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"Being dealt with as a whole person." Care seeking and adherence: the benefits of culturally competent care

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Abstract

The purpose of this study is to characterize the relationship between identity and health care experiences (including antiretroviral therapy utilization) among HIV-positive sexual minority males. This qualitative study used grounded theory with data collection occurring through focus groups and interviews. A questionnaire was used to complete a demographic profile. The study included 47 HIV positive participants from three minorities: gay men, bisexual men and transgendered persons, gender identifying as female and or living as women. Sessions elicited information on: (1) general experiences with health care, (2) experiences with HIV antiretroviral therapies and issues surrounding access, and (3) adherence to these therapies and identity in relation to health care. These textual data revealed three themes: (1) the importance of sexual identity and its social and cultural context, (2) the differences in the health concerns between the sexual minorities and (3) a wide spectrum of experiences with the health care system that provide information surrounding the access to and adequacy of health care. Successful health care providers are aware of different issues that may play a role in the provision of health care to these sexual minorities. Providers awareness of sexual and social identity and the related different cultural values, beliefs and custom enhance care seeking and therapeutic adherence. For sexual minorities, primary care remains the most important entry point into the health care system. Cultural competence of care providers can foster patient's care seeking and adherence to treamtment. © 2001 Elsevier Science Ltd. All rights reserved.

Keywords: HIV; Sexual minority health; Sexual identity; Social identity

Introduction

Access to timely and adequate health care for persons with HIV disease is an ethical issue given the success of newer HIV treatments (Hogg & Montaner, 1999), especially when health care and HIV medications are universally available, and free. Thus, it is a professional concern to understand the psychological and social contexts within which antiretroviral therapies are used (Stall et al., 1996; Kelly, Otto-Salaj, Sekkema, Pinkerton, & Bloom, 1998; Ferrando, 1998). Our objective was to gain an understanding of the health care experiences of transgendered persons, gay men, and bisexual men, all of whom have high rates of HIV infection. Current literature suggests that the caregiver/consumer interaction influences patients' care seeking and active

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participation in their health care (Ong, de Haes, Hoos, & Lammes, 1995; Holzemer & Tierney, 1996; Gerbert et al., 1999; Lerner, 1998). This knowledge reveals that an understanding of culture is a skill of identifying the components of a patient's whole social and physical being. Our study endeavors to reveal the complexity and differences in health care challenges for these sexual minorities. Similar challenges are encountered among ethnocultural communities for whom care seeking is compromised by a lack of description (Feinlieb, 1993) or an exclusion of cultural beliefs and values (Silenzio, 1997b; Penn, Kar, Kramer, Skinner, & Zambrana, 1995; Flack, 1995; Yee et al., 1995; Johnson et al., 1995).

Health care practitioners can improve their understanding of customs, values and beliefs as well as their abilities to distinguish and identify sub-groups that exist among sexual minorities. To reveal the barriers, complexity and nuances of access to care for sexual minorities, information is needed on (1) general experiences with health care, (2) experiences with HIV therapies and (3) identity and its relation to health care.

Health care experiences

Sexual minorities may experience hostile, phobic and negative attitudes of health care workers (Kass, Faden, Robin Fox, & Dudley, 1992; Olsen, 1997) about their identity. Minorities often have difficulty articulating their health needs because of negative assumptions and attitudes in the health sector (Blaxter, 1997; McConaghy & Armstrong, 1983; Morrissey, 1996; O'Hare, Williams, & Ezoviski, 1996; Williams & Ezoviski, 1996; Schwanberg, 1990). Health professionals may exhibit prejudices towards those involved in the sex-trade or substance abuse (McLaughlin & Long, 1996) or those with non-heterosexual orientations. These attitudes may impair care seeking or contribute to reliance on hospital emergency rooms for primary care.

The marginalization of transgendered, gay and bisexual communities is compounded by environmental and social degradation, drug use, and the sex trade into inner city areas (Harvey et al., 1997; Patrick et al., 1995; Patrick, MacDougall, Knowles, & Rekart, 1994; Wong, 1997; Munro, 1997). This all contributes to increased vulnerability to HIV. The high incidences of HIV infection, sexually transmitted diseases, hepatitis A, B and C, drug and alcohol abuse, child sexual abuse (Lenderking et al., 1997; Strathdee et al., 1998; Jinich et al., 1998), and psychiatric disorders found in these minorities may invite a climate of social disapproval. These attitudes may imperil care seeking and support avoidance of health care (Green, 1997). For those who seek care, the experience may not support a healthy partnership in care. The absence of adequate drug treatment and recovery programs (Strathdee et al., 1997; Bognar, Legare, & Ross, 1998) limits dialogue with health care professionals who already have difficulty identifying the needs of these populations (O'Connor & Samet, 1996).

HIV therapies

The new therapies have profoundly improved the health of many persons with HIV disease. Despite this, antiretroviral therapies carry a reputation of serious side effects (Sahai, 1996; Taburet & Singlas, 1996; Bates, 1996; Dykeman, Wallace, Ferrell, Jasek, & Tortorice, 1996; Saint-Marc et al., 1999). Research about patients' decisions to take or adhere to therapy has just begun to take into account the fears, trauma, and stigma associated with these drugs. Frequently, these patients have explored alternative therapies (Ostrow et al., 1997) because of beliefs that antiretroviral drugs are toxic and developed by a system that exploits them. Assumptions, beliefs and attitudes about those who use drugs or are involved in the sex trade are supported by judgmental policies which limit access to antiretroviral therapy (McLaughlin & Long, 1996; Lyons, 1997). Poor adherence and impaired care seeking, especially in the presence of addiction, are seen by providers as evidence of untrustworthiness. Recent research findings associate impaired adherence with depression, mental distress and/or substance and alcohol abuse (Stephenson, 1999; Gordillo, 1999). Adherence is also influenced by other factors which include complex medication regimens, cultural issues (Crespo-Fierro, 1997) (Flack, 1995; Penn, Kar, Kramer, Skinner, & Zambrana, 1995; Silenzio, 1997a), poor social support (Gordillo, 1999) and low literacy (Kalichman, Ramachandran, & Catz, 1999).

Identity and health care

Health systems are not constructed with sexual minorities in mind (Schwanberg, 1990), often treating them as *risk groups*, with no systematic research into their unique needs (De Cecco & Parker, 1995). Mainstream health care omits their complete social and sexual identities in research and practice. Identity is medicalized rather than considered in a social context. For instance, policy and practice prefer terms such as *homosexual*, referring to behavior, to *gay*, which is the social and cultural identity (Eliason, 1996). Health professionals also use such terms as "*men who have sex with men*" (MSM), making it possible to ignore affectional relations, cultural values and beliefs that exist within these groups. Hospital administrative procedures typically do not promote opportunities for sexual minorities to give pertinent information about their identity or needs by not directly acknowledging their social identity or choosing only to see specific facets of sexual identity. For example, there is an inclination to defer to families of origin rather than same-sex partners or to exclude the gender identity of transgendered persons, acknowledging only their biologic sex (Schilder et al., 1998).

Health planning may be frustrated by a lack of description of cultural beliefs, values, and group-specific experiences, thus missing opportunities to gather epidemiological, demographic and statistical information. Little research has focused on the social and medical concerns of sexual minorities (Sell & Petrulio, 1996; Grimaldi & Jacobs, 1998; Council on Scientific Affairs, 1996). Research is limited to anecdotal references about STD risk, mental distress and substance abuse without any appreciation of other intrinsic health concerns of each group (Rothblum, 1994). Earlier research has often ignored the mental, social and other concerns of these communities (De Cecco & Parker, 1995). A lack of ethnographic research inevitably leads to an absence of knowledge about the cultures of sexual minorities which may translate to incomplete training of health care professionals (Silenzio, 1997a). Therefore, these deficiencies in care provision combined with negative attitudes of providers may contribute to poor care seeking leading to avoidance of health care and thus poor therapeutic access.

Methods

Design

A qualitative, grounded theory design was used to characterize (1) general experiences with health care, (2) experiences with HIV antiretroviral therapies and (3) identity and health care of HIV-positive persons who are identified as transgendered persons, gay men or bisexual men. Grounded theory assumes that a group with similar experiences shares basic social and psychological issues and will process them similarly (Strauss, 1990). This study took place in the summer of 1998 in downtown Vancouver, BC, Canada in the wake of the 11th International Conference of HIV/AIDS, which heralded advances in therapy. Before the conference, combination therapy was in common use in the Vancouver area, making informed experienced participants familiar with these therapies.

Sample

Participants were recruited using the purposeful sampling technique which uses advertising, word-of-mouth and social networks (Strauss, 1990). As outlined by Strauss, this approach to sampling in qualitative research potentiates the probability of uncovering the greatest diversity of phenomena. Targeted advertising describing the objective and methodology of the study occurred in community and health care settings where HIV-positive persons usually congregate. Community gatekeepers in the gay and transgendered communities assisted in the recruitment of 47 participants. Participants were recruited from the local persons with HIV [consumer/disability] society, AIDS service groups, HIV day center, Gay & Lesbian Centre and Infectious Disease Clinic.

The first group was 10 transgendered persons who gender identified with and/or lived within the sex-roles of women. As gay men are the largest infected population, we recruited them by generation and stratified groups by age within the focus groups. This approach was utilized to reveal potential differences in health issues between the generations. We recruited five gay youth ages 25–27 but were unable to attract HIV-positive gay youth below the age of 24 to attend our focus groups, which was probably due to the shame of infection and concerns about confidentiality among peers. To capture the issues of this younger group of HIV-positive gay youth we recruited four participants below the age of 24 for one-on-one interviews. For the remaining generations, nine younger adults (ages 28–39) and nine older adult (ages 40–60) were easily recruited. Due to the invisibility of bisexual men (Boulton & Fitzpatrick, 1997), community leaders were not available; thus, the principal investigator through advertising in community and health care environments undertook recruitment of 10 bisexual men (ages 27–47). Bisexual men were pre-screened by telephone as self-identifying as "bisexual" and reporting having had sex with both men and women in the last 2 years (Meyers & Allman, 1997).

Procedure

Peer investigators from community agencies facilitated stratified focus groups (transgendered, bisexual, and gay social identities). Each session lasted approximately 3 h including lunch. These facilitators were social peers and with one exception were HIV-positive. The relationship between the study population and both principal researcher and peer investigators was not caregiver/patient but community researcher and leaders/community member, which enhanced the quality of these data. This approach removed barriers and insured insights that an "outsider" in this type of research would have had great difficulty overcoming. Focus groups and one-on-one interviews were used to document the lived experiences of 47 HIV-positive persons. All focus groups and interviews occurred in community agencies except the interviews with bisexual men, which because of confidentiality concerns occurred in a hospital. At the beginning of each session, participants completed a short questionnaire and then read an introductory statement outlining the intent and purpose of the study and the measures taken to protect confidentiality. All focus groups and interviews were audio recorded. At the end of every focus group and interviews, each participant was provided with a cash honorarium of 40 Canadian dollars.

The same structured questions were utilized in all sessions. The following are examples:

- "*What is your experience with doctors and other health care providers?*"
- "*What have you heard people saying about the new HIV medicines?*"
- "*What do you think people in the health system see when they look at you?*"
- "*What do you think health care providers do not see?*"

A safe comfortable environment, affirmation of social self-concept and the clarification and acceptance of participant comments were inherent to the data collection process (Field & Morse, 1991).

Data analysis

Quantitative data on socioeconomic factors, sexual identity, social identity, ethno-cultural background, age, ethnicity, length of infection, risk factors, and housing were from the questionnaire and summarized in tables. These data did not constitute the basis of our analysis but enhanced the depth of these textual data (LeCompte & Schensul, 1999). Verbatim transcriptions of the audiotapes were prepared excluding all identifying information. QSR NUD*IST (non-numerical unstructured data indexing searching theorizing) software was used to manage, explore and analyze these data.

Canada maintains a universal health care system. Within the province of BC HIV therapies are free to all who meet the standards of the therapeutic guidelines. Systems of health care may vary; this acts as a limitation on these data. Because these participants were recruited from urban health care and service agency settings where HIV-positive persons were known to congregate, this sample does not account for *hard-to-research* non-agency groups. In addition, adoption of and adherence to therapy was self-reported by participants and could not be directly observed or verified. Our findings should not be generalized beyond the populations in this study.

Results

Three primary themes emerged: (1) sexual identity and its cultural and social context within the health care system; (2) differences in health concerns between the sexual minorities; and (3) a wide spectrum of experiences regarding access to and adequacy of health care.

Cultural and social context

Sexual identity

Each group had shared values and beliefs about their own adult social and sexual identities. Observation and textual data (Table 1) revealed that for each group, sexual identity was unique and distinct. Biologic sex, gender identity, sexual orientation and social sex-roles are the components that form sexual identity (Shively & De Cecco, 1977) and emerged in association with data on social self-identification. Illustrated in Table 2 are the stated and observed differences in the *mixes* (of the components) of sexual identity for each social group.

Confirmation of social identity and community of attachment was generally determined by the *mix* of these four components. *Transgendered* persons were born male and gender identified and/or lived as women. They could present all three variations of sexual orientations. Men who had affectional and sexual relations with men gender identified as men, acted within male social sex-roles, identified as *gay*. Gay men gender identified as men but distinguished their difference in sexual orientation. Bisexual men acknowledged their sexual orientation, gender identified as men, specified they were "straight acting and straight looking" (sex-roles). Bisexual men placed great importance on stereotypic social sex-roles and did not culturally identify with the other two communities.

Transgendered persons asserted that providers failed to recognize unique sexual identities, and would instead reaffirm and project their own heterosexual self-concepts on their patients (Schilder et al., 1998).

> "Being addressed in the right gender. Like 'she'! A doctor will come in, look at the form, and see male. Then he looks at me and says 'he'. Although, it is she he sees. I feel like a character in a Dr. Seuss story." (Transgendered person).

"Passing" as a woman in health care was an important self concept issue that included affirmation of social sex-roles and gender identity for the transgendered. The transgendered found that a lack of understanding of the different components led to confusing their gender identity with their biologic sex or sexual orientation.

> "But it does piss me off that people confuse human sexuality for gender issues. My gender is not about my sexuality. My sexuality is about my sexuality. My gender identity is not a sexual thing, that is about

Table 1
Socio-economic descriptive data

Sample [$N=47$]	Transgendered ($n=10/47$)	Gay men ($n=27/47$)	Bi-sexual men ($n=10/47$)
Primary sources of income			
Sex-trade	1	0	0
Regular job	0	3	1
Part-time job	0	1	0
Disability income	0	7	0
Social assistance	9	16	9
Housing[a]			
Rooming house	2	0	0
Single room hotel	2	3	5
Apartments	6	24	5
Median annual income			
Transgendered Persons	\$10,000. PA	(Range, \$10,000.–\$70,000. PA)[b]	
Gay Youth	\$13,100. PA	(Range, \$10,000.–\$15,000. PA)	
Young Adult Gay Men	\$14,400. PA	(Range, \$10,000.–\$15,000. PA)	
Older Adult Men	\$14,400. PA	(Range, \$10,000.–\$40,000. PA)	
Bi-sexual men	\$10,000. PA	(Range, \$10,000.–\$30,000. PA)	
Median Age			
Trangendered Persons	32 y old	(Range, ages 23–40)	
Gay Youth	24 y old	(Range, ages 19–27)	
Young Adult Gay Men	34 y old	(Range, ages 28–39)	
Older Adult Men	48 y old	(Range, ages 41–55)	
Bi-sexual men	36 y old	(Range, ages 27–47)	
Average education in years			
Transgendered Persons	11 y	(Range, 10–12 y)	
Gay Youth	12 y	(Range, 11–14 y)	
Young Adult Gay Men	13 y	(Range, 12–18 y)	
Older Adult Men	13 y	(Range, 10–16 y)	
Bi-sexual men	12 y	(Range, 10–12 y)	

[a] Unstable housing' is defined as no-fixed address, a day-to day hotel rental, or a rooming house.
[b] PA (per annum)

Table 2
Confirmation of adult social identity and corresponding mixes of the components sexual identity

	Components of Sexual Identity (Shively & De Cecco, 1977)									
Social Identity	Biologic Sex			Gender Identity		Social Sex-Roles		Sexual Orientation		
	Male	Inter-sexed	Female	Man	Woman	Masculine	Feminine	Hetero-sexual	Bi-sexual	Homo-sexual
M *t* F[a] Transgendered Person	▼	▼			▼		▼	▼	▼	▼
Gay[b] Man	▼			▼		▼				▼
Bi[c] Man	▼			▼		▼			▼	

[a] M *t* F corresponds to gender identity, *male to female* and/or social sex-roles, *masculine/feminine*
[b] Homosexual identifying men do not claim a 'gay' social identity and only acknowledge their sexual orientation.
[c] 'Bi' is a term used for social identification among men who are behaviourally bi-sexual.

> correcting a biological mistake". (Transgendered person).

Social identity

Transgendered persons

The questionnaire asked each person to choose one of the listed adult social identities (Table 3) from a prepared list or provide a term that best described them. During the focus groups, the transgendered agreed with and accepted the term "*transgendered*" which they said defined persons who gender identified with and/or lived within social sex-roles of women. Unlike other sexual minorities, transgendered persons often exhibited multiple variations in the mix of their sexual identity, which increased confusion among health providers. These *mixes* varied among the sub-groups, which identified as *transsexuals, drag queens*, *intersexed, and crossdressers*. "Transsexuals" would gender identify with and/or live as women, pursue sexual reassignment

Table 3
Characteristics of identity and social context

Sample ($N=47$)	Transgendered persons ($n=10/47$)	Gay men ($n=27/47$)	Bi-sexual men ($n=10/47$)
Ethnicity and cultural background as derived from questionnaire			
(46 persons born in Canada, one born in Ecuador)			
First Nations[a]	4	4	4
White	6	19	6
Asian	0	1	0
Latino	0	1	0
French Canadian	0	1	0
Jewish	0	1	0
Self-defined social identity as stated in questionnaire			
Trangendered persons	3 as "transsexual"	5 as "transgendered"	2 as "gay"
Gay Youth	8 as "gay"	1 as "homosexual"	
Young Adult Gay Men	4 as "gay"	4 as "homosexual"	1 as "fag"
Older Adult Gay Men	6 as "gay"	3 as "homosexual"	
Bi-sexual men	1 as "gay"	9 as "bi-sexual"	
Self-defined social identity as stated within the focus groups or interviews			
Trangendered persons	10 as "transgendered"		
Gay Youth	8 as "gay"	2 as "homosexual"	
Young Adult Gay Men	6 as "gay"	2 as "homosexual"	1 as "fag"
Older Adult Men	6 as "gay"	3 as "homosexual"	
Bi-sexual men	3 as "gay"	2 as "bi-sexual"	4 as "straight"
Experience within the sex-trade			
(7 reported being runaways, 6 reported prostitution before the age of 16)			
Trangendered persons	10 persons (4 FN)[b]		
Bi-sexual men	7 persons (4 FN)		
Experience with incarceration[c]			
Transgendered persons	2 persons (4 FN)		
Bi-sexual men	5 persons (4 FN)		
Experience with injection drug use			
Transgendered	9 persons (4 FN)		
Gay Youth	3 persons (2 FN)		
Older Adult Men	2 persons		
Bi-sexual men	9 persons (4 F)		

[a] First Nations represented 25% of this sample whereas in BC they represent only 4% of the provincial population.

[b] FN includes First Nations, Metis, Aboriginal, or Indigenous peoples.

[c] Includes: prisons, detention centers, group homes, psychiatric facilities.

surgery and take hormones. "Drag queens" could gender identify with and/or act out women's social sex-roles but did not pursue physical change. The "intersexed" were born with ambigous sexual organs but gender identified and/or lived as women and would pursue physical change. "Cross dressers" had heterosexual orientations.

Gay men

Most gay men self-identified as "gay" within the focus groups; however, several men identified as "homosexuals" in both the questionnaire and the focus group. In western societies, "gay" is recognized as a term of social self-identification within urban communities. "Fag" is used to indicate a more militant "gay" identification. A "homosexual" man identifies with sexual behavior but not with a community culture and prefers not to identify as "gay", maintaining a "straight" social profile in order to preserve social access, economic status and safety.

> "I don't live in a gay community. I live in a very family oriented community. I do not really label myself 'gay' or go around and parade it. It's hard to say I'm homosexual, but that's what I am." (Gay man-young adult).

Those who identified as "homosexual" were concerned with being identified or excluded if they asserted their sexual identity in social or in health care settings. Some men socially identified with "leather" (gay men who wear black leather), or as a "bottom" (sexually passive in anal intercourse) as part of their sub-cultural identity.

> "I can use a label to describe myself like gay man, leather bottom, HIV-positive, or person with AIDS, or Irish, Canadian, actor". (Gay youth)

Bisexual men

Bisexual men socially identified differently. Some said they were "gay" and lived closely *attached* to gay communities and were reluctant to self-identify their orientation to gay men for fear of being ostracized. The second group identified as "bisexual" and were *unattached* to either a gay or straight community. Finally, men who said they had sex with both men and women defined themselves as "straight". Bisexual men took great care to control biographical information.

> "The only people I tell that I'm bisexual are people I actually know that are either bisexual or gay. I never disclose as bisexual to anybody who's straight, heterosexual or Catholic." (Bisexual man).

In this sample of bisexual men, the drug culture also played an important role.

> "It is automatically assumed that you're gay and you only get HIV because of your sexual behaviour. That is not how I got my HIV. I always played safe as a bisexual man. I just got HIV from IV drug use." (Bisexual man).

Social context

Same-sex spouses, roommates, networks of friends, HIV-positive peers, physicians, health care workers and especially HIV-positive social networks were reported as providing support to the participants. For most participants having an HIV-positive sub-identity also insured having an HIV peer support network.

> "I feel more attached to the HIV-positive community than the gay community." (Gay man-younger adult).

The transgendered identified with their "sisters" in the sex-trade and depended on their lovers, roommates, and other HIV-positive peers. Gay men had developed strong social networks and were likely to volunteer in community agencies; they also depended heavily on pets, families-of-attachment and the HIV-positive community for emotional and social support. Bisexual men had very poorly developed social support systems, which was in part due to both reluctance to socially self-identify and the lack of a visible community. Their community was often comprised of casual drug and sex-based relationships from the street and bar scene. They often sought support from transgendered persons and gay men.

> "You have to know people who are more active in the community. You are not going to see bisexuals in heterosexual places. You find bisexual men in the gay community. With transgendered persons especially that is where you find a lot of bisexuals." (Bisexual man).

In this sample, 33 persons lived alone and few maintained ties with their family of origin ($n = 6/47$). The passage of time, migration to urban communities and revealing their sexual identity often led to alienation from their family of origin.

> "I used to phone my Mom, but she lives 700 miles away. I go see my doctor for support." (Transgendered person).

> "The greatest villains would probably be my relatives. I don't hear or see from them at all." (Gay man-older adult).

> "And I have no contact with my family. I spoke to my mother on the phone once in five years." (Bisexual man).

Families of attachment replaced *families of origin* in the adult lives of these participants ($n=36/47$) as the important source of emotional and social support.

> "My friends, they are everything in my life. They're my family, my friends, my substitute partner sometimes, they're my life support." (Transgendered person).

> "My friends. We are family." (Gay man-young adult).

> "Usually, I just rely on the friendship of my friends. They are the first people that I go to, if I need any type of help or support." (Bisexual man).

All groups described a primary network of friends as those who had the *greatest knowledge and affection* for them. A lack of understanding of *families of attachment* meant that frequently these essential figures were not included in the caregiving relationship. Social networks provided safety and caring while society at large remained a threat in their lives. Fear of physical and social violence was a strong theme. Transgendered sex trade workers had clients who would sexually and physically assault them. Suburban blue-collar workers were known to bash gay men in their neighborhood. Private and public disability pension payers would attempt to cut off pensions. Doctors often were judgmental or patriarchal. Lovers would not accept an HIV diagnosis. Parents and relatives often were abusive or hostile. Evangelical and Roman Catholic Christian groups were all seen as uniquely threatening.

> "The greatest villains would be probably be reborn Christians." (Gay youth).

> "I got bashed, for being bisexual and almost killed my arm broken, my spleen ruptured. I had 40 stitches in my head." (Bisexual man).

> "I don't feel safe in my neighborhood after dark. You get yelled at and I find that threatening." (Gay youth).

In adolescence, abusive and violent home situations frequently resulted in running away and surviving on the streets through the drug trade and *survival* prostitution.

> "I left home and went to Montreal when I was 14. And then after a while I was so hungry, 1 ended up in prostitution." (Bisexual man).

All transgendered participants and nine bisexual men but none of the gay men reported working in the sex trade. For transgendered and bisexual participants the sex trade had resulted in frequent violent encounters and an increased rate of incarceration ($n=9/47$). Prostitution was a means to survive on the street but also a profession.

> "I've been a prostitute for ten years and I'm not ashamed of it. Being a hooker has been very good to me and brought me a lot of money." (Transgendered person).

Health concerns

Disease and illness

Gay youth, perhaps like bisexual men appeared to be the most recently infected (Table 4 below) and had known about their HIV infection on average for 3 years.

Table 4
Risk factors and length of HIV infection

Sample ($N=47$)	Transgendered persons ($n=10/47$)	Gay men ($n=27/47$)	Bi-sexual men ($n=10/47$)
Risk factors for HIV infection			
Multiple risks[a]	2	5	5
Sex with a man	6	23	1
Injection drug use	2	2	4
Average time since testing HIV-positive			
Transgendered persons		10 y	(Range, 1986–1994)
Gay Youth		3 y	(Range, 1988–1996)
Young Adult Gay Men		7 y	(Range, 1986–1994)
Older Adult Men		7 1/2 y	(Range, 1986–1993)
Bi-sexual Men		2 1/2 y	(Range, 1989–1996)

[a] Sexual assault, blood products, sex with a woman, and injection drug use

Older gay men had known about their HIV-positive test results for approximately 7 years, and the transgendered had known for an average of 10 years.

Profiles of disease and illness differed among the groups, each reporting specific health concerns that prompted care seeking and an entry point into the health care system. Injection drug related complications such as septicemia, endocarditis, hepatitis C and abscesses were often reported by transgendered persons and bisexual men.

Sexually transmitted diseases, hepatitis, and upper respiratory infections were concerns for gay youth. In these data, human papilloma virus (HPV) particularly was an issue for gay youth. Predictably, older gay men reported conditions associated with advanced HIV disease such as recurrent bacterial pneumonia, herpes zoster, generalized genital herpes (simplex), anal cancer, *Mycobacterium avium* complex (MAC), and recurrent *Candida albicans* infections.

Mental distress

The stress of being from a marginalized community, dealing with HIV infection and stigma, adjusting to sexual identity was an issue for young gay men. Ongoing distress in coping with declining health and disability was reported by older gay men. Other concerns included being able to obtain assisted suicide, and difficulties in obtaining timely referral to psychological care were all factors identified as "psychological stressors" sometimes leading to suicide attempts ($n = 3/47$).

> "I attempted suicide a couple of times." (Bisexual man).
>
> "It is difficult to deal with past issues that need to be addressed in order for your life to go forward. People are having problems in terms of HIV and need to see different specialists. The wait for a psychiatrist is very long." (Gay youth).

Eight bisexual men reported childhood histories of sexual abuse, which are reported elsewhere (Schilder, 1999). Mental distress due to grief and loss was abundant among transgendered and older gay men who cited substantial losses in their social networks, including lovers and families of attachment, due to AIDS.

> "The people who have already left us — all my good friends — I miss them — very, very much." (Gay man-older adult).

Substance use

Different substance use profiles appeared for each group. Marijuana, tobacco, and alcohol appeared as staples for gay men. Bisexual men used a variety of drugs such as marijuana, MDA, LSD, and prescription drugs. Gay men from 28 to 39 years old did not report any injection drug use whereas the youngest gay men and the older gay men did. Injection drug use by all participants was reported to be 46% ($n = 23/47$). Transgendered persons and bisexual men reported high rates (90% or 18/20) which may explain the different disease profiles among the groups. Aboriginal persons were overrepresented amongst the injection drug users ($n = 10/12$).

Experiences in health care

General health care experiences

The majority of participants reported histories of current or past homophobic care. Often providers would make judgements implying promiscuity and immorality associated with sexual orientation.

> Question: "And what do you think providers see when they look at you?"
>
> Participant: "A cheap slut!" (Gay-youth).
>
> "I experienced homophobia in the hospital regarding the fact that I was HIV-positive. Because I am gay, they will see me as immoral. As somebody who is very promiscuous because I am HIV-positive. I have been labeled a slut. When it comes to straight people; gay men are all immoral. I don't give a shit, because when it comes to loneliness; I'm the one who deals with my own life." (Gay-Young Adult Men).
>
> "And then I had the other people in hospital that still look at me as a faggot with AIDS and as someone who is going to die." (Gay man-young adult).

Rural and suburban health practitioners especially were viewed as hostile or phobic when presented with variations in sexual identity.

> At a walk-in medical clinic in [a small city] I told the doctor I wanted hormones. This doctor rolled his chair all the way across the room to put his back against the corner. He couldn't get far enough away from me." (Transgendered person).
>
> "My friend, a gay man with AIDS was in a suburban hospital and had one nurse in particular who was just awful. Instead of doing her job she stuck to her mortal views and treated him as if he deserved AIDS." (Gay man-young adult).

> "You're a prostitute, that's the stigma that is attached to every transgendered person. They see us as all the same, dirty, HIV-positive, addicts, bad people. Taboo! Stay away from them." (Transgendered person).

Because of perceptions of prejudice and negative attitudes towards their sexual orientation, bisexual men reported a reluctance to disclose their sexual identity to providers.

> "When I do see a doctor; I don't tell them I am bisexual. If they knew, it would probably affect to their decisions. I only let them see what I want them to see." (Bisexual man).

Primary care

Transgendered participants were likely to have established satisfactory relationships with a physician if they discontinued drug use and/or they discontinued in the sex trade.

> "My doctor is very good. Because I am not on the street working in the sex trade for heroin. I am on AZT, 3TC and methadone. The methadone is to curb my heroin addiction and the AZT and 3TC is to fight the HIV disease." (Transgendered person).

Competent care for transgendered persons who were transsexuals was perceived to address hormone therapy in addition to psychological interventions.

> "My doctor's good with both hormones and HIV treatment and he's very well educated for dealing with transsexuals. I am going to stick with him. He has a heart. He actually cares and he shows it." (Transgendered persons).

Gay participants were most likely to seek physicians who had a greater understanding of their social context and identities. The majority of these physicians were *gay men*. Many participants expressed discomfort with heterosexual male doctors due to past homophobic experiences.

> "Health professionals bring their own personal biases into the room. I have dealt with straight male doctors who had a very judgmental attitude. Sort of a high and mighty kind of attitude because I am gay and they are straight. That is prejudicial. I'm sensitive to the personal bias that a doctor brings." (Older gay man).

Physicians providing sensitive care to their patients were more likely to encourage care seeking behaviors, activate self-help, motivate adherence, and encourage communication.

> "I prefer to have a gay doctor. I can relate far better, and feel a lot more comfortable and much it is easier to open up to a gay doctor because they understand the life that we live. Period". (Gay man-older adult).

Younger gay men often chose a doctor based on sex appeal and experienced more difficulty in establishing balanced relationships with their physicians. Feeling safe enough to disclose the psychological and social issues related to their identity, managing same-sex attractions and being able to articulate legitimate needs often seemed to be factors in establishing good relationships with physicians.

> "It is especially hard to find doctors who are sensitive and have some understanding of what it is like to be a gay youth." (Gay-youth).

Gay men primarily utilized gay physicians whom they viewed as part of their social support network. All three generations of gay men offered positive views of straight women as physicians.

> "I have a straight woman physician who had given me as much time as I need. She listens to my concerns specifically around treatment. She asks me what other things are happening in my life that may be affecting my physical health. I bring them up quite comfortably in her office. I'm happy where I'm at now." (Gay man-Young Adult).

This may be attributable to the absence of same sex attraction and the ability to understand sexual health, provide safety and support empowerment.

Bisexual men reported unsatisfactory relationships with their doctors when injection drug use continued ($n = 7/10$). Adherent bisexual men were more likely to be in recovery ($n = 3/10$), to be out as *bisexual* ($n = 2/10$) and live in close association to the gay community. These men used gay physicians with whom they had developed an excellent relationship.

> "My hero would be my doctor." (Bisexual man).

> "Health care workers are my friends. Doctors and the Nurses." (Bisexual man).

Gay physicians were less familiar with the transgendered and bisexual populations and were likely to be competent with injection drug use for these two groups. Despite this, bisexual men and transgendered persons in recovery who also had a satisfactory relationship with their primary care physician most likely reported that their doctor was gay.

Hospital care

Transgendered persons, bisexuals and gay youth sought care in emergency room at times of a health crisis whereas older gay men had learned to go directly to their primary care doctors. Experiences in the emergency room consistently impaired future care seeking and promoted avoidance.

> "I went into the hospital emergency room with an abscess on my neck the size of a golf ball from intravenous drugs and got this doctor who didn't put any freezing in my neck. He put that cloth with the hole and started pressing. I was screaming 'it hurt'. Do you know what he told me? 'You were not screaming when you stuck the needle in your neck for drugs. So take it.' No freezing! No nothing! I haven't gone back there since." (Transgendered person).

Addiction care was scarce, unavailable or incompetent and did not offer a continuum of services that supported recovery. Often health professionals dealing with addicted participants were viewed as prejudiced and lacking understanding.

> "Right away! I get that 'you're a junkie' attitude. I get a bad reaction in the emergency room when they first see me because they look at my arms and they look at the scars. They do not look to see that there are no fresh injection sites. They do not look at my tracks as a scar. I am junkie and always will be! But I'm clean!" (Bisexual man).

Older transgendered persons sought care from an assortment of physicians who would address their diverse health care needs. These physicians provided HIV care, and also could co-ordinate multi-disciplinary care including addiction counseling, urology, endocrinology, and gender counseling. It was difficult to obtain gender reassignment surgery because of their HIV-positive status. They felt health care providers often refused to affirm their gender self-concept as a *woman* (as opposed to female) which was perceived as humiliating and let to avoidance.

> "My recent experience in the emergency room at the hospital was for stomach problems. They knew of my reassignment surgery. The doctor had come in when I am on a gurney and lifted the blanket and he says 'oh, yes! You did have sex reassignment surgery.' (All participants gasped in horror)" (Transgendered person).

Younger transgendered persons used street clinics and felt that health providers did not address their specific needs and so often turned to the black market.

> "My doctor didn't know much about gender care and referred me to the gender clinic. I have never been there but because of the stories that I have heard, it t sounds to me like bullshit. So I just buy my hormones on the street." (Transgendered person).

Care seeking

Care seeking behaviors varied widely in this study, especially if they were addicted transgendered or bisexual. They often seemed more concerned with the expectations of the physician than with their own legitimate needs.

> (Person high on drugs with visible sepsis and a productive cough observed in the focus groups) "My Doctor's excellent. I have not had any major health issues so she is very happy with me. That makes me very happy with her. As long as she is happy with me, I am happy. So I haven't had any trouble with her." (Transgendered person).

Addiction, street involvement, and unstable housing interfered with the care seeking capacities of the bisexual men. Bisexual men exhibited the highest degree of dependence on community agencies and the least control over their health. They were largely unable to maintain stable doctor–patient relationships.

Young gay men made efforts to inform themselves and sought out physicians found by word-of-mouth from other gay men. Experience taught gay men to become self-reliant in finding care that would address their specific care issues.

> "I was stubborn before. When I would get sick and not go to the doctor. I paid for that later. Now as soon as I'm sick, I call my doctor". (Gay-youth).

> "I usually try and make them see me and let it be known that I'm there. So for the most part, I don't think they see me as a number anymore, because I won't let it happen." (Gay man-younger adult).

> "Once I decided to become informed and take the initiative; I would say, I am not just going to sit back and just accept what he told me, things started working well." (Gay man-older adult).

Identity in care

Overall, participants felt that health providers should be more aware of their patients' social context and culture. Some participants were more positive about health care when providers took into account their specific lived reality and acknowledged their identities. They felt that being accepted for who they were played an important role in their care.

> "If you're in the hospital the thing that makes you feel better; is if you have your big, pink fluffy slippers and your pink frock. You can not do that in a hospital. If that makes you feel better; well then sure; that is good. You can feel comfortable being who you are. If you're with a queeny old girlfriend, or whatever, you can be like that and not have to worry." (Transgendered person).

> "I've had some wonderful people treat me very well, specially. Like on medical short stay. They treat me like a human, they talk, they sit and chat, ask me how things were going. They want to know how things are, and they know about me, my life. I have had people in black leather come up and visit me. They just accept it as part of me." (Gay man-older Adult).

Even in the hospital, bisexual men continued to be reluctant to disclose their identity because of previous experiences:

> "It shocked me in the emergency room of this major AIDS hospital when I was admitted and told them I was HIV out of consideration for the staff. The Nurses attitudes just changed all of a sudden. Number one, I am young! If they know that you are bisexual and you tell them you are HIV-positive. It was frightening. They treated me like a leper." (Bisexual man).

Overall, gay and transgendered participants wanted to have their identity, values and beliefs affirmed and acknowledged. They often felt health care providers did not acknowledge their unique identity and ignored the stress of living in a stigmatized and marginalized community.

> "I don't think they health care professionals see the years of isolation and struggle. They don't see our feelings." (Transgendered persons).

> "I think they don't see what I don't show them. But mostly, I think they don't understand how I got to be standing in front of them." (Gay-youth).

The tendency reported by bisexual men was of allowing the physician to assume their needs depending on the physician's sexual identity.

> "I kept quiet about being bisexual because the doctors were straight and they couldn't relate to what I would be saying. When I picked up STD infections, I would prefer to let them think it was from sex with a woman." (Bisexual man).

Many bisexual men found it difficult to attend the offices of gay physicians as this was viewed as cultural space. When an individual was seen in these spaces, it was assumed the person was gay.

Experience with therapy

Physician social identity

During data collection, prompts were introduced to obtain the surnames of the participants primary care physicians. In the context of local HIV care, it was a simple matter to determine which physicians were self-described in the community as "gay" or were known to be "straight" women or men. In this sample (Table 5), 47 participants identified 21 primary care physicians of whom gay physicians were associated with the largest number of patients overall, and the majority of the gay and transgendered participants. The utilization of therapy in this sample was 57.4% ($n=27/47$). Gay physicians treated the greatest number of participants who used HIV antiretroviral therapy and expressed adherence.

Transgendered persons were less specific in their choice of doctors, possibly due to their need for sub-specialist care. Bisexual men appeared equally likely to use a gay or straight man as a primary care physician. Seventy percent of gay men used antiretroviral therapy as compared to four transgendered persons and three bisexual men. Gay physicians were more likely to be associated with patients among the bisexual and

Table 5
Primary care physicians' social identity

Physician's Social Identity (PSI)	Gay men	Straight women	Straight men	
Number of physicians in each PSI	9	4	8	
Number in each sub-group of participants treated based on PSI				
Transgendered persons	4	2	3	[1]
Gay men	18	4	3	[1]
Bi-sexual men	4	1	5	[1]
Number of patients treated by each PSI	26	6	11	[3][a]
Participants from sub-groups who self-reported utilization within each PSI[b]				
Transgendered persons	2	1	1	
Gay men	16	2	2	
Bi-sexual men	2	0	1	
Number of patients treated by each PSI	20	3	4	

[a] Did not have a physician

[b] Utilization meant current access and adherence to HIV antiretroviral regimens which were self-reported. Reports were accepted at face value. Having accessed HIV antiretroviral in the past was not defined as accessing therapy in this calculation.

transgendered participants who indicated access, and self-reported adherence.

Factors influencing utilization of therapy

There was a collective memory among many of the participants, especially as they got older, of failures and traumatic experiences with HIV antiretroviral therapies and side effects.

> "My twin brother died six months after being on AZT. I could not handle it. I got sick so then stopped taking AZT. I would never recommend AZT. It will kill you faster than it will keep you alive." (Transgendered person).

Fears of side effects, being medicalized, sustaining organ damage and being disabled were often mentioned. Participants not using HIV therapies were more likely to report substance and/or alcohol abuse, liver and mental distress. Bisexual and transgendered participants using therapy reported attending addiction recovery programs, using methadone treatment and implementing life changes.

> "Because of injection drugs I was really sick and lost a lot of weight. I was admitted to hospital 6 times with pneumonia and blood infections. I became healthy when I started on methadone, stopped the sex trade and doing drugs. Since then I've gained 85 pounds." (Transgendered person).

Lifestyle changes included improving their diets, seeking out safe social support, taking vitamins, engaging in routine exercise programs, using less alcohol and drugs, and above all, securing stable housing. Participants adhering to therapy secured treatment information from their doctors and then HIV-positive peers. Low literacy was a barrier for many.

> "I'm not sure what the pills are doing for me. I try to read about how it helps, but I do not really understand it sometimes I have to bring my friend to come with me to a doctor and he explains it to her. She explains it back to me." (Gay youth).

> "I ask older HIV-positive people what exactly these drugs are and why is it good for me. And why I should take them." (Gay youth).

For some, adherence proved difficult because scheduling often conflicted with the timetable of employment, community life, sex trade activities and chemical dependency. Mental distress, unstable housing, the difficulty of concomitant management of other medications and just the challenge of understanding treatment information were other difficulties.

Summary

Our study elicited information on (1) experiences with health care, (2) experiences with HIV antiretroviral therapies and issues surrounding adherence to these therapies and (3) identity and health care. Three themes emerged: (1) the importance of sexual identity and its cultural and social context; (2) differences in health concerns; and (3) experiences with the health care system that affected access to and adequacy of health care.

Cultural and social context

Each group held beliefs about themselves and their identity. These different "mixes" of sexual identity were predictive of an adult social self-concept and adult community of attachment. Persons born as male, gender identifying and/or living as women identified as *transgendered* and/or with one sub-group within the transgendered confederation. Transgendered persons expressed the greatest variations in their *mixes*. A male who had affectional and sexual relations with a man, gender-identified as a man, and acted out masculine social sex-roles identified as *gay*. Bisexual men were reluctant to self-label as "bisexual". These men preferred invisibility and did not socially identify with the other two minorities. Providers were not trained to understand sexual identity, as they often assumed that transgendered persons were gay men in "drag", that gay men gender identify as women, and that bisexual men were "gay".

All groups lived within different communities, social contexts, and locations. There were differences between the groups in terms of income, education, and housing. Few participants maintained supportive ties with families of birth or origin but sought emotional and social support from *families of attachment*. Family was best defined as *those persons closest in knowledge and affection*, which should be the criteria in interpreting any individual's social support. Gay men had the strongest and most functional social networks. Transgendered persons dealt with isolation and relied on networks of peers linked to the sex-trade, which often conspired against recovery from addiction. Due to the desire for invisibility, bisexual men had loose social support networks linked to the street and to substance abuse.

All reported common threats to their social safety and security, and continued marginalization because of their identity and disease. For some participants, the lived reality was as a runaway with the likely introduction into the sex trade, illicit drug abuse and sometimes incarceration. Aboriginal persons were overrepresented in this sample and among those indicating experience with injection drugs, incarceration and the sex trade.

Health concerns

Although profiles of disease and illness differed among the groups, each reported specific health concerns that prompted care seeking and their entry point into the health care system. Injection drug-related complications such as septicemia, endocarditis, hepatitis C and abscesses were often reported by transgendered persons and bisexual men. Gay men were overall the healthiest of the three groups. Sexually transmitted diseases, hepatitis, and upper respiratory infections were concerns for younger gay men, but for older gay men conditions were associated with advanced HIV disease.

All three groups dealt with stigma and psychological issues surrounding disease, and physical disability. Mental distress was different for all groups but included histories of addiction, recovery, attempted suicide, depression and the psychological issues of "coming out". Transgendered persons reported psychological problems associated with gender identification. Gay youth dealt with stress and psychological issues and reported feeling marginalized. Bisexual men dealt with histories of childhood sexual abuse, being runaways and barriers to care because of a reluctance to disclose.

Experiences with health care

Most participants had experienced past and present hostile or incomplete care within the health system. Participants felt they were treated as "*risk factors*" and not "*being dealt with as a whole person*" which impaired the health care experience. A good amount of textual data came from experiences with sub specialist care received in the emergency room and acute care settings received in an urban teaching hospital. For the most part, they anticipated prejudicial care from providers but especially from care providers outside the urban centers. Fears were especially prevalent about receiving care from health practitioners with religious lifestyles.

Gay men were the most successful in developing relationships with care providers, possibly as a result of peer information acquired through strong community networks. Through trial and error, older gay participants were able to locate culturally competent providers who would address their health needs within their social context. This information was passed on to younger gay men who often described unclear boundaries with their new providers. Overall, aboriginal persons, bisexual men, and transgendered persons did not fare as well in health care relationships.

Hostility towards providers, often the result of perceived moral attitudes, interfered with establishing nurturing relationships with health care workers. Participants often reported discomfort with *straight* physicians. Competent primary care was perceived to come mostly from *gay* physicians and a few acculturated *straight* physicians. Affirmation of social identity and an accurate knowledge of sexual identity were important ingredients in the successful care giving relationship in this sample. Adherence to therapy was associated with physicians exercising skilful care that affirmed the participant's social and sexual self-concept and encouraged self-help behaviors.

Depression and mental distress as well as substance and alcohol abuse compromised adherence. Factors such as poverty, low literacy, and unstable housing also impaired adherence. There was a collective knowledge of drug development, side effects, and unsatisfactory therapeutic experiences dating back to AZT [zidovodine]. Some non-adherent participants believed Western medicine to be iatrogenic and preferred non-traditional remedies. Complex regimens of antiretroviral drugs often appeared to control one's life by interfering with schedules of employment or community involvement. These issues along with deficits in health practitioner skills contributed to impaired care seeking and access to antiretroviral therapies.

Conclusions

Each group has a unique and distinct sexual identity. Biologic sex, gender identity, sexual orientation and social sex-roles are the components that form sexual identity (Shively & De Cecco, 1977) and are predictive of social self-identification (Simon, Hastedt, & Aufderheide, 1997). Providers focused on sexual orientation and often confused sexual identity, biologic sex, gender identity and sex-roles (Oudshoorn, 1995; McConaghy & Armstrong, 1983; Eliason, 1996). Medical training generally does not include sufficient information about sexual identity to assist physicians. This situation suggests further research is needed to inform training for health care professionals (Frable, 1997). The experiences of the participants reveal that neglecting social identity and misunderstanding sexual identity can cause harm.

All groups lived within different communities in social contexts (Baumeister & Leary, 1995) and held cultural values and beliefs about themselves and their social and sexual identities (Cox & Gallois, 1996; Simon, Hastedt, & Aufderheide, 1997). It is often difficult for health providers to understand identity when a minority group itself often has discomfort self-identifying, stating their needs when their social identity is also associated with stigma and health disparities. Thus, to self identify and seek care may also devalue the patient's identity as to describe ones health issues and needs may be describing one's oppression (Blaxter, 1997).

In this sample, *families of origin* were replaced with *families of attachment*. The strong sub-themes of early substance use, survival prostitution and incarceration suggest that child health care practice needs to reconsider targeted interventions for these groups (Rotheram-Borus & Hunter, 1994; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996; Rotheram-Borus & Fernandez, 1995). Ethnocultural background can impair access (Paradis, 1997) as seen in the overrepresentation of aboriginal persons in these data, for whom timely research, policy and action is necessary (Heath, 1999). Disease and illness vary in these populations and require strategies addressing the consequences of these differences in access.

Adherence is influenced by many factors including psychosocial issues, complex dosing schedules, cultural issues (Crespo-Fierro, 1997) and low literacy (Kalichman, Ramachandran, & Catz, 1999). Impaired adherence was associated with depression and mental distress or substance abuses; addiction and psychological concerns are thus a priority (Stephenson, 1999; Catalan, 1995). The absence of psychological services seems poorly advised and suggests an inadequacy in our health care system. The unavailability of methadone treatment, poor attitudes on the part of the providers and reluctance to treat long-term drug abusers require exploration in order to provide appropriate addiction interventions for the chemically dependent (Strathdee et al., 1997; Haverkos & Stein 1995).

The advances in HIV antiretroviral therapy have presented a series of complex social, ethical and professional challenges that include the *duty to treat*, the *duty to do no harm* and the *duty to accommodate* (Senak, 1997; Ostrow & Kalichman, 1999). In our view, health practice the maintains prejudicial attitudes which fail to see or avoid including social and sexual identity impedes access to health care and to life prolonging drugs. This is an ethical and professional liability. To be ethically responsive, health care professionals must deconstruct personal attitudes that may act as impediments to providing complete care, and address the marginalization and discrimination that act as barriers to access (Morrissey, 1996; Eliason, 1996a).

Sexual minority patients reported successful therapeutic relations with health care practitioners who understood their social confirmation and cultural contexts. This phenomenon, known as *cultural competence* (Lavizzo-Mourey & MacKenzie, 1995) has three components (1) an understanding of population-specific health-related cultural beliefs and values, (2) knowledge of disease incidence, prevalence and mortality rates and (3) an understanding of population-specific treatment outcomes. In this definition, medicine and the health care system recognize distinct populations with health disparities, and intervene appropriately within their cultural context. Culturally competent health care providers have "a set of congruent behaviors, attitudes and policies" (Cross, 1993) to interact with their patients.

This study highlights the need to improve deficits in knowledge, practice and access to primary, hospital, addiction, psychological and gender care in order to improve utilisation of HIV antiretroviral therapy by sexual minority groups. Care seeking, utilization of HIV antiretroviral therapy and adherence were associated with culturally competent providers. These providers could identify and include the social and sexual identity of their patients, and were aware of inherent cultural values and beliefs. They understood the specific health concerns of each group and could anticipate the therapeutic outcomes of their interventions. Consequently, health practitioners must obtain these necessary skills to care for people with HIV disease. Primary care is the critical entry point to health care for sexual minorities and thus it is of the utmost importance that these issues are included in the research agenda and training of health care professionals. This approach in health care is likely to reduce health care avoidance and improve care seeking behaviors in these populations, thus fostering access and adherence to HIV antiretroviral therapy.

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References

Blaxter, M. (1997). "Whose fault is it?" Peoples own conceptions of the reasons for health inequalities. *Social Science and Medicine*, *44*, 747–756.

Boulton, M., & Fitzpatrick, R. (1997). *Bisexual Men in Britain*, Taylor & Francis.

Catalan, J. (1995). Psychological interventions in infection with the human immunodeficiency virus. *British Journal of Psychiatry*, *167*, 104–111.

Crespo-Fierro, M. (1997). Compliance/Adherence and Care Management in HIV Disease. *Journal of the Association of Nurses in AIDS Care*, *8*, 43–54.

Cross, E. A. (1993). Moving toward Cultural Competence in the Transplant Milieu. *Transplantation Proceed*, 2499–2501. as cited in: Lavizzo-Mourey, R. J. and MacKenzie, E. (1995) Cultural competence—an essential hybrid for delivering high quality care in the 1990's and beyond. *Transactions of the American Clinical & Climatological Association, 107*, 226–235; discussion 236–227.

Eliason, M. J. (1996). Identity formation for lesbian, bisexual, and gay persons: beyond a "minoritizing" view. *Journal of Homosexuality*, *30*, 31–58.

Ferrando, S. (1998). Behavioral Research on AIDS—Protease inhibitors and the new millennium: comment on Kelly, Otto-Salaj, Sikkema, Pinkerton, and Bloom (1999). *Health Psychology*, *17*, 307–309.

Gerbert, B., Love, C., Caspers, N., Linkins, K., & Burack, J. H. (1999). Making all the difference in the world: How physicians can help HIV-seropositive patients become more involved in their healthcare. *AIDS Patient Care*, *13*, 29–39.

Harvey, E., Strathdee, S. A., Patrick, D. M., Ofner, M., Archabald, C. P., Eades, G., & O'Shaughnessy, M. V. (1997). A qualitative investigation into an HIV outbreak among injection drugs users in Vancouver, British Columbia. *AIDS Care*, *10*(3), 313–321.

Haverkos, H. W., & Stein, M. D. (1995). Identifying substance abuse in primary care. *American Family Physician*, *52*, 2029–2035.

Heath, K. V., Cornelisse, P. G. A., Strathdee, S. A., Palepu, A., Miller, M. L., Martindale, S. L., Schechter, M. T., & O'Shaughnessy, M. V. (1999). HIV associated risk factors among young aboriginal and non-aboriginal Men Who Have Sex With Men HIV associated risk factors among young aboriginal and non-aboriginal men who have sex with men. *International Journal of STD and AIDS*, *10*, 582–587.

Holzemer, W., & Tierney, A. (1996). How nursing research makes a difference. *International Nursing Review*, *43*, 49–52.

Johnson, K. W., Anderson, N. B., Bastida, E., Kramer, B. J., Williams, D., & Wong, M. (1995). Macrosocial and environmental influences on minority health. *Health Psychology*, *14*, 601–612.

Kalichman, S. C., Ramachandran, B., & Catz, S. (1999). Adherence to combination antiretroviral therapies in HIV patients of low literacy. *Journal of General Internal Medicine*, *14*, 267–273.

Kass, N. E., Faden, R. R., Robin Fox, M. S., & Dudley, J. (1992). Homosexual and bisexual men's perceptions of discrimination in health services. *American Journal of Public Health*, *82*, 1277–1279.

Lerner, H. L. (1998). Rethinking non-adherence: historical perspectives on triple-drug therapy for HIV disease. *Annals of Internal Medicine*, *129*, 573–578.

Lyons, C. (1997). HIV Drug Adherence: Special Situations. *Journal of the Association of Nurses in AIDS Care*, *8*, 29–36.

O'Hare, T., Williams, C. L., & Ezoviski, A. (1996). Fear of AIDS and homophobia: implications for direct practice and advocacy. *Social Work*, *41*, 51–58.

Ostrow, D. G., & Kalichman, S. C. (1999). *Psychosocial and Public Health Impacts of New HIV Therapies,* Kluwer, 1999.

Oudshoorn, N. (1995). Female or male: the classification of homosexuality and gender. *Journal of Homosexuality*, *28*, 79–86.

Paradis, B. A. (1997) Multicultural identity and gay men in the era of AIDS.' *American Journal of Orthopsychiatry,* 67.

Rotheram-Borus, M. J., & Hunter, J. (1994). Suicidal behavior and gay related stress among gay and bisexual male adolescents. *Journal of Adolescent Behavior*, *9*, 498–508.

Rotheram-Borus, M. J., Mahler, K. A., Koopman, C., & Langabeer, K. (1996). Sexual abuse history and associated multiple risk behaviors in adolescent runaways. *American Journal of OrthoPsychiatry*, *66*, 390–400.

Rotheram-Borus, M. J.,& Fernandez, M. I. (1995). Sexual orientation and developmental challenges experienced by gay and lesbian youths. *Suicide & Life-Threatening Behavior,* 25, 26–34; discussion 35–29.

Wong, C. (1997). The Hardest Hit, *Georgia Straight*, Vancouver, BC, Canada, Vol. 31, pp. 15–20.

Yee, B. W., Castro, F. G., Hammond, W. R., John, R., Wyatt, G. E., & Yung, B. R. (1995). Risk-taking and abusive behaviors among ethnic minorities. *Health Psychology*, *14*, 622–631.