immigrants without health cards as having few places to go for assistance. Most agencies do not budget for non-insured clients and even where they do exist budgets are insufficient. Lack of services for non-insured women was noted by three of those interviewed. Newcomers to Canada are isolated and lack the basic resources available to other women. Coupled with this is the rising cost of health care. It is very expensive for women without OHIP to access abortion and often newcomers do not have abortion and birth control information available to them. There is a very limited supply of pro-choice family doctors in the Greater Toronto Area (GTA) who are taking new clients. This creates a large barrier for many women who often go for “quick fixes” to walk-in clinics.

Women without medical insurance are another group that experiences many

overwhelming barriers. Informants reported that as funds decrease the numbers of women with limited access to OHIP or medical care increases. Women from this community have difficulty getting extended care such as specialist referrals and abortions because of their lack of coverage. Service providers also noted a lack of information and materials on sexual health needs that reflect the reality and diversity of women's lives. As well, there is a gap in services and materials in different languages that women from diverse communities can access. Women are restricted by catchment areas, a problem for women in under serviced locations such as Scarborough and the west end of the city. "Often times women will use a friend's downtown address, in order to access services".

Informants also noted that the uneven location of sexual health services in Toronto acts as a barrier to women attempting to access health care. Inconsistently distributed throughout the city, many services exist in the downtown core while those in the outer GTA remain under served. As well, women living with a disability have difficulty locating inaccessible sexual health services. **An analysis by Hardwick & Patychuk (1999) addresses the need for geographically targeted and accessible sexual health programs for youth in Toronto based on a geographic mapping of socio-economic, demographic and sexual health indicators.**

Stereotypes are a barrier to access. One Key Informant noted, "the perception of women from Africa and the Caribbean is that you are loose". One of her clients went to her doctor when she was diagnosed with HIV and the doctor said, "A lot of you have it". The woman said "I came to Canada when I was 12 years old and I got HIV in Canada". The stereotype of women as "vectors of disease" is still one that many African and Caribbean women experience in accessing healthcare.

All Key Informants noted that staff attitudes play a large role in accessing sexual health services. As one Key Informant stated, "Negative staff attitudes towards marginalized groups need to change to overcome systemic barriers". The Key Informant at EWA stated, "Racist, ableist and negative attitudes of health practitioners and institution's play a role in limiting access for women, as well as lack of training, awareness and caring". In addition, from the Mid-life/Menopause program, "Some women do not have the freedom to make their own choice within their family regarding their sexual health needs". Power imbalances, traditional roles, and abusive relationships impact the older woman's ability to get the information she needs. As stated by the Key Informant from the Sexual Assault and Domestic Violence Care Program, "The energy just to survive does not allow for promotion of health and well-being".

All Key Informants emphasised poverty, homelessness, addictions, and mental illness as major determinants. Lack of money for food leads to poor nutrition that impacts on feeling good about oneself. Resulting decreased self-esteem brings an increase in "risk taking behaviour" and further isolation and marginalization. Agencies identified issues such as misogyny, homophobia, racism, class, financial difficulties, discrimination, and language among the difficulties facing their client groups. Women had expressed frustration at dealing with the law and in paying for the services of lawyers, conditions that increase their sense of fear and anxiety. Lack of financial resources and money remain a major difficulty for women. According to

Health Canada's report "Toward a Healthy Future: Second Report on the Health of Canadians" it has been shown that health status improves at each step up the income and social hierarchy. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are key influences. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.

Women lack a voice in their own health needs. They identify unavailable, inadequate or inappropriate care and quality of services as the problem. They further recognise the discrimination that is felt towards particular communities. As an example, women in the sex trade industry feel stigmatized and stereotyped. To further complicate their difficulties those women whose first language is not English face isolation because they do not know how to access the information they need.

Women who have experienced abuse have increased difficulty in accessing information because of the impact this experience has had in their lives. They distrust future relationships and experience increased levels of stress. **It is well documented that homeless women have long and complex histories of family violence and spousal abuse. As a result of abuse and violence, women are isolated and unexposed to education and training opportunities necessary to become employable. Women enter shelters in order to flee recent violence. Violence Against Women (VAW) funding is not equitably distributed among community-based shelters and emergency shelters. Funding for counselling and support services, while available to community-based shelters, is not granted to emergency shelters.**

Evidence from Health Canada's report "Strategies for Population Health: Investing in the Health of Canadians" notes that some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure. An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates.

Major barriers identified by these agencies included homophobia compounded by other forms of discrimination and inaccessibility. Lesbian and bi-women often encounter assumptions made continually on the gender of a lesbian's partner. One of the informants stated that "homophobia is alive and well in Toronto". Commenting on language and cultural barriers, one interviewee stated, "Many people think differently-abled women have no sex life!" Assumptions made by physicians further increase barriers for women. A lack of knowledge and assumptions regarding the activities people engage in make accessing services difficult. For example Maggie's has recognised that many women have experienced a reaction to saying they are in the sex trade industry by assumptions they are prostitutes.

Discrimination based on identity continues as a barrier. In many agencies, health care professionals are not reflective of the communities that they serve. Health care professionals may lack the knowledge or sensitivity to deal with the sexual health needs of women from diverse backgrounds. Non-judgmental and culturally sensitive

services, programs and materials are essential in providing appropriate sexual health to the diversity of women living in Toronto.

The major barrier identified in the interviews with Key Informants was the issue of access and equity. They overwhelmingly expressed the need for inclusive programming and services. The Prevention and Education Co-ordinator from ASAP expressed it this way, “For women from diverse backgrounds, issues of marginalization with respect to mainstream services are central. Often services and information provided overlook their unique circumstances”. This experience extends to communities defined by sexual identities. Service providers observed that women from transgendered communities, lesbians and bisexual women don’t receive accurate information or appropriate services from many agencies. There are conflicting messages and misconceptions about their sexual health needs.

All determinants contribute to a lack of opportunity and social isolation for women with disabilities. The impact of social, environmental and political determinants of health affects the very basic rights of the individual with a disability regarding sexual health. Barriers that currently exist deny access to basic sexual health information and services, further promoting the pervasive attitude that people with disabilities are not even sexual. The internalisation of this attitude can be the greatest barrier, as lack of personal entitlement to a sexual identity provides little incentive for the woman with a disability to seek out this information if/when it does become available.

All Key Informants called for “one stop shopping” integrated health care, as women needed to access six different places to take care of their primary and sexual health care needs. This makes it “frustrating and difficult to take care of your health”. All Key Informants referred to services that “keep bankers hours” as a barrier.

## **The Gaps**

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Moreover, there are few services that are accessible, age-appropriate, and disability and culturally sensitive. There are no community wide, integrated services that provide sexual health services for women with disabilities. Women in this group have to work harder to get the services that are readily available for women without disabilities.

And finally, sexual health services typically focus on the medical aspects of sexuality and reproduction. “There are no sexual health services that focus on pleasure,” said a Sexual Health Educator. “There is a failure to recognise that a focus on pleasure can be a preventative measure against many problems in sexual health”. As with barriers, there is a reverse relationship between the primary sexual health needs of women with disabilities and the existing gaps. Women with disabilities need health care professionals to be knowledgeable and sensitive, information that is relevant to disability and services that are accessible. The existing gaps show that appropriate sexual health services and information are still lacking for women with disabilities. Filling in these gaps would directly fulfil the primary sexual health needs of women with disabilities, provided that barriers are also addressed.

The lack of targeted materials to specific communities such as the transgendered community, women who are incarcerated, and HIV positive women were identified as a significant gap. In addition, holistic programming that focuses on nutrition, self esteem, communication and relationships as well as clinical services provides a “one stop shopping” for women around their primary and sexual health needs.

“We need a list of places for women to go for a physical without a health card in the city”. All Key Informants noted the need for a co-ordinated effort across the GTA around non-insured clients. All Key Informants recommended a network be formed for exchange of ideas around non-insured clients and advocacy with the Ministry of Health.

All Key Informants identified that when a highly marginalized woman – such as a transgendered woman or an HIV positive woman – comes into their agency she is referred out to one or two agencies in the city. Better systems would develop and integrate services and programs within their own agency for these women.

Three Key Informants saw a gap in partnering with the guidance counselling system in schools to offer programs and services on sexual health and parenting.

Two Key Informants stressed that sexual pleasure is absent from sex education. Instead, there is a large focus on birth control and sexually transmitted infections. This only reinforces heterosexuality as the norm further isolating queer identified women. There was consensus amongst all Key Informants that there is little discussion regarding sexual pleasure for older women, queer women and women with disabilities. Women with disabilities face further gaps in service when there are no deaf women (or other women with disabilities) working as service providers. As the Key Informant from Education Wife Assault stated, “Deaf women need to see themselves represented, not just as clients, but as service providers”.

A Key Informant from the Sexual Assault and Domestic Violence Care

Centre made the point, “Education and programming that focuses on men respecting women regarding their sexual health issues is needed. Topics such as condom use, sexual pleasure, coercion, rape, early sexual intercourse and STIs should be covered. We focus on women rather than on men as causing many of her problems!” In addition to this was a response from Good For Her regarding the lack of safer sex negotiation. It seems that sexual health education lacks the “how to” in terms of breaking down power dynamics that are at play when negotiating safer sex practice.

All informants clearly indicated that specific health services that address different communities of people and that provide appropriate information related to the population was necessary. Specifically, there are no clearly identified lesbian health services or services specific to the issues for bi-women, differently-abled women or women in the sex-trade industry.

## **FOCUS GROUPS**

Four focus groups were held for the purpose of the Women's Needs Assessment.

The first group was held at Beatrice House, which is a shelter for women with young children and is considered a planning shelter. They provide childcare, schooling and workshops. Their goal is to promote the independence of their clients in order for them to become self-sufficient. Women at Beatrice House range in age from 18 years and up. The participants in this group represented the Caribbean or African, South Asian, and Eastern European communities.

A second focus group was held at the Bay Centre for Birth Control. This was a pre-established group of women between the ages of 45 and 65 years who meet on a monthly basis at the Regional Women's Health Centre. The group is called the Mid-Life/Menopause Group and deals with the issues faced by women in post menopause. The group represented the Asian, European, Caucasian and disability communities.

There were nine participants in the Client Focus group, all aged in the early 20s. This group represented the Asian, Caucasian, East Indian, Russian, and Black communities.

A General Women's group was the final focus group. Six women who ranged in age from early 20s to mid-30s attended. There were 2 women of colour and 1 queer identified woman.

## **Dealing with Health Concerns**

Discussion took place around how participants deal with their health concerns, about what works and what does not work. The conversation also addressed what participants' felt kept them from dealing with their health concerns.

Resources that participants found useful in dealing with their health concerns included accessing telephone hotlines, such as TeleHealth and TSI, and books for health information. The Internet was also reported to be a good source (e.g. "Dr. Know"). However, participants reported that they often found conflicting information. One participant commented that health information is conflicting in general.

The resource that was discussed to be the most unhelpful was medical doctors. Two participants reported that they do not have a regular medical doctor, and another says that her doctor is "a bitch". The reasons stem from many frustrations associated with medical doctors. One involves long waits for appointments, often needing to book as much as six weeks in advance. Another is the time spent in waiting rooms. Some participants commented on the restraints they have in this regard. "I'm too busy," said one participant. "I can't book time off from work or school to sit in a doctor's office for hours!"

Participants were also irritated with the way they were treated by medical doctors. "They don't address your questions and are quick to brush you off" said one participant. "And as a result, they give you bad advice". Participants also noted that medical doctors belittle their concerns. "You feel like a hypochondriac" commented one participant. **In recognizing that medical schools and most other graduate education programs for therapists do not provide adequate training for physicians in taking a sexual history of patients, Maurice (1999) emphasises the importance of learning how to talk with patients about sex. Gender and sexual orientation are areas in which physicians and other therapists are generally either uncomfortable or insufficiently knowledgeable to discuss. As such, Maurice also includes a section on how to bring Gender and Sexual Orientation issues into the interviewing and assessment process. Maurice supports the assertion that sexuality must acknowledge the impact of cultural and cross-cultural phenomena on individual human sexuality.**

It was agreed though that Walk-in clinics offer quick service, as no appointments are needed. But participants felt like they were "like fast food", providing only quick fixes, more likely to prescribe medication than to look at a problem holistically.

Aside from frustrations with health professionals, participants admitted barriers constructed in their own mindsets. One participant was apprehensive of medical test results. "I don't want to know if I really have lupus". There is sense of denial for some participants, a tendency to pretend that problems don't exist.

Both the external barriers of poor medical treatment and internal barriers of mental/emotional tendencies about health result in the deferring of health concerns particularly if they do not seem urgent or are not painful. This phenomenon reflects the existing structure that medical health has a reactive approach to health problems as opposed to focusing on prevention. A great number of health problems could be avoided through awareness and preventative measures. Among other social, economic and political implications of this trend is the detriment to the overall health of women. **A report by Fisher & Boroditsky (2000) on the sexual activity levels, contraceptive choices and sexual and reproductive health indicators among single young Canadian women leads to important implications for the development of strategies to address sexual and reproductive health concerns in this population. The findings suggest the need for educational interventions, public health policy, and clinical management strategies which address the fact that sexual activity is widespread, begins at a very young age, and is consistent, thus leading to an accumulation of sexual partners over time. The findings also suggest the need for education, policy, and clinical strategies to increase women's awareness of effective and appropriate contraceptive choices beyond the pill and the male condom.**

**While the findings suggest a high level of contraceptive protection among sexually active single young Canadian women, contraceptive use is inconsistent and involves decreasing use of dual protection over time, and to include ineffective methods, such as withdrawal. STI is one consequence of inconsistent condom use; the report found that 17% of 18–24 year old women and 22% of 25–29 year old women had already been diagnosed with an STI.**

**Reproductive health education, public health policy, and clinical management strategies should therefore address the need for consistent use of contraception over time and the limitations of the withdrawal method.**

Women spoke frankly about their needs while living in a shelter. Most did not have family doctors and went to different Walk-in clinics depending on the health concern. Many women spoke about fragmented care, receiving one service in one place for one health concern and other services at The House for sexual health concerns. **According to a study conducted by the Kappel Ramji Consulting Group (2002) homeless women experience extra health concerns such as poor nutrition; difficulties in maintaining menstrual hygiene; higher than average incidences of abnormal Pap smears and STIs; and higher risk than most men for HIV positive status and HIV infection.**

All women spoke about nutrition as a concern and lack of access to information and nutritional services due to being isolated and under housed in the shelter system. All women voiced their need to have more “control over all aspects of their lives”. This extended to their health. One woman said, “I am angry that I need my husband’s consent to tie my tubes, it makes me feel like I have no control over my body”.

All women expressed a need for services that address their well being such as counselling, healthy eating, nutritionist services, self-care events, and childcare for medical appointments.

Women spoke about being homeless and in the shelter system as contributing to their feeling powerless in their lives. Poverty, unstable and insecure housing, inadequate childcare spaces and subsidies prevent women from seeking and maintaining work. Many women identified that abuse, immigration and the breakdown of the family contributed to their being in the shelter system. Many women noted that they were particularly vulnerable to men who “promised to take care of them” and their children, leaving them open to abusive partners.

**According to Health Canada, poor nutrition and health practices are associated with poverty. The following are key and interrelated factors that influence health: income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture. Evidence indicates that higher social and economic status is associated with better health because it determines living conditions such as safe housing and the ability to sufficient healthy food. Also strongly associated with better health is support from family, friends and communities that help people solve problems, deal with adversity and maintain a sense of control over life circumstances.**

The focus group for post-menopausal women discussed the changes of menopause and how it affects their sexual health. Issues of hormone replacement therapy (HRT), the medications that are used and how they affect a person if they are to stop using were among the discussion topics. Questions also arose around hysterectomies, cancer, and osteoporosis. In addition, this group had questions such as, “Who will care for me (if I get sick) – children or no children?” **This part of the 1998 Canadian Contraception Study examines the contraceptive attitudes and practices of women in their later reproductive years. Women aged 35 to 44 years made up 36% of the sample and their responses to many questions indicated that they constitute a distinct group worthy of particular attention. Women in their later reproductive years were more aware of permanent contraceptive choices than were younger women, and they had more positive opinions of sterilisation, and tended to use this method more than did younger women. In addition, they reported lower rates of several types of sexual dysfunction, compared with younger women.**

The women reported not having a lot of earning power. Some did not have a pension and suggested the need for programs that include financial assistance. One participant stated, “I have a good job but if you start something (i.e. treatment) you have to continue paying for it”.

The group claimed that women’s sexuality has been medicalized. They observed that at mid-life women’s sexuality varies and that they feel “set up” as dysfunctional if they don’t want sex. Many group members stated that they contact the group facilitator or their medical centre when they have questions. One participant spoke favourably of seminars and workshops on various topics held at Mt. Sinai Hospital and shared the registration information with her group members. Another talked about the yearly Women’s Health Forum (WHF) as a means of gathering information. “That’s where I learned about menopause”, she said but cautioned that the WHF was becoming commercialized under the influence of drug companies. Their involvement, she felt turns people away.

Some participants reported that they could not always access the information they need or the alternatives they are looking for. As an example, one participant stated that “I can’t afford what my doctor is suggesting”. Her Doctor suggested both alternative and traditional medicine, but she could not afford it.

Women in the Post Menopausal Group felt that health programs in the community needed to expand in time and location. They know they need exercise, for example, but they don’t know where to do it. Long waiting lists for popular programs prevent easy access. One participant with arthritis stated “By the time you get in (to the program) you won’t be able to walk”. The group felt that it would be good to offer programs in the evening, as there is not much available at night. Also people had to learn to move around the city to register for programs that they need. A group member who had seen a spinal specialist at a hospital reported, “They responded to my illness but did not provide me with programs that can help me feel better. Instead they asked for a donation, but no information about what programs would be beneficial to me”.

All participants utilised personal networks such as friends and colleagues to discuss health issues. Two women went to Naturopaths and all participants used the Internet, sites such as E-medicine, Medscape, Canadian Medical Association, and Society for Gynaecologists & Obstetricians, PFC and PPT. Two women stated that they used “home remedies” to cure minor ailments.

All participants avoided family doctors for a variety of reasons including long wait times, cost, negative attitudes and judgement from clinic staff and doctors. Three participants stated that finances keep them from obtaining the “best” health they can have. Additional fees restrict many women from accessing regular health care.

Numerous participants declared the three-week wait to see their family doctor too long; they opted for “quick fixes” at Walk-in clinics instead. All participants stated unanimously that they often “feel judged” by their family doctor for taking up their “precious time”. They also stated that reception staff could be rude. One participant noted that clinic staff seem to be overworked and lacked solid supervision and guidance.

## **Sexual Health Needs**

All groups extended their discussions into sexual health needs, how participants deal with them, and what they find useful and not useful.

Participants all agreed that they need education and information about sexual health, and on topics such as sexually transmitted infections, testing, and birth control.

**Findings from the Canadian Contraception Study (Fisher, W.A., Boroditsky, R. & Bridges M.L., 1999) suggest that educational and clinical counselling regarding sexual and reproductive health is lacking due to misperceptions of contraceptive choices among women as well as lack of knowledge of their own sexual health and reproductive needs. Clinicians should expand their efforts to effectively educate women about their contraceptive options; explain the importance of preventive behaviour; ask about sexual/reproductive health concerns and promote safer sex behaviours.**

**In particular, education regarding birth control is needed to address Canadian women’s misperceptions about the pill, and its safety, use and side effects. Inconsistencies in condom use and misperceptions about condoms among Canadian women indicate a need to continue to provide effective STD/HIV prevention education. In addition, it was found that women aged 35 to 44 years had more positive opinions of sterilisation, were more aware of permanent contraceptive choices and reported lower rates of sexual dysfunction than younger did women.**

Many women identified the challenges of being from conservative religious backgrounds and not having sex until marriage. Now married and divorced, they face new challenges negotiating safer sex and healthy relationships as single mothers in a new country. One woman said, “ My mum told me don’t have sex with anyone until after marriage, and I waited until 23 when I was married”. This woman is Muslim and is now considered “tainted” as she is divorced with children.

Participants who migrated from countries where women did not have access to sexual health information, find that now, even in Canada, these cultural barriers persist. Women also commented that they are “more comfortable getting their information from other women”. Women wanted access to information and practical services and more information on STIs, as most of these women did not get information growing up before coming to Canada. Women commented on the importance of STI materials focused on women of all ages, not just youth.

Negotiating safer sex and communication within relationships featured prominently. Women commented that they came from countries where women are powerless, and “the man has all the power”. Living now in Canada, they are expected to protect themselves without learning the skills. Women want integrated care around their sexual and primary health care needs. **According to the Second Report on the Health of Canadians, the socio-economic environment causes additional health risks due to dominant cultural values that perpetuate marginalization, loss of language or culture and lack of access to culturally appropriate health care services.**

Women identified economics as the primary barrier in accessing health care. Many do not yet have OHIP and most agencies have very limited budgets for the non-insured, their budgets do not include regular health care checkups. Women living in the shelter system said they could not afford condoms, birth control and childcare services in order to take care of their primary and sexual health needs. **A study (Eleanor Maticka-Tyndale, E., Barrett, M. & McKay, A., 2000) found that social disadvantage (as measured by household income and school and labour force participation) and immigration status contribute to differing profiles of sexual behaviour. Overall, social disadvantage is associated with more permissive sexual behaviours. These findings support research in Canada that demonstrates that the burden of teenage pregnancies, teenage motherhood, and STIs is concentrated among census tracts with a higher proportion of residents in low-income categories.**

All the women identified sexual health information as primarily targeted at women. “Men are sliding by” while the responsibilities for sexual health are put on women. Women noted that clinic care is “too fast and impersonal” and doctors don’t spend enough time. They expressed frustration at having to go to “six different places to take care of your health when you are trying to survive”.

The Mid-Life group stated that “there is a need for programs for women like us. We are getting older”. Back care, chronic care, and hip replacements were among the important issues to discuss and there were many programs available. They wanted more non-medical information, and a place to be separate from young women’s groups. One member expressed the desire for an “opportunity to be alone with women so I can get my thoughts on what I need”. All women stated that they need to hear others’ experiences. Such interactions help them to feel less isolated, “like I’m not the only one.” They recognise that information from other women is valuable. “Women need to talk to each other rather than be catty” advised one participant.

The importance of adequate time with health practitioners was also stressed.

Participants want time with practitioners to address questions, where they can be confident that the practitioner is not hurried and not quick to simply prescribe creams or pills.

Unfortunately, the biggest frustration in dealing with sexual health needs is the poor treatment received from medical doctors. As with general health needs, concerns about insufficient attention to the patient during consultation arose. “I hate when they brush me off”, said one participant. “They don’t take the time, and they’re always in a

## Helpful Programming

Participants showed interest in regular discussion groups/seminars for women. Such groups were seen as helpful and as spaces of common interest where women would know they were not alone, where they would not be judged and where friendships could form. Topics to include: messages about sex, societal attitudes, gender issues, women's issues (political), (un)healthy relationships, birth control (including possible allergic reactions, feelings/ideas about birth control), orgasm (how to, how to know, etc.) things to consider when becoming sexually active, self-esteem, issues/struggles even when with friends, body image ("Anti-Cosmo – How to Defend Yourself Against Models") how to prevent eating disorders, healthy lifestyles (diet, nutrition, stress), feeling good, and being single.

There was also much enthusiasm to combine such discussion groups with a social atmosphere, where group members can have discussions while doing things together, outside of the office or Health Centre (e.g. "Bowling and Orgasm Night"). It seemed that participants found the focus group itself to be such a setting. There was disclosure of personal and confidential information from a number of participants. One said, "I've learned a lot here". **In Maticka-Tyndale's assessment of the sexual health status of Canadian youth, she emphasises the need to listen to our youth. According to research that has consulted youth in British Columbia, Alberta, Ontario, Quebec and Nova Scotia, youth consistently relate the need for sexual health education that deals with feelings, arousal, foreplay, making choices, gay and lesbian issues, confidential access to information and contraception and condoms. Also critical is sexual health education that is respectful of the choices youths make (Maticka-Tyndale, Spring, 2001).**

Participants in the Client Group said that young women need more places like The House, where it is not intimidating, where there is music, it is laid-back, where there are peers working, and it is specific to youth. The group suggested that the age limit of The House should be extended to 27, 29, or 30. "I'm sad to have to leave soon", said one woman.

Some participants thought that there should be more groups for men's sexual health. They thought that although men have a hard time talking about sex and may only be comfortable doing so with females, they may attend if it such a group were offered. In contrast, one participant shared that in 12-step meetings, men *do* share. Couples sessions for education and counselling were also suggested in the group. These sessions would cover topics such as communication, awareness about, and how to identify unhealthy relationships.

Participants agreed on the need for wide outreach. "I only knew about this focus group when my friend told me about it," said one participant. "People would come to groups and events as long as they hear about it."

Group contact between women about sexual issues is evident in their suggestions for programming. There is a high value placed on this type of setting for information and for connection. Programming for women should incorporate this tendency towards more supportive group environments.

Some women stated they would prefer sexual health groups for women where they could drop-in and get information on a variety of topics. Clinical staff could be available for individual consultation if needed. One participant requested a group for men or even a “mixed” group, dealing with condom use and STI information and general information on women’s bodies. In addition, some women stated that they would like to see more “progressive” services outside of the downtown core.

The Mid-life group of women 45–65 years wanted a place to talk about sexual health, where they would get more information and a group that would be specifically for older women. They were interested in the possibility of a group for both men and women or couples to talk about sex and not to separate the sexes.

## CONCLUSIONS and RECOMMENDATIONS

### Conclusions:

*“Women are more than fifty per cent of the world’s population, perform two-thirds of the world’s work, receive one -tenth of the world’s income and own one-hundredth of the world’s property”- United Nations*

Throughout this assessment, we have heard how the social determinants (including race, ability, sexual orientation, immigration status, ethno-cultural identity and language) of health are intrinsically connected to a woman’s sense of self, autonomy, and esteem. From Key Informants to a diverse range of women, we heard how those determinants and other social realities affect a woman’s sense of health, and, by extension her sexual and reproductive health. We heard about powerlessness and the insensitivity of physicians to listen and address a broad range of women’s health needs. Women described barriers to sexuality concerns as they age and programs that are compartmentalized or overly medicalized. We heard about programs lacking ethno-specific sensitivities and capable staff, environments that keep women with disabilities out and services that ignore their sexual needs. We also heard that there is a lack of government financial support for women’s health in general and, even fewer resources for women who are the most marginalized.

Health promotion strategies and prevention programs for women must address the social, economic and political realities of women’s lives. Such initiatives can only be successful if there’s an acknowledgement that women come to their sense of health differently; that how the social determinants interact with each of us is unique; that programs need to be accessible, appropriate, uplifting, respectful, and, of course, supportive.

We need prevention strategies and programs that decrease our risks of infection. Traditionally social determinants are not easily connected to women’s sexual health; yet, as we have re-affirmed with this assessment a women’s social and economic status are intrinsically connected to her sexual health and her ability to achieve overall well being and health. The impact of these conditions on women’s health is greater for the more vulnerable members of society.

Freire (1998) stated that “Self efficacy and self esteem is the critical consciousness which recognises the link between personal problems and social structural problems”.

Many of the women we interviewed spoke about living “without power in their lives”. Two components of this sense of “powerlessness” are the level of economic independence and inherent gender inequities. Both factors increase a woman’s vulnerability in our society. Other social factors add layers that marginalize women further. Building individual power means access to practical resources, information, time, money, services, supports as well as psychological and personal resources. Empowerment-supporting initiatives need to be redirected to address the sense of powerlessness many women feel, to build a renewed sense of self-esteem and

independence. Only when a woman can feel a sense of power can she transfer this to other areas of her life and to her ability to influence or control her sexual interactions with her partner. This control or power allows her to advocate for her health, negotiate safety in her relationships, “to state her autonomy and to be free from abuse or threat” (Freire 1998).

“An [HIV-positive] woman comes to Canada at 19 due to abuse. When she goes for treatment they are treating the HIV. She is not treated for loneliness, abuse, culture shock, and emotional health. If she is not emotionally healthy how can she be physically healthy?” - Key Informant

The Key Informants and the women interviewed also addressed the need for a “holistic” approach to health care services. They stressed the importance of health as being more than medical or treatment-based; health service must care for *all* of the individual – her physical, emotional and spiritual selves. They resisted the traditional “compartmentalization” of service delivery – i.e. going here for this service; going there for that. For many agencies, like PPT, understanding this need goes without question, but finding the resources to address the holistic needs of women in one location is difficult and overwhelming. The ideal would be a “one stop shopping model” of service that includes counselling, clinical services, nutrition services/workshops, self care events for women, childcare, and education for men; and, educational workshops on such topics as masturbation, preparation for becoming sexually active, and groups/workshops for couples on communication. The reality, which is highlighted in the recommendations, will mean that PPT recognize that women need to be cared for, respected, and given tools for empowerment in achieving overall health; that we approach community partners that can help us to provide a continuity of care so “holistic health” moves from being less of a dream and more of a reality; and, finally, that PPT encourage our funding partners to acknowledge the links between holistic health services, the determinants of health and healthy communities and provide financial resources to support it.

For highly marginalized women the most significant social determinants of health are attitudes and stereotypes about homelessness, HIV, and cultural issues that lead to isolation, depression, low self esteem and increased vulnerability to abusive relationships. The most profound environmental determinant of health is the lack of access to services and relevant information on healthy sexuality for HIV positive women, transgendered women, immigrant women and women in conflict with the law. All Key Informants identified the lack of priority in funding for women’s health that addresses the needs of highly marginalized groups of women, as the main *political* determinant of health.

When we examined existing barriers, we found that the primary and sexual health needs of highly marginalized women (HIV/HEP C positive, incarcerated, and transgendered women, and immigrant women) are currently not being met. The lack of knowledgeable/capable staff and culturally-relevant, sex-positive information for transgendered, and HIV-positive women and immigrant women are fundamental gaps in meeting the sexual health needs of marginalized women. In order to address these gaps PPT needs to look at who our community partners are, and identify potential community partners that are already working within marginalized

communities to explore what role PPT can play in providing our knowledge and services on healthy sexuality in a flexible, culturally appropriate way. It is important for PPT staff to become knowledgeable and capable about the work currently being done in these communities so that our clinical services and program initiatives are enhanced and not delivered in isolation.

For women with disabilities the most significant social determinants of health are attitudes and stereotypes about people with disabilities that also lead to isolation, depression, and increased vulnerability in the aspect of sexual health. The most profound environmental determinant of health is physical accessibility to services, medication and relevant information about healthy sexuality. Finally, as with other marginalized groups of women there is a lack of priority in funding for addressing the health needs of women with disabilities, and even fewer for sexual health.

A comparison between determinants of health and existing barriers and gaps reveal an alarming lack of fulfilment of sexual health needs for women with disabilities. Physical and attitudinal inaccessibility create barriers that prevent women with disabilities from accessing the needed services and information; and the lack in knowledgeable staff and professionals and in relevant, sex-positive information show gaps in the delivery of basic, fundamental sexual health services for women with disabilities.

It seems that the attitudinal barrier is the core issue. Indeed, it is implied in the existence of physically inaccessible facilities and in the lack of knowledge amongst service providers and caregivers. It is therefore recommended that sexual health work with women with disabilities at this time focus on addressing this attitudinal barrier, taking into account effective outreach methods identified by Key Informants. One way is to provide relevant sexual health education (particularly dispelling myths) to women in familiar settings, where interaction and a chance to discuss are facilitated. It is also important to work in conjunction with service providers and caregivers, as they are often filters to information and services, providing them with awareness and gaining their support in the provision of these services to women with disabilities.

This work should strongly support the input of experts in the field of disability. Sexual health information will not be useful for women with disabilities if it is not relevant to them and if it is not delivered in a way that they will respond to. Key Informants have observed that this group is generally slow to trust new initiatives from unfamiliar agencies. Therefore, work must be done in collaboration with trusted individuals and organizations already working in the disability field.

It was also recommended that awareness about disability become incorporated into the culture of sexual health agencies, like PPT, to further promote the shift in attitude about sexuality and disability.

The discussion anticipated that when awareness increases and attitudes and beliefs about sexuality and disability start to change, the filling of gaps and lifting of barriers will naturally follow. Service providers will likely seek to collaborate with known and trusted experts in the disability field in efforts to provide more relevant sexual health information in a sensitive way to women with disabilities. Facilities will also likely

seek accommodations to become more physically accessible and to provide information that is also accessible. The ultimate benefit of changes in attitudes and beliefs about sexuality and disability, however, is the positive effects on the mental and emotional health, and overall well being, that comes from the much deserved empowerment of women with disabilities.

Social determinants are significant factors impacting women's health, but so is the natural evolution of a woman's sexual health as she ages. Sexual health and sexuality mean different things to different women anyway. Sometimes women's experience of sexuality is influenced by values and attitudes about sex, but most significantly, we found that it is the natural changes in our sexuality as women grow older that affect our sexual health. Women's sexual health priorities may change over time from the more clinical to those that are more related to re-affirming and celebrating our sexuality. Women's sexual health programs and services need to acknowledge these shifting complexities and reflect the diverse stages of sexuality in women's lives.

This assessment has been an exciting and rewarding initiative. Its findings gave our committee much to discuss and ponder and reconfirmed PPT's commitment to women's health programming. The recommendations listed here highlight the evolution or coming of age of our women's services and set out the enormous potential for working within diverse women communities.

## Recommendations:

- 1. Partner with a broad range of agencies in order to break down the compartmentalization of services.** Cultivate relationships with agencies that address the broader determinants of health and examine how these determinants impact women's sexual health.
- 2. Provide concrete resources and tools that will assist in empowering women about how they can become advocates for their own health care.** All Key Informants recommended programs for women around empowerment, self-esteem, healthy choices, and nutrition, to be offered in conjunction with clinical services. As one Key Informant said, "We empower them, they then can encourage and empower others".
- 3. Expand the referral bases used by PPT to include agencies that address the broader determinants of health and work with ethno-cultural communities.** This initiative will include our own agency development on what resources and services exist in the community from which we can increase our knowledge.
- 4. Promote the "demedicalization" of woman's health.** Promote "holistic" services that address women's physical, emotional and spiritual needs and that target women who are at different stages of their sexual health journey and those most vulnerable.
- 5. Explore building partnerships that support a continuity of care or mobile services** where groups and information services can reach a wider and more diverse section of women and may better reach women who are most at risk.
- 6. Recognize that "one size does not fit all" by developing programs that increase access and erode barriers.** Sexual health information needs to be delivered in different ways depending on which community we are working with. To explore creating services and programs that are fluid, mobile and flexible.
- 7. Ensure our programs and services across the agency embrace a focus on sexuality** that encompasses the diversity of women needs and experiences as they age.
- 8. Integrate a greater awareness of the issues faced by women with disabilities throughout all aspects of our programs.** Build and continue partnerships that include working with community organizations to build public awareness and eliminate service barriers facing women with disabilities.
- 9. Ensure that women's health remains a priority at PPT.** PPT agrees to seek financial support to continue to assess the needs of women, particularly women whose first language is not English and who are from differing ethno-cultural groups.
- 10. Investigate extending more of its services to women over the age of 25 who have more diverse sexual health needs.** PPT can play an important role in assisting women over 25 to have access to sex positive, non-judgmental and potentially ethno-specific sexual health information.

**11. Encourage our funding partners to acknowledge the links between holistic health services, the determinants of health and healthy communities** and provide financial resources to community-based organisations delivering or wanting to deliver such services.

**12. Continue to offer client-focused, pro-choice, respectful, non-judgmental, and woman-centred services that use peer-based models of delivery** to advocate for women's health.

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## **APPENDIX**

1. Terms of Reference
2. List of Key Informants
3. Key Informant Questions
4. Focus Group Questions

Women's Needs Assessment Project Working Group

Terms of Reference

PPT Mission Statement:

Planned Parenthood of Toronto is a community-based, pro-choice agency committed to the principles of equity and to providing accessible and inclusive services, which promote healthy sexuality and informed decision making to the people of the City of Toronto.

Goals of the Working Group:

- 1) To identify new programming initiatives to address the diverse sexual health needs of women living in Toronto.
- 2) To explore how social, cultural and environmental determinants impact women's overall health and how these determinants specifically impact their sexual health.
- 3) To identify the sexual health needs of women living in Toronto.
- 4) To identify gaps and barriers for women in accessing sexual health services and gaps in our services to women.
- 5) To identify what services are being provided.

Target Population: Women (18 + years of age from diverse backgrounds including race, culture, orientation, class etc.)

Structure:

Staff across the agency are committed to examining present and future programs for women of all ages. The working group will include those working directly with women. It will consist of but will not be limited to the following individuals:

Bridget McFarthing	Mental Health Counsellor
Rose Gutierrez	Health Promoter
Mary O'Campo	Program Co-ordinator – SexAbility Program
Andrea Joyce	Program Co-ordinator - PPT Program at BCBC
Leslie Molnar	Manager, Clinical and Counselling Programs

The "Women's Needs Assessment Working Group" will meet monthly or bi-monthly according to the workplan agenda items. Leslie Molnar is the chair of the Working Group.

Functions:

The Working Group will begin by following its workplan and will conduct Key Informant Interviews and Focus Groups. The Key Informant Interviews will be conducted with various agencies and individuals from across the City. Focus groups will be conducted with the target population, women (18 + years of age from diverse backgrounds including race, culture, orientation, class etc.) The results from the interviews and focus groups will be tabulated and pulled together for a Final Report.

### KEY INFORMANTS

AIDS Committee of Toronto

Alliance for South Asian AIDS Prevention (ASAP)

BlackCap

Bloorview Macmillan Children's Centre

Choice in Health Clinic

Come As You Are

David Kelley Lesbian and Gay Community Counselling Program

Education Wife Assault (EWA)

Good For Her

Hassle Free Clinic

Immigrant Women's Health Centre (IWHC)

Maggie's: Toronto Prostitutes Community Service Project

Meal Trans

New Directions

Prisoners with AIDS Support Action Network (PASAN)

Shout Clinic

The Anne Johnston Health Station

The Bay Centre for Birth Control (BCBC)

The Regional Women's Health Centre

The Women's Sexual Assault and Domestic Violence Program

Toronto Public Health

Voices of Positive Women

Women's Health in Women's Hands Community Health Centre (WHIWH)

**Women's Needs Assessment**  
Key Informant Interview

Name of Organization:	
Contact Information: (name, job title, address, phone, fax, e-mail)	
Date of Interview:	Interview done by:

**Goal Of Women's Needs Assessment:**

1. To identify new programming initiatives to address the diverse sexual health needs of women living in Toronto.
2. To explore how social, cultural and environmental determinants impact women's overall health and how these determinants specifically impact their sexual health.
3. To identify the sexual health needs of women living in Toronto.
4. To identify gaps and barriers for women in accessing sexual health services and gaps in our services to women.
5. To identify what services are being provided.

We are looking to involve and interview women, 18 + years of age, from diverse backgrounds including race, culture, orientation, class, etc.

1. Describe your current work with women?
  2. What are the ages of the women that you work with? Why this age group?
  3. What would you identify as the primary health needs of women that you serve? (Can they be categorized into age groups?)
  4. What would you identify as the primary sexual health needs of women that you serve? (Can they be categorized into age groups?)
- 
1. What would you identify as the social, environmental and political determinants that impact women's overall health?
  2. How do these determinants impact their sexual health?
  3. Can you identify any barriers for women accessing sexual health services in Toronto?

4. Can you identify the gaps in sexual health services for women in Toronto?
5. Can you describe any outreach you have done with women. Where and how have you done the outreach?
6. What have you found to be effective?
7. What were some of the challenges you faced when starting your program and how did you address those challenges?
8. Can you identify any issues unique to women of colour, queer women, trans women, women with disabilities in accessing sexual health services?
9. If you are currently working with women, would you be willing to help us contact them as a part of this needs assessment?
10. Are you aware of any/other sexual health work being done specifically for women living in Toronto?
11. Any last thoughts....

## Appendix #4

### Women's Needs Assessment Focus Group Questions

**Focus Group:**

**Date of focus group:**

**Number of participants:**

**Age range of participants:**

**Cultural/racial background of participants:**

**Facilitated by: Intro - PPT**

**Goal Of Women's Needs Assessment:**

1. To identify new programming initiatives to address the diverse sexual health needs of women living in Toronto.
2. To explore how social, cultural and environmental determinants impact women's overall health and how these determinants specifically impact their sexual health.
3. To identify the sexual health needs of women living in Toronto.
4. To identify gaps and barriers for women in accessing sexual health services and gaps in our services to women.
5. To identify what services are being provided.

We are looking to involve and interview women, 18 + years of age, from diverse backgrounds including race, culture, orientation, class, etc.

1. What general health concerns do you have?
2. How do you deal with these health concerns? Where do you go? What works well? What doesn't work? What's missing or frustrating for you?
3. What keeps you from dealing with these concerns? What gets in the way of obtaining the "best" health you can have?
4. What are your thoughts on sex? Sexuality? What did you learn as a child? How have those messages impact/shape your attitudes today?
5. What does sexual health mean to you? What are your sexual health needs?
6. How/Where do you go to deal with them? What works? What doesn't? What's missing or frustrating for you?
7. What keeps you from dealing with these concerns? What gets in the way of obtaining the "best" sexual health you can have?
8. How would you describe your relationships? (supports)
9. What type of programming would you find helpful?