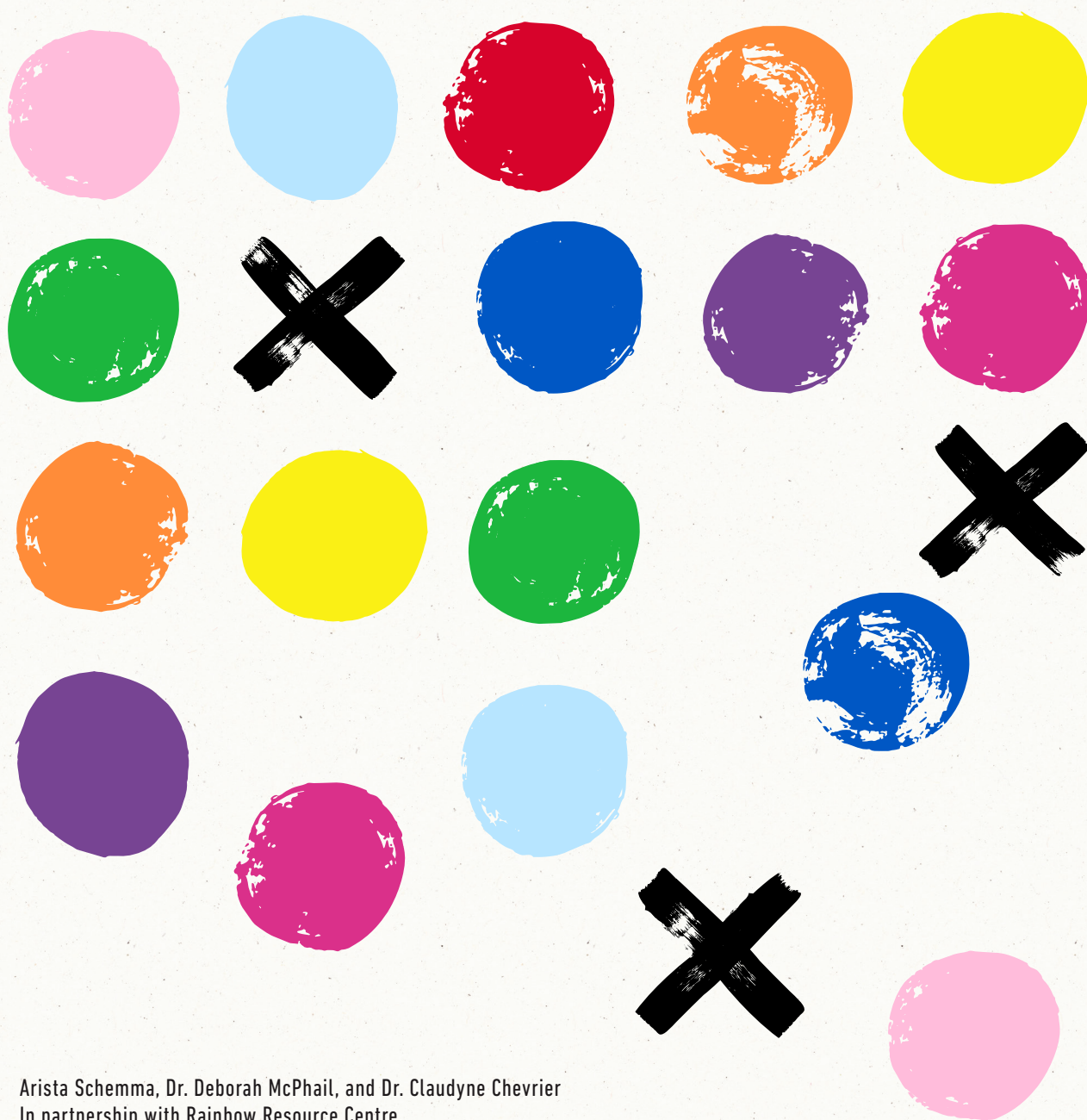


Assessing the Quality of Healthcare for
**TRANS WOMEN, QUEER WOMEN,
LESBIANS, AND NON-BINARY PEOPLE**
in Manitoba



Arista Schemma, Dr. Deborah McPhail, and Dr. Claudyne Chevrier
In partnership with Rainbow Resource Centre

"For me not to be able to talk about my life with healthcare practioners, it takes so much energy, to shut yourself down, and to try and, you know, it's like cutting off pieces ... It depletes you. It fills, there's a sadness that comes with that, that you can't actually be who you are."

Quotations are those of study participants



Acknowledgements

We have been honoured and humbled by the community response to this study. We sincerely and deeply wish to thank every participant of this study who dedicated their time to this project and so generously entrusted their stories with us – stories that were often traumatic and always profound. Thank you to Sarah Dack and Sarah Paquin from Rainbow Resource Centre for engaging with us in the project and for your exceptional and ongoing patience with us as we struggled through life circumstances and a global pandemic while analyzing the findings of the research. Deborah McPhail would personally like to thank Claudyne Chevrier for conducting half of the interviews. Thank you to Arista Schemma for their secondary analysis of the data and for writing the bulk of this report. This study was made possible in part by funds from the University of Manitoba.

This study was conducted on Treaty 1 territory, on the original lands of Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and on the homeland of the Red River Métis. We are white, settler researchers working within a colonialist institution. As such, we are implicated in the ongoing process of colonialism in Manitoba. We are therefore humbled and grateful for the opportunity to have been entrusted by Indigenous participants with their stories, and we sincerely hope that this document honours this trust by advocating for adequate healthcare for 2SLGBTQIA+ people based in anti-racist and anti-colonialist approaches.



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Background

In 2013, a queer researcher from Community Health Sciences at the University of Manitoba, Deborah McPhail, approached Sarah Dack and Sarah Paquin at Rainbow Resource Centre to inquire about potential research projects. From their series of conversations, a project developed exploring the healthcare experiences of queer women, trans women, and non-binary communities in Winnipeg, Manitoba. This project is called *Assessing the Quality of Healthcare for Trans Women, Queer Women, Lesbians, and Non-Binary People in Manitoba*. Over 2013 and 2014, Deborah McPhail and Claudyne Chevrier conducted qualitative interviews and organized one focus group (led by Sarah Dack) with 43 participants in an effort to find answers to the following questions:

1. What are lesbian, queer women, trans women, and non-binary people's experiences of healthcare in Winnipeg?
2. Do lesbian, queer women, trans women, and non-binary people experience healthcare access issues related to discrimination locally – as reflected in the larger literature? If not, what are we “doing right”?
3. What are lesbian, queer women, trans women, and non-binary people's recommendations for achieving health equity in terms of healthcare access?

Findings

Study results demonstrate that while moments of competent care do occur for queer women, lesbians, trans women, and non-binary people in Manitoba, there is much work to be done on the part of healthcare institutions in this province. Participants related difficult experiences encompassing both homophobia/transphobia and, perhaps even more insidiously, heterosexism/cis-sexism.¹ These experiences of oppression were filtered through and reproduced by intersecting systems of oppression, such as racism, colonialism, sexism, classism, agism, ableism, and fat phobia – some of which are detailed below. Experiences of 2SLGBTQIA+-based oppression described by participants were as follows:

1. Access Issues

Participants described an inability and/or difficulty in accessing healthcare professionals who understood and had a knowledge base in 2SLGBTQIA+-specific health issues. Participants were often in the position of having to educate healthcare professionals about their health and healthcare needs. Many participants also described being

¹ We define heterosexism as the assumption and normalization of heterosexuality and heterosexual experiences, and cis-sexism as the assumption and normalization of cis-gender experiences and identities.



“handed off” to feminist and/or queer-centred community health centres in the city for even basic healthcare needs, thus causing these centres to be overburdened and difficult to access. Participants also described an inability to find affirming and even simply non-homophobic/non-transphobic care. As a result, participants would often put off visits to the doctor or clinical space, and sometimes refused to return to healthcare spaces altogether due to experiences of past discrimination.

2. *Colonialism, Race, and Racism*

BIPOC participants related profound instances of racism within healthcare experiences and described navigating a healthcare system that was not only homophobic and transphobic, but also racist and based in colonial knowledges and assumptions about health, disease, and bodies. As such, it becomes evident that racism, classism, and colonialism continue to ground medicine as a whole and must be challenged *at the same moment* as homophobia and transphobia.

3. *Intersectionality*

Along with racism and colonialism, other forms of oppression and/or discrimination were interwoven into participant stories, including agism, fat phobia, and judgements about substance use and sexual activities such as Kink. For example, participants over 50 years old discussed fears related to aging and homophobia within long-term care centres. Many participants related the ways in which their bodies were not only judged as “abnormal” because they may have been read as queer, but also because they were regarded as “too large” within a medical paradigm that typically equates fatness with poor health, which is often erroneous (see McPhail & Mazur, 2019).

4. *Gender Identity and “Coming Out”*

Participants who were “read” as queer in healthcare spaces described the ways in which they negotiated the hostility that healthcare professionals could immediately, upon sight, direct their way. Typically, participants who were “read” as femme or feminine did not experience such reactions until they “came out” to healthcare professionals. Most participants in this study related the ways in which they were forced to come out to healthcare professionals who assumed heterosexuality and cis-gender identities. Such processes of coming out were carefully negotiated by participants, who often described knowing almost instinctually and instantly if a clinical space was “safe” or “unsafe.” Trans and non-binary participants in the study related instances of incorrect pronoun use, incorrect name use, and a general lack of understanding about their identities, embodiments, and healthcare needs on the part of healthcare professionals and healthcare staff (including receptionists and other healthcare workers).



5. ***Interactions with Practitioners***

While participants discussed interactions with a number of types of practitioners working in healthcare, they primarily focused on their relationships with nurses and doctors, including specialists. While some participants related encouraging stories of positive interactions with either queer or allied nurses and doctors, unfortunately many experiences were mired in homophobia, transphobia, heterosexism and cis-sexism. While homophobia and transphobia are unacceptable and need to be addressed, participants described how heterosexism and cis-sexism were particularly rampant and insidious in their interactions with healthcare practitioners. Many details of this are provided below. As one example, participants who did not have sex with cis men were continuously recommended birth control and pregnancy tests and were sometimes not believed when they insisted pregnancy was not possible.

6. ***Clinical Space***

Most participants agreed that “safe space” paraphernalia such as rainbow stickers and posters were important in clinical spaces and allowed them to anticipate a certain degree of acceptance and knowledge-base pertaining to 2SLGBTQIA+ care. However, almost all participants agreed that such paraphernalia *must* signify that all staff – from the receptionist to the highest paid specialist – be trained in 2SLGBTQIA+ identities and healthcare needs, and have, through examining their own biases, developed a certain level of aptitude in queer healthcare delivery. Most participants argued that gender-inclusive bathrooms should be available in all healthcare spaces.

7. ***Strategies Negotiating Healthcare***

Participants often adapted to homophobic/transphobic and heterosexist/cis-sexist healthcare spaces through such survival skills as changing intake forms to better reflect their gender and/or sexual identities; avoiding particularly oppressive healthcare spaces all together through word-of-mouth; bringing partners or an advocate with them to appointments; avoiding “coming out” through the use of gender neutral language and refusing to discuss their partners, sexuality and/or gender; and parcelling out their healthcare to different clinical spaces, seeing their family physician for general care but then accessing 2SLGBTQIA+-specific clinics for particular health needs such as gender-affirming hormone therapies.

8. ***Ramifications of Oppression and Discrimination***

Apart from the general sense of injustice about the inability of 2SLGBTQIA+ people to access satisfactory healthcare within a public system paid for by their own tax dollars (generally speaking), the emotional ramifications of the oppression and discrimination



participants experienced were often intense. In particular, participants felt profound sadness and grief that they could “never be themselves” in moments in life during which they were often their most vulnerable and in need of basic human kindness. As one participant said: “... it’s like cutting off pieces ... It depletes you. There’s a sadness that comes with that, that you can’t actually be who you are.”

Recommendations

Participants had a number of recommendations for change. Based on these, this report recommends the following as a way forward in achieving competent, compassionate healthcare for queer women, trans women, non-binary people, and lesbians in Manitoba:

1. Training in 2SLGBTQIA+ identities, health, and healthcare needs in rural and urban clinical sites in Manitoba. This training should be mandatory and could be administered through the health regions. Training should be provided to *every member* of the healthcare team who may interface with patients.
2. Medical and nursing curricula in universities and colleges should include a *substantial* number of mandatory hours/credit hours dedicated to 2SLGBTQIA+ identities, health, and healthcare needs. These curricula should be community-based and comprehensive; that is, curricula need to *cut across all aspects* of student learning and also be founded in an intersectional understanding of medicine that de-centres the settler, white, heterosexual, cis, thin, and able body that typically founds medical knowledge.
3. Heterosexism and cis-sexism must be addressed within healthcare. Certainly, healthcare spaces are not only accessed by heterosexual and cis-gender people, and services should not be provided with this assumption. To assume heterosexuality and cis-gendered bodies communicates that these are the only “normal” sexual and gender identities and this prevents people who do not fit those “normative boxes” from accessing care.
4. All intake forms and medical documentation need to be reviewed and re-vamped to be inclusive in terms of sexuality and gender. We recommend allowing patients to “fill in the blank” on forms and use their own language pertaining to sexual and gender identities. If this is impossible, providing as many “check boxes” as possible, in consultation with the 2SLGBTQIA+ community, is another strategy. Any reference to next of kin or spousal relationship in documents should be gender inclusive and not assume heterosexuality or heterosexual marriage.
5. “Safe space” material, such as rainbow stickers, posters, and reading material, can and should be used in healthcare spaces. However, such material should *not* be



used if healthcare providers working within that space have not had training about 2SLGBTQIA+ identities and healthcare needs and policies are not in place regarding the safe provision of 2SLGBTQIA+ care. Further, “safe space” is in and of itself a controversial term because a space that feels “safe” to one person may not feel “safe” to all. As such, a “safe space” for a white settler may not be “safe” for an Indigenous person, Black person, or Person of Colour. We therefore recommend anti-oppressive, anti-colonial, and anti-racist training alongside 2SLGBTQIA+ safe space training.

6. All clinical spaces should have gender inclusive bathrooms.
7. While many hospitals in Manitoba are funded in part by religious groups, it is important to note the high degree to which our participants found Christian iconography felt unsafe in clinical spaces, which was due to a history of anti-2SLGBTQIA+ sentiment in some Christian denominations. We suggest, then, that clinical spaces in which Christian iconography is present work hard, through policy statements, press releases, and especially in practice, to communicate that they are committed to providing affirming 2SLGBTQIA+ healthcare. In these spaces, in particular, 2SLGBTQIA+-positive materials are imperative.
8. We recommend the ongoing support of 2SLGBTQIA+-specific community clinics *in addition* to the development of accessible and affirming care *throughout all healthcare spaces* in Manitoba. While 2SLGBTQIA+ community clinics are integral to queer communities, the over-burdening of these clinics due to a lack of knowledge about or understanding of 2SLGBTQIA+ care in other clinical spaces creates conditions of healthcare inaccessibility as described by our participants.
9. We recommend that healthcare professionals be patient-directed and “meet patients where they are at” in terms of their gender and sexual identities. Healthcare professionals can mirror the language that their patients are using about their body parts and experiences of health and illness, ask respectfully about correct pronouns and names, and should not assume they know what types of behaviour, practices, and health risks are associated with a particular sexual or gender identity.
10. We recommend comprehensive, rigorous, and well-rounded 2SLGBTQIA+-related policy in every health region in Manitoba. These policies should be guided by the 2SLGBTQIA+ communities in which health regions are located.



“There’s actually a kind of feeling like you’re shrinking. It’s like, ‘There’s something wrong with you,’ or ‘You’re not wanted here.’ Like, I don’t want to have to deal with you.’ Those kinds of feelings, which they’re just undermining to self-esteem and sense of self.”

Quotations are those of study participants



Introduction

In 2013, a queer researcher from Community Health Sciences at the University of Manitoba, Deborah McPhail, approached Sarah Dack and Sarah Paquin at Rainbow Resource Centre to inquire about potential research projects. From their series of conversations, a project developed exploring the healthcare experiences of queer women, trans women, and non-binary communities in Winnipeg, Manitoba. Data collection, in the form of qualitative interviews, took place over 2013 and 2014. We analyzed the results of this research over the better part of 2015 and 2017. The gap between 2017 and the publication of this report is the result of a number of factors, including impacts of the Covid-19 pandemic. Despite this time gap, however, the findings from this research remain pertinent and, we would speculate, have become even more critical during the Covid pandemic which, as research is beginning to show, has exacerbated health inequities in Canada (Gibb et al., 2020).

Background: Healthcare and 2SLGBTQIA+ Communities²

Previous literature has demonstrated well-established, across-the-board health inequities for 2SLGBTQIA+ communities in Canada and elsewhere (Dysart-Gale, 2010; Goldberg et al., 2003; Hoffman et al., 2009; Logie et al., 2011; Logie et al., 2012; McPhail et al., 2016; Scheim et al., 2017). For example, lesbian-identifying women demonstrate higher risks of developing breast and gynaecological cancers, higher rates of substance use, and higher risks to mental health as compared to heterosexual women (Baker & Beagan, 2014; GLMA, n.d.), while transgender people experience higher rates of suicide attempts, depression, and other struggles with mental health (Scheim et al., 2017) compared to the population as a whole. A growing literature demonstrates that such negative health outcomes for 2SLGBTQIA+ communities are related to experiences of stigma and oppression. While variation exists among the 2SLGBTQIA+ community, health disparities arising from minority stress caused by stigma and discrimination are highly prevalent (McKay, 2011), and can lead to such health outcomes as cardiovascular illnesses and other stress-related disease (Pascoe & Richman, 2009; Veale et al., 2017). Scholars have also shown that homophobia and transphobia have direct and often devastating impacts on mental health, including increased suicide ideations (Marshall et al., 2013; Mustanski et al., 2010; Saewyc, 2011). Yet, even as 2SLGBTQIA+ people are a priority population for healthcare, research demonstrates a troubling trend of discrimination within the healthcare setting. For example,

² Parts of this literature review have appeared in McPhail, D., Lorway, R., & Chevrier, C. (2022). Safe spaces that matter: Material semiotics, affective bodies and queer readings of clinical spaces in Winnipeg, Canada. *SSM-Qualitative Research in Health*, 2, 100126.



literature shows how harmful stereotypes about lesbian, gay, and bisexual people as “diseased” and as ubiquitous STI contagions can negatively influence the ways in which healthcare providers characterize patients as risky (Herek et al., 2005; McPhail & Bombak, 2014; O’Byrne & Watts, 2014). 2SLGBTQIA+ people also report discomfort from healthcare professionals, in the form of eye contact avoidance and other negative body language (Harbin et al., 2012), a general lack of understanding about 2SLGBTQIA+ healthcare needs and identities (Kuzma et al., 2019; McPhail et al., 2016; Wilkerson et al., 2011), and outright transphobia and homophobia from healthcare professionals and other clinical staff (McClain et al., 2016). In turn, these experiences of healthcare lead to healthcare avoidance which, in a circular manner, negatively impacts health (Baker & Beagan, 2014).

Furthermore, important research on femmephobia (see Hoskin, 2019), which unpacks the historical and contemporary roots of femmephobia, colonial violence that extends to the construction of health (Eni et al., 2021), and racism within Canadian healthcare (Mahabir et al., 2021) serve as an invaluable contextual scaffolding. Rampant anti-Black and anti-Indigenous racism, misogyny (Michinson, 2013), ableism (Rice, 2014), and classism (Mahabir et al., 2021) – among many other harms – are perpetually and violently reproduced within our healthcare system and are inextricable from individual narratives.

In their 2018 study of LGBTQ populations and medical practitioners in Nova Scotia, Gahagan and Subirana-Malaret (2018) noted “only 9.4% of non-LGBTQ identified health care providers ... indicated that they felt ‘very knowledgeable’ about issues related to sexual orientation and sexual behavior, and 3.8% about issues related to gender identity/expression” (p. 4), and a recent survey of emergency room physicians and residents across Canada revealed that “83% (n=221) [of] respondents agreed that they would like to increase their knowledge in taking care of 2SLGBTQI+ patients” (Lien et al., 2021, p. 617). However, the proliferation of cis-sexism and heteronormativity in healthcare extends beyond practitioner bias or misinformation and instead is replicated in existing digital healthcare infrastructure (Digital Health Systems) across Canada, which operates on fundamentally binaric and heterosexist premises that require M/F designation to complete patient charting (Antonio et al., 2021). Undoubtedly (and often unwittingly), practitioners and systems fail 2SLGBTQIA+ patients. None of these communities is a monolith, and they embody a dynamic and ever-changing *series* of complex identities, each of which has an acute and compounding impact on the care required: People of Colour, parents, fat people, disabled people, sex workers, elderly people, abuse victims, etc.

Throughout health research there persists a fracturing of these complex intersectional (Crenshaw, 2006) identities, which fails to recognize the acute and compounding harms experienced most disproportionately by Black and Indigenous people; by disabled people; by people living rurally or remotely; by parents; by drug users; all of whom may also be 2SLGBTQIA+ identifying. Works such as Burrow et al.’s “Vulnerability, Harm, and Compromised Ethics Revealed by the Experiences of Queer Birthing Women in Rural Healthcare” (2018), which provides insight into the labour and delivery experiences of a racially diverse group of rural parents, or Williams et al.’s 2017 study, which interrogated the experiences of “[d]epression and discrimination in the lives of women, transgender and gender liminal people in Ontario, Canada” as they navigated mental healthcare, move beyond



this isolated 2SLGBTQIA+ singularity – studying distinct populations seeking distinct care in distinct locations. Scheim et al.'s (2021) more expansive research pinpoints a defined issue – healthcare access and a particular population: transgender and non-binary people in Canada – and allows for a broader, more generalized summation of the existing care landscape, wherein participants “reported considerable unmet needs or delays in primary, general and gender-affirming care, with significant regional variation” (p. 1214). In “Healthcare Experiences of Underrepresented Lesbian and Bisexual Women: A Focus Group Qualitative Study,” LaVaccare et al. (2018) deliberately selected participants who “represent[ed] the ‘multiple minority’ of being a woman, identifying as a member of a sexual minority, and belonging to an underrepresented group in healthcare research” (p. 132), effectively capturing the participants most often excluded and shedding light on chronically underserved members of the 2SLGBTQIA+ community. Like the work that follows, Logie et al. (2019) and Fredericks et al. (2016) consider healthcare experiences of distinct 2SLGBTQIA+ individuals within specific geographical locations – queer, lesbian, and bisexual women in eastern Canada, and sexually and gender diverse persons in Arctic Canada, respectively. In doing so, the authors create space for participants to bring their complex, nuanced, and intersectional identities to the table.

While research in the area of 2SLGBTQIA+ healthcare experiences is growing, very little recent research on individual narratives of healthcare experiences in Manitoba exists particularly relating to queer women, lesbians, trans women, and non-binary people (though see Janice Ristock's work with colleagues on queer chest/breast and gynaecologic cancer experiences in Manitoba; cf. Bryson et al., 2020). In what follows, we hope to fill these research gaps somewhat, delving into the healthcare stories of queer women, lesbians, trans women, and non-binary people in Manitoba, not only describing profound moments and homophobia, heterosexism, transphobia, and cis-sexism, but also moving forward by proposing recommendations for providing competent and compassionate healthcare grounded in the research findings.



The Research Process and Research Methods

Based in the above literature as well as input from Rainbow Resource Centre, the researchers developed three questions to explore in the project:

- What are lesbian, queer women, trans women, and non-binary people's experiences of healthcare in Winnipeg?
- Do lesbian, queer women, trans women, and non-binary people experience healthcare access issues related to discrimination locally – as reflected in the larger literature? If not, what are we “doing right”?
- What are lesbian, queer women, trans women, and non-binary people's recommendations for achieving health equity in terms of healthcare access?

To explore these questions, we (Deborah McPhail and Claudyne Chevrier) undertook a qualitative study in Winnipeg, Manitoba, in which we conducted interviews with 39 research participants. Additionally, Sarah Dack from Rainbow Resource Centre led one focus group. In total, we talked to 43 participants throughout the research process. For a qualitative study of this nature this is a large and robust group, and we were extremely humbled and grateful for the interest shown in our study by queer communities in Winnipeg. Interviews took about one hour, sometimes a little longer. At times, participants chose to be interviewed with their partner or, in one case, with a small group of friends. Interviews took place wherever and whenever participants felt most comfortable, and we met people in their homes, at coffee shops (many different Tim Horton's around the city!), at community centres, public libraries, and at Deborah McPhail's office at the University of Manitoba, Bannatyne campus. Interview questions were developed in partnership with Sarah Dack and Sarah Paquin and focused on identity, healthcare experiences, and recommendations for healthcare professionals regarding respectful interactions with lesbian, queer women, trans women, and non-binary people.

Recruitment

We recruited participants by putting up posters in venues such as coffee shops, community centres, drop-in centres, restaurants, and so on. We also advertised via Facebook and Instagram, and also through pertinent email listservs. Many participants contacted us because they heard of the study through friends who had also participated (snowball sampling).



Participant Demographics

As noted, we were extremely fortunate that 43 people shared their time and stories with us. Below is a break-down of some demographics for the participants (excluding focus group participants).

AGE RANGE	NUMBER OF PARTICIPANTS
18-20	1
20-29	10
30-39	15
40-49	4
50-59	5
60-69	1
70-79	1
No Response	2
Total	39

SELF-IDENTIFIED RACE AND/OR ETHNICITY	NUMBER OF PARTICIPANTS
First Nations	3
Métis	6
Person of Colour	3
"Mixed"	1
White	23
No Response	3
Total	39

Data Analysis

Once all interviews and the focus group were complete, researchers sent recordings to a professional transcriptionist who signed a confidentiality agreement. Once Deborah McPhail received all transcripts, she deleted all voice recordings and analyzed transcripts using the software NVivo. Using this software, she organized the data into major commonalities and themes, which are discussed below.



Study Results

Overall, 11 major themes emerged from the interview and focus group data: Access Issues; Colonialism, Race and Racism; Intersectionality; Gender Identity and Cis-sexism; Sexuality and “Coming Out”; Interactions with Practitioners; Clinical Space; Strategies for Negotiating the Healthcare Space; Ramifications of Oppression and Discrimination; Positive Experiences; and Recommendations. We discuss each of these, in turn.

Access Issues

Multiple participants noted their need to “out themselves” (discuss their sexuality and gender identities) in order to access care, despite their sense that doing so was unsafe. These concerns were managed by participants in myriad ways. Rurally located participants, feeling these concerns acutely, noted the challenges that small-town environments, proximity to providers, and concerns about confidentiality posed. One participant shared:

I had to come out to my doctor, younger than I wanted to, because I wasn't out to my parents at the time. And I felt it was awkward, because it's a small town and he's close to my parents ... [S]o when I was sixteen, they, like, basically made me go on the pill ... But like, six years later, nothing, like, I wasn't in any relationship. I just kind of started to fall off the pill. And he [my doctor], like, really kept pushing for it. He's like, 'You know, you should be on the pill. You know, it'll help with acne, and' blah, blah, blah. 'You should just, just in case, maybe you should just be on the pill.' And I'm like, 'No, I don't, I don't need to be on the pill. Thank you. I don't need to be on the pill.' And, then for a while, he was like, he let it kind of lapse, and then I came out, and I said 'No, I don't need to be on the pill, because I'm a lesbian.'

Another participant noted, “in terms of my experiences within rural communities ... due to my profession, I myself have found myself a little bit less comfortable to disclose certain things.” This highlights precisely these concerns of proximity and confidentiality, which directly informed the care sought by this participant. More significantly, these two participants reveal what will be a prevalent theme throughout this report: the conscious and constant labour of 2SLGBTQIA+ patients in their navigation of their own identities within numerous healthcare contexts.

Other rural participants noted alternate navigation strategies, some specifically seeking out spaces or practitioners vocal about 2SLGBTQIA+-friendly practices, which often proved challenging: “it was really hard to access information about who was lesbian positive or lesbian in the system ... And trying to, like, trying to access information about who's positive within the system, I found really, really difficult. [One clinic] said 'Oh now, we used to keep a directory, but we haven't done that for years.' Like, well, who is?



Like, how do you find out, as a newcomer to town?" At the time of this summary's completion, we have not been made aware of any such database currently in use.

Participants noted that while there were spaces within urban centres that signified their practice as 2SLGBTQIA+-friendly, with signifiers such as pamphlets in waiting rooms that depicted not only diversity but referenced health-concerns specific to 2SLGBTQIA+ patients, non-gendered washrooms, and rainbow flag stickers, this was not always the case in rural areas: "regarding 2SLGBTQIA+-type paraphernalia being out in the open ... out of my experiences in rural communities, I can't actually remember seeing anything regarding that kind of an invitation towards it being a safe place. In the city, for the most part, I would say yes. But in the rural communities, I'm really trying to think if I ever saw a sticker. And I can't say that I have."

This perceived dichotomy of 2SLGBTQIA+-friendly healthcare spaces versus unknowns left a number of participants with valid concerns regarding their ability to access necessary care outside of (markedly few) widely known 2SLGBTQIA+-friendly spaces. Multiple participants reported experiences where practitioners directed them to these purported 2SLGBTQIA+-friendly healthcare centres, rather than engage with patient concerns themselves: "just having, like, trans healthcare, kind of be standard, rather than something that I need to like, bring up and then pursue elsewhere, would be really nice."

Given the scarcity of these 2SLGBTQIA+-specific resources, participants reported numerous strategies to circumnavigate barriers to receiving care at these sites:

we live rurally, but we begged [site] to keep us. Cause we're not in their catchment area, and we don't intend to be, ever again. But I was just like- 'We need you. We have a close family member who's trans, who needs your services. And we need your services, because you're inclusive; you think about us when you make decisions, like, policy wide. You advocate for us.'

Another participant reported being advised to "play up" their need for services in order to ensure they retained care through an 2SLGBTQIA+-friendly site: "one of my friends ... said 'Okay, there's been this big shake up at [a care site] and now - 'cause I lived in [area name] - 'so now you're in the catchment area, so play the lesbian card, and you'll have a chance to get in.' And I did get it, so that's been, that's been great."

Several participants reported that they did not receive regular care, with one participant noting they felt they received better care in emergency rooms, as it was generally more needs-based than person-based: "I feel that also, hospital walk ins, or ERs are almost, even though you shouldn't use an emergency room just for whatever, I find they're almost better, because there's so much going on at any given time, they just, they're like 'Okay, what do you feeling? This is the result.' Like they, it's like, 'bang, bang, bang.' Get you in, get you out." Another participant acknowledged just how differently the varying practitioners they engaged with during their time in emergency rooms approached their "sexual preferences":



[F]or the most part, ambulance workers, they don't care. They want to know 'Are you going to die right now or not? How can we patch you up to get you to the hospital?' Past that, you could be anybody. You could be anything. You, like, you could be Andre the Giant, for all they care. It's when you get in the emergency room, and the doctors come and are asking their questions, as soon as they know your sexual preference, and that you are sexually active in that way, gloves come on, blood tests immediately. Every time. Every time. You could be in there, you know, checking on me, feeling my throat, pounding on my back. It's the second I say I'm gay, that's when they start putting on their gloves. And they ask for blood tests. Okay? ... You know how many blood samples I've had to give, and why are you testing me for these diseases, or these STIs when I have an infection? I have straight up walked out of emergency rooms.

Colonialism, Race, and Racism

Numerous participants acknowledged that there were times at which they were uncertain which component of their identity caused the discrimination they faced in healthcare settings. As one participant noted, "it's the body language ... you don't know if they don't want to treat you ... you don't know if it's cause you're female, or if you have dark hair, or Jewish, or, like, you don't know." For another participant, the precise intersection of their identity led to acutely discriminatory experiences: "I've had triple discrimination. One being an open lesbian; two being you know, of First Nation descent, and three being a large woman. The medical profession hates us." Multiple participants reported either directly witnessing or experiencing first-hand anti-Indigenous racism within healthcare contexts. One participant discussed navigating anti-Indigeneity as a white relative of an Indigenous person: "[person's relative] is First Nations. And so, there are all these assumptions, right? Like, so because she's sort of the, she has the traditional First Nations look, what people, like, if people think about the First Nations person, they think about the way she looks. Right? And so, I know that there are certain assumptions." Another participant described their own relationship to Mohawk ancestry as "a more complicated thing that I try to work through," which further demonstrates the necessity for healthcare providers (and beyond) to interrogate broadly held and damaging constructions of Indigeneity as a singular and monolithic experience.

For one participant, the systemic anti-Indigeneity experienced within healthcare contexts led to a series of escalating non-consensual, invasive, and violating interventions (and many threats of intervention) from CFS (alerted by healthcare practitioners) throughout pregnancy, delivery, and post-partum: "CFS has this thing called birth alert, and they harass women during their last months of pregnancy constantly ... And then they apprehend the babies. [I]t's a young First Nations women policy ... And I mean, through this whole time, I was thinking like, if [partner] was a white man, I doubt anything would have happened to the two of us. Like, no one would be calling us."



Another participant articulated the acute anti-Black racism they had experienced within healthcare contexts with “frustration, disappointment,” noting that “negative experiences probably [had] more to do with the fact that [they were] Black, and ... a woman.” This same participant noted how their name alone informed the care they received:

It's not a typical Canadian name ... [a]nd so I think people make certain assumptions when they see those things, like, they'll look at the file, and they'll see my name. And they look at me, and they see my ethnicity, and, they will maybe make assumptions like, 'She's not going to be that well informed in medical practice or what should be happening versus not happening.' Yeah. I think it would probably be more related to that, than anything else.

Intersectionality

In addition to colonialism and racism, identities such as age, substance use, identification with the Kink community, and body size were discussed by participants as factors that intersected with homophobia, heterosexism, transphobia, and cis-sexism within the healthcare setting.

Multiple participants discussed aging as 2SLGBTQIA+ individuals with trepidation in relation to healthcare. One participant referenced an ailing family member and the lack of supports and care available, while another expressed worries regarding staff education and potential discrimination they might face in personal care homes. While several participants acknowledged that more recent healthcare experiences were notably improved to prior overt discrimination they had faced, all participants who discussed aging in the existing healthcare paradigm as 2SLGBTQIA+ individuals did so with concern: “queer women are just getting kind of, older, ... we're getting older. And then, like, it's just sort of like, who takes care of them? You, know? And so many queer people are going back in the closet [as they age], right? Just cause it's safer. And it's scary.” Another participant noted how their age, ongoing healthcare cuts, and their own experiences with illness meant they needed to be prepared for interactions in healthcare settings as there was a necessity to “be your own advocate. You gotta know what you're talking about. And this goes for anyone. You gotta know what you're talking about and you have to stand up, and I say 'Yes, I'm gay. Yes, I've had a partner for twelve years. Get over it. I've dealt with it. You deal with it.”

Some participants also discussed the importance of harm reduction and non-judgmental healthcare professionals pertaining to substance use. For example, as one participant noted: “part of being a good queer doctor is being open and non-judgmental about drug and alcohol use as well. Like, that's kind of all tied to it, cause some doctors ... have a zero tolerance policy for that or they get, or you just feel very judged by that ... [I]t just creates a safe environment.” In addition to substance use, additional participants noted how a practitioner's comfort and familiarity in navigating conversations about Kink, BDSM, and other sexual practices from a harm reduction standpoint was integral to the care they sought. Commentary from these participants illuminate how 2SLGBTQIA+ individuals move within various circles and communities, and require deliberate, informed care beyond any singular 2SLGBTQIA+ “standard practice.”



Many participants also reported overtly size-discriminatory healthcare, which often pre-empted any discrimination they faced due to their 2SLGBTQIA+ identity. One participant reported: “[t]he best I’ve gotten is my family doctor, who weighed me and was like ‘Well, you know, like, the numbers are a little higher than I would like, but you know, look at your family. Look at your mom. I’m not too worried about it,’ which I interpreted as a positive response to my high BMI ... [S]o she doesn’t care about the BMI, but then I was like ‘Why don’t you just not do it then, if you don’t care?’” Another participant noted how the discrimination they faced was inextricably linked to both size and 2SLGBTQIA+ identity: “[t]hey’re not going to say anything. But then they’re not going to treat you, they’re just, you don’t know if they’re not treating you because, see my partner’s very much overweight. So she didn’t know if the treating was because she’s overweight or whatever. You don’t know ...” One participant described that in seeking healthcare they were left prioritizing certain elements of their identity over others, noting “cool with fat stuff would be more of a priority, because I can get somebody who’s cool with the queer stuff at a place like [a clinic] ... And yeah, like, my regular family doctor, if every single time I go in with a health problem they’re going to attribute it to me being overweight, that’s a problem, rather than actually looking at my symptoms.”

Gender Identity and Cis-Sexism

Although participants reported a myriad of experiences with gender identity and presentation and, subsequently, each had unique experiences within Manitoba’s existing healthcare paradigms, across these varying identities there were distinctive and emergent concerns. Many participants reported practitioners lacked the knowledge necessary to providing meaningful and nuanced care in terms of gender identity:

With my doctor, I don’t have faith that she, like, really knows anything about trans healthcare, in the first place. So that is like already a barrier ... [I]t feels shitty to, I guess, like, language is a shitty thing. Like, when people talk about different parts of my body, and use, like, I don’t know, like, women-centred language, maybe, that I don’t identify with. And that is actually, like, really hard for me, to like, it makes it hard for me to talk about things. So it makes me, like, less willing to access healthcare in that moment. And then less willing to like, return to access healthcare in the future, for sure.

Cis-sexist assumptions made by practitioners and other healthcare providers and support staff were a frequent concern:

I have PCOS, or, like, suspected PCOS. And it’s really hard to get any kind of treatment for that, that’s not really feminizing. Most people just want to prescribe birth control, and most of the information online is about how to manage PCOS if you’re trying to get pregnant.



The receptionists were bad at, you know, calling everybody Mrs. There's the assumption around everybody wants to be girly and look good while they're having treatment. So, kind of steering it towards all the pink stuff, which I was just like, 'I'm not – no. Do I look like I'm into that?' [laugh] Um, yeah, so, and you know, none of it was really horrible, nasty, made me feel like something . . . squashy, but it was that, kind of, the assumption of heterosexuality that was like, 'You guys are in the biz, you should know better, really.' And you're not in a, I think, dealing with a tough diagnosis, you're not in a place to really, well, I wasn't anyway, to be super advocate. It was just like, 'No, no thanks. I'm not even going to have the conversation with you, cause I'm focused on this other piece.'

Well, I think like, because queer women tend to be less binary about their gender expression or their sexual expression, there's a lot of psychiatric opinion on that, when there should be more of like an accepting sort of expansion of like, world view [laugh]. So, when I was younger especially, I was a little more butch, and, or I flip flopped between femme and butch, just as part of, like, experimenting with what I was and wanted to look like, and act. And, counsellors or therapists that I was seeing were really concerned and I felt like that was like, the least of my troubles . . . It was more like other people's reactions that, it was like the marginalized experience that was the issue. And they'd pathologize me, as opposed to validated, like, my, you know, existence.

Concerns around pathologization were echoed by another participant who noted: "just the idea of getting diagnosed, as on the trans spectrum is, like, a terrifying, scary thing that takes a really long time and you have to go through a lot of psychological assessments and, yeah, it's like, fucked, right now, I think. So yeah, I guess I would want to communicate that [responding in a pathologizing manner is] not an okay perspective on gender non-conforming situations."

Several participants noted the implications of gender presentation on care they received, which for one participant meant narrowly avoiding the blatant homophobia faced by many others:

So, when I walk into the hospital room, you know, I don't look like the standard dyke that everyone thinks [whispers] 'Oh, she's a lesbian.' You know? I don't look like that. Right? So I think my experience would be very different if I would be a butch dyke, right? Or butch or whatever, and be, having that look that people stereotypically think about when they think about the lesbian. So, I think my experience would have been very different. And I recognize that, right? ... [M]y experience hasn't been that bad. And I think partly, maybe because I, you know, I just don't look like a dyke. Right?"

Another participant was met with the other side of cis-sexism:

There's been clinics, you know, friends will say 'Oh, I went and it was totally okay.' And, it's like, it's really different, because people have different rules or whatever they look like even, affects their service, right? And so, a cool doctor may be cool for you, and then is super judgey, like, honestly. Like, if you're, like, my partner's a femme, like, very femmey, right? And she has absolutely no problems anywhere. And she'll see the difference in the way that I'm treated versus her, right?



These broader social narratives regarding gender presentation became additional labour for participants who were already made vulnerable through the seeking of medical care and acutely aware of the implications of presentation:

I think because I can pass, right? Like there's nothing about me that necessarily, I mean, I can butch it up a little bit if I want to, or whatever. I can, you know, do whatever. And I have a pretty broad range in which I can comfortably operate socially. I can feel when I'm pushing it. You know, if I put on a leather jacket, and hiking boots and you know, walk a certain way, if I walk into a certain space with that clothing on, right, I'd probably get a different response than if I'm going in in my business suit. So, I know my partner, I mean, she wore makeup; she used hair products, all that stuff, and yet she often was told 'Sir' ... So, I wonder what her experience would be, walking into a place like that ... Interactions may be very different for her. Generally, all my life, have had very positive reactions with people. I like people; I feel like I walk into a space comfortably. I don't, I'm not expecting anything negative. And so, for the most part, the world greets me eagerly.

There were also numerous blatant and incredibly harmful experiences with transphobia within the medical system, including one participant who drew out the ways in which trans identities are often collapsed with transphobic stereotypes about "sexual promiscuity" and STBBIs:

I did have one incident, recently [laugh]. And, it has more to do with being transgender than it does lesbian ... One nurse refused to call me Miss ... It was just 'Sir, sir, sir, sir.' So I walked out ... Yeah. If I may, the one thing I have noticed, I tell people that I'm transgender. I usually don't tell them my sexual preference, because that's none of their business. But one thing I have noticed is that when you tell doctors that you're transgender, it's almost automatic that they ask if you would like to have an HIV test.

Another participant noted the complexities of engaging with a largely cis-sexist institution in seeking care as someone with a transgender partner, and the painful dissonance they experienced:

I think I said something, like, when [practitioner] asked if I was pregnant, I said 'I don't have sex with men,' which is like a disservice to, like, my partner's identity and our relationship identity. But at the time, it just felt like the easiest thing to say, which is like, as soon as you say, it's like a knife in your heart. You know? Like, it feels so inauthentic and like you're totally betraying somebody by saying that, because, like, you're completely disregarding their gender identity that's like, you both work together, especially my ex, like, he started to transition while we were together. And I was with him through all of that. So, just to like, take one bullet to that whole identity that like, he's been working so hard to build up and I've been supporting him through so much, and to like, with that one question, and then being like, 'What's the safest and easiest way for me to deal with this, and also, like, how do I do that without disregarding my partner's identity, gender identity?'



Sexuality and “Coming Out”

A common concern among participants was navigating whether to, and subsequently when and how, come out to practitioners. In acknowledgement of the practitioner misinformation and lack of awareness reported by many participants, others approached coming out differently: “I mean, if they want, if that’s part of, on the questionnaire, I’ll tell you. But if it’s not on the questionnaire, you don’t need to know about it ... I mean, some people want to blow it from top of the mountains, but for me, it’s just like, ‘Well, that’s part of me.’” For another participant, coming out was a circumstantial consideration and one wherein safety and necessity were balanced, which demonstrates the not insubstantial and ongoing individual labour undertaken by 2SLGBTQIA+ individuals accessing healthcare:

If I had a really serious illness, and I, whether I was single or not, whether my sexuality was an issue or not, for that illness, if I was really seriously ill, I would need to be there fully, to be healthy, to get better if I could, right? So I thought, there may be some circumstances where I would want to be out, because of my need for my identity to be fully there, whether or not it had anything to do with the health issue or not. Like, there’s times, if I’m getting my eyes checked, who cares, right? It doesn’t matter. But there’s other times, if I had cancer, I would want [to come out].

Overt and substantial heterosexism was reported by several participants, and often when seeking care for sexual, genital, and reproductive health. Heterosexist assumptions forced participants to “out themselves” and sometimes even contradict practitioners in order to receive the care needed:

And the doctor was so ill-equipped to deal with me as a lesbian that it was a terrible experience. And she basically said, you know, she kind of had her questions and I think she asked, like, ‘Are you sexually active?’ and I said ‘Yes.’ And she said, and I can’t remember, and I said, ‘But you never asked me yet about, like, in what context or anything about my –’ nor did she necessarily need to. But I said ‘You know, I’m a lesbian. And so my, and I’m in a relationship where I have one sexual partner right now, who is a woman.’ And she sort of just, like, at that moment, kind of like, I could tell she was uncomfortable. And she sort of just, sort of started looking at me a little bit funny [laugh], and honestly, I was quite surprised at that. But anyway, and then, and I think I said something about, um, and I said, ‘So, I don’t really have penetrative sex at this point.’ And she said ‘Oh, so I’ll put you down as a virgin –’ or something. Or, ‘I’ll put you down as non-sexual.’

This blatant erasure of 2SLGBTQIA+ sexuality was echoed in the experiences of other participants: “she said, ‘Are you sexually active?’ And my ex said, ‘Um, like, –’ she was really, really awkward, and just kind of looked at me. And I was like, ‘Well, I’m her partner and we are sexually active.’ And the woman was like, ‘So there’s no penis?’ [laugh] Like, ‘No, there’s no penis.’ And she’s like ‘Okay. Well, we’ll use the speculum for virgins then.’”



Rampant misinformation and practitioner lack of awareness about 2SLGBTQIA+ care left many participants reporting that they were denied cervical screening:

I told him I actually would like to have regular PAPs, so then you can test for if there's a possibility of cervical cancer, because it's not just about, like, whether or not I'm straight, like, and you feel I need it, it's about the fact that this is medically needed for all women, right? And so again, had to push him to give me, like, a standard PAP. So, and then they changed it to you have to do a PAP every three years. So, we actually are scheduled to do a physical soon, in a week, so it'll probably be the same debate, where he tells me, like, 'You really don't need it. If you insist that I do that one, I can do one, but you really don't need it.' It's always that kind of conversation.

So she comes in, yeah, the doc, with the med student. And I'm like, totally fine. I was like, 'Look, I teach sexual health. I know why I'm here.' She's like, 'Well, if you're not having sex with a man, then we don't need to do a PAP.' And I said, 'This is about my cervical health.'

When I first went to see [practitioner], and when this wasn't on my radar at all, I, like, talking about the, um, like, being a lesbian meant that we kind of ignored all of the health risks of having sex with men. So, she was like 'Oh well, you don't need a PAP smear in that case, because you're a lesbian.'

Others were repeatedly issued pregnancy tests even when they insisted pregnancy was not possible given their sexual partners:

... [W]hen I first went in, she insisted that I just absolutely must take a whole bunch of pregnancy tests because that was my problem.

Oh yeah. I've taken so many pregnancy tests in my life, even when I know I'm not pregnant, but because my partner is a female at the time, like, it's always the first thing. I'll be like, to the doctor, I'm like, 'No, you know, like, it's not that problem. There are other signs. Like, I don't know, you haven't asked me if I've missed my period. You just assumed because my partner, because I'm sexually active I'm pregnant. You haven't even asked me, like, the possibilities of why pregnancy's not a thing.' Like, they'll be like 'Oh okay. So you're sexually active?' Nowhere in the conversation does it come in that I'm dating a woman yet. They're like 'Are you sexually active?' 'Yes.' 'Let's take a pregnancy test.' I'll be like 'Well, there's no way that I'm pregnant,' not thinking that like, every time I have to mention, it's like coming out, every single time. It's like coming out, over and over again, every time you go to a doctor. Like, 'No, there's absolutely no way, there's no way I'm pregnant.' 'Well, do you wear a condom when you have sex?' 'Ah yeah, but still, there's ah, no way I'm pregnant.'



I went ... with my ex, who was experiencing just crazy stomach cramps. And we thought maybe she was having, I don't know, like, a gall bladder attack or appendicitis or something. But we didn't want to go to an emergency waiting room if it wasn't actually an emergency. And we went in and the first thing that she was asked was if she had taken a pregnancy test yet. The first thing. And again, we tried to explain, 'No, you know, we're partners. We're in a relationship. That's not a thing. She's not -' and, and 'Oh, you don't know your partner. Your partner might just be having all kinds of sex with all of the guys on the side, so right now, we are going to have a pregnancy test or two if we feel like it -'

I haven't really encountered a ton of outright, like, homophobia. But I find one thing I have noticed is, like, as a 'young woman,' I think specifically, when they're like 'Okay. Are you pregnant?' 'No, I'm not pregnant.' 'Are you really sure that you're not pregnant?' 'No, I'm not pregnant.' 'Well, how can you be sure?' 'Okay, well, I'm not with a man, so the chances are -' So there's, I've encountered some of that.

The emotional implications of this blatant homophobia on participants cannot be overstated, particularly when they are experiencing acute unwellness and seeking support: “for me, on the part of that nurse, it certainly felt like [homophobia]. And, like, even thinking about it right now, like, it hurts; it hurts a lot for a practitioner to treat you that way, talk to you that way, especially when you're already in such a vulnerable position.”

Interactions with Practitioners

Participants in this study were quick to identify stand-out staff – helpful, compassionate, and engaged healthcare workers – throughout every level of care: clinic and hospital staff, paramedics, physicians, administrators, midwives, nurses, and specialists. They were also willing to share challenging, difficult, and painful experiences with patient-facing staff involved in their care. When referencing perceptions of this patient-facing group, these specialists, nurses, physicians, and midwives will be called “practitioners.” While these practitioners cover a vast range of healthcare professions and undoubtedly different practical, social, and systemic locations, there were several cross-disciplinary thematic concerns that persisted in participant statements, which suggest broader patterns.

First, numerous participants reported feeling aware of the discomfort felt by practitioners upon disclosure of the participant's sexuality and/or gender. Participants noted this in a variety of ways. Several reported that practitioners completely redirected conversation and subsequently failed to do necessary medical follow-up regarding participant sexual and genital health. Others stated that practitioners were frozen or unable to meet their eyes following disclosure. Additionally, multiple participants referenced the lack of knowledge displayed by practitioners regarding 2SLGBTQIA+ identity, and subsequently any relevant 2SLGBTQIA+-specific health concerns. To address this, some patients avoided care altogether, while others reported an awareness that they may need to fight to receive adequate care and had strategies for doing so in mind. Not a single participant expressed an expectation that practitioners hold an encyclopedic knowledge of 2SLGBTQIA+ identities. Instead,



many reported the frustration felt when practitioners made assumptions about their sexual practices, rather than asking them directly for clarification. Lastly, participants felt that practitioners likely had not received the necessary training to provide 2SLGBTQIA+ individuals with the proper care, which led to many participants reporting a lack of confidence in the care they received.

The select commentary presented below further demonstrates the diversity of experience reported by participants with particular healthcare professionals.

PHYSICIANS

One participant shared some of the difficulties they encountered while navigating needed care, and characterized their existing relationship with their family physician as “adequate”:

She's okay. She's like, adequate enough that I don't want to find a new doctor, cause I think the risks would be too high. But, I wouldn't say she's like, super helpful when it comes to queer and gender stuff ... I tend to, if there are like, particular things that I find aren't being met by her, I'll go to [clinic name] or just talk to, I have a few friends who work in healthcare, and just like, muddle my way through it.

Participants like this one and others reported how this lack of physician knowledge often led to participants seeking alternate health resources, whether they be friends, online research, or practitioners in other clinics.

Lastly, one participant reported a particularly challenging interaction with one physician who didn't engage, ask questions, or clarify information regarding this participant's sexual health:

I felt that there was danger that, you know, certain aspects of my health and well-being could be overlooked ... Like there literally was nothing about sexual health. I don't necessarily expect them to explore my biopic, but [laugh], you know, but there was literally not one question that anything to do with my vagina. So, it's at that point, where I'm like, 'Well, this is, this is concerning because that means I have to be the instigator for all these conversations.' And in the moments that I might need that, I might not be in a position comfortable enough to instigate. It left me feeling uncomfortable, and I would say that what sealed the coffin was that there was no conversation about it. You know, I might not even have brought up that experience if the doctor had followed through with any number of questions about sexual health.

While participants noted numerous other concerns, such as uncertainty when or if to disclose their sexual/gender identities with physicians and associated strategies (discussed in the Strategies segment of this summary), concerns about practitioner knowledge and perceived discomfort were commonly voiced.



NURSES

Several participants noted the capacity of nurses to act as helpful navigators of a potentially harmful medical system, noting that known 2SLGBTQIA+ nurses and those identifying as allies were often able to offer crucial support. As one participant related: “there was a nurse ... at [a care site], that took us in, and, she realized what our relationship was, and she made sure that all the doctors and everybody knew that we were together. So, even when we went to go see the doctors, there was no problem. I could ask questions. I could be there.” Another commented on how nurses were able to set a tone with other staff:

Sort of a nurse that came in after, and asked like [in a full room of people including the new parents], “So it is just, like, are you both breastfeeding or just like, mom?” and this is like, a middle-aged nurse, at [a care site]. And I’m like, ‘That is like, an exceptionally progressive question to ask.’ I was like, blown away. And it was asked from a real genuine, like, ‘We’re gonna get this kid latched. Like, where are we at here? Are we both breastfeeding or just one?’ And I was like, ‘Wow.’

However, another participant shared a particularly upsetting interaction with a nurse:

[A]nd then, this nurse came in. I had no idea she was a nurse. I had no idea who she was. She never looked, like I said, she never looked at me. And, the first thing out of her mouth was ‘Sir, why aren’t you on the bed? I need to take your blood pressure.’ Now, if she had looked at the chart, it would have said female, right? All my identification says female. Legally, I am a woman. So, I’m looking, she didn’t even look at my chart. And yeah, so yeah, it really upset me. And even after I corrected her, she didn’t [acknowledge my correct gender].

Whether positive or negative, multiple participants noted how nurses were able to set a tone with other staff and meaningfully impact participant experiences in healthcare settings.

SPECIALISTS

More generally, participants raised nearly parallel concerns with specialists and physicians, although there were several thematic patterns regarding specialists. Most notably, many participants reported feeling that interactions with specialists had “higher stakes” as there were often longer waits for appointments and less time at the appointments. Multiple participants reported having uncomfortable interactions with specialists because of the awareness of these stakes:



So I showed up at the gynaecologist's office. And I was there by myself. I was taking off work, so I was pretty much wearing what I'm wearing now. It was just sort of gross and sweaty. And I get into the office, and he took one look at me, and said, 'Where's your partner?' And I said 'Well, I am here for an appointment.' And he's like, 'Okay, fill this form out.' And he came back in, and he looked at it, and he said 'Okay, so you're presenting with signs that may be endometriosis. If that's the case, before I do the physical exam, I want to talk to you about your options.' And I said 'Okay. Before you get started, I am going to need a female in the room, for the physical exam.' And he stopped me, and told me that they were understaffed, so I could either get over it, or I could wait another two months for an appointment.

Challenges and barriers in boundary-setting with specialists were echoed by other participants:

Dr. [name] at [medical care site], she, I had many, weird things with her, as I said ... I expressed my reservations about going on birth control with her, because it's, I don't have sex with cis gendered men, so I wouldn't see the benefits of that. Like, she was kind of selling it at me as like, 'It's a win/win situation. You know, like, moderate your hormones. You don't get pregnant.' I'm like, 'I'm pretty sure I'm taking care of the birth control aspect of this pretty well, by myself, actually.' Anyway, so she talked me into it ... Dr. [name], the gynaecologist who was like, blatantly disregarding my sexuality at first, saying, like ... 'Well, there's still other benefits. What if you do have sex with a man?'

Another participant discussed a particularly challenging interaction with a midwife:

We were meeting with a midwife for the first time. And she launched, launched into the meeting in a way that was, you know, like, 'Oh, let's, what tests need to be done?' blah, blah, blah. And then she sort of, was like 'Oh, I'm so sorry. This is our first meeting, and you know, we just jumped right in. I haven't even asked you, like, what's your story? How did you get pregnant?' And that was very shocking. Cause I, like, our previous midwives had not, it was like 'You have, you're pregnant. That's all I need. We'll take it from here. Like, the rest is irrelevant.' So that was really, like, shocking to me, that she placed, like, that she, like, wanted to know or placed such emphasis on that. And then we gave her that information, which I regret doing, because it wasn't relevant to our care. But we gave her that information because she was an authority figure in a medical setting. And she asked me a question. And I was shocked, and I waited for a moment. And then I told her. And then I really regretted it, because it was a mistake. On principle, I regretted it, because it wasn't relevant to my care. And she was, she was really coming, like, she was, talked about how she, like, had worked with lots of queer couples before, and like, really kind of, like, selling that she was, like, down with it. But like, was like, overly, like to the point that it was overly intrusive.



Clinical Space

Multiple participants noted how integral reception and/or administrative staff were in their perception of a clinical space: “a lot of like, people who are on, like, who are gay, bisexual, whatever, like, they’ve been through things. Like, I know, like, that from experience, and like, a lot of people are hard to approach, sometimes, when they have a serious look and sometimes, like, I won’t even go into a doctor’s office, because the person behind the desk is looking, like, all stoic, like, being stoic and not very inviting.” Staff tone and presence were impactful for yet another participant who noted: “most of, a lot of who can make you feel comfortable period, is the first person you meet in the clinic, or in the hospital. You know, the face of the place, and there has not been a lot of, there’s much work that needs to be done, in helping those people learn how to greet people kindly and appropriately, and acknowledge, ‘Okay, oh, you’re with so and so, is this your partner? Is this your friend? Is this your cousin?’” This statement captures how an exclusive focus on practitioner education fails to acknowledge the vitally important group of administrative, support, and other healthcare staff who have a resounding impact on patient experience.

Other participants commented on how visible 2SLGBTQIA+ information or statements of welcome helped to inform how they felt in a clinical space:

[I]f you, if you see some, like, posters on the wall that sort of have things, like, [medical clinic] has them, I’ve noticed, like about, like, PAP tests and stuff, other things that I can’t really remember. But like, same sex couples getting tested for things or whatever, right? And that seems like more informed or I guess welcoming, I guess, in a way, if they’re advertising, like, they’re trying to get your attention that ‘Hey, this is important for you too,’ or whatever, right?

Another participant acknowledged the potential impact of these visible materials in clinical spaces:

[L]ike, even just like a row of pamphlets for things that would affect, like, our community. So like, reproductive rights, sexual health, and like, I don’t think that, in our, I mean, in my own experience, I’m not going to speak for the whole community, but you said, like, whenever you meet a partner, you would make sure that they get tested. Never have I asked somebody to be tested. Like, but I haven’t been with a lot of people either, right? ... I think, like, especially for lesbians, because I find that, like, and queer women, that we’re a bit more neglectful with our sexual health. And like, there isn’t, like, dams used, even though they’re encouraged. Like, I don’t, I don’t know anybody that uses dams.

Several participants commented on the practical components of clinical spaces, noting the need for non-gendered washrooms, and acknowledged how the physical space had ramifications in client care:



People use EMR, like, the Electronic Medical Records now, and so they have a screen to look at, instead at you, right? And so, being able to shift the actual space, right, so it's like, 'Here's a screen, that we're both looking at,' right? Like, why does it have to be so like, 'Okay, so you're going to tell me about that. And when I think it's weird, I'm going to look at you funny and then go back to my screen.' And then you're left with, 'Is that about me? Is that, like, –' right? But I think that shift too, in the records, and I think having things actually scripted for, for docs is important.

Some participants were strongly in favour of a designated 2SLGBTQIA+ care site:

... [J]ust to be, I don't know, just to feel, um, welcomed, I guess, like, just relaxed, somebody that you can interact with, like, that's had the same sexuality as you and you feel relaxed around them, and you don't have to feel like, like, everybody is staring at you and 'Oh yeah, you lesbian, you shouldn't be here.'

Yeah. And so I feel like a queer clinic is a place where people are like, 'LGBT health is what we do, so straight from like, top to bottom, we talk to people –' and much of it is the same. Like, actually, when you get down to the physical assessment stuff, most of it is the same. But I feel like that way that we, like, that we want to talk about our lives is just a little, like, it's more open. It's more, you feel more comfortable having the conversations about who your family is. That's, to me, the difference. Like, I think about it a lot, about how could we have, kind of a hassle-free queer clinic here. Regularly, I think about it. I would a hundred percent go to, like, a queer clinic, easily, without any doubt. Yeah.

One participant acknowledged that while a 2SLGBTQIA+ site may be beneficial for some, there was still a need for practitioners outside of designated 2SLGBTQIA+ spaces:

I think a really good doctor, they would be open, in my mind, right? ... Being able to provide some level of support to make sure that everyone feels welcome. Because the same thing is, I mean, even if you're talking about say, newcomers, or Indigenous populations. I mean, there are different forms of ways in which kind of our society is pushed to understand or have an experience of diversity, like for good, good ways ... But the point is, we do actually kind of have, usually kind of somewhat uniquely defined communities that have different kinds of needs, right? Or not even different needs, but maybe the needs are just more or whatever. Who knows, right? But the point is that our system needs to be able to address that kind of diversity, regardless of what it is, right?

For another participant, their existing practitioner provided such a positive and welcoming space they felt they would not switch if provided the option to pursue care at a designated 2SLGBTQIA+ care site: "I'd stay with my family doctor, definitely. Yeah ... I feel like the type of place that I go to is very open. Like, I think that it's very ... [f]orward and I think that, like, it's just such a positive place to go to that I wouldn't like, even if there was a really amazing queer facility, I'd still go to my place."



Strategies for Negotiating the Healthcare Space

In response to the persistent harms experienced as they navigated healthcare services in Manitoba, various strategies were reported by participants who sought to keep themselves and their community safe. Exemplifying the oft-celebrated resiliency of the 2SLGBTQIA+ community, these individuals curated tailored responses, workarounds, and plans of action that enabled them to more safely engage with necessary care. Numerous participants reported that they had either been advised to pursue a particular “safer” practitioner by another 2SLGBTQIA+ community member or they had been approached by community members seeking “safer” care recommendations. For many, this led to significant wait times or further strategizing to ensure they remained eligible: “we heard from this friend who recommended [a medical site] that they were looking for folks who were marginalized, you know, to take on in their practice. Like, they were looking for folks who were having trouble finding doctors elsewhere. So she [laugh], she told her, she’s like ‘Really play up the queer stuff and the drug use ...’”

One participant explained how they sought particular care from their general physician but saw other practitioners for different health concerns, which was a strategy for circumnavigating practitioner discomfort and essentially functioned as triage:

I don't necessarily go to my family doctor for everything, unless I'm wanting to, cause the nice thing bout a doctor is they have your previous history. So if it's something that I need to have previous history on, or maybe, it'd be good to have [someone who's experienced in my healthcare], I'd go to them. As far as like, if I was doing, like, STI checks, or like, just general kind of health check ups, I much prefer going to [a medical site] or ah, some type of, more of a walk in place ... I just find there's lots of organizations that are really great for that in the city. And my family doctor is not, I don't think he's comfortable ... [A]t one point, he's like 'Have you gotten a PAP or anything like that? And you know, are you sexually active?' kind of thing. And I was like 'Yeah, like, I get a PAP from [a medical site] or whatever ..., and there is that kind of shaming. So I think maybe, from a young age, I was just like, 'You don't go to your family doctor for these types of things.'

For some, this necessitated hypervigilance and the near-constant re-evaluation of each arising situation and interaction. This vigilance was in addition to the inherent vulnerability of a patient seeking healthcare:

[I]f you're in a medical environment, and there's missteps, which occur, right? And, you're cautious or on guard, then there may just be a matter of patient confidence, of being like: is this, are people being less careful or less scrutinizing because I'm gay? ... [I]n that environment, I think people behave a little differently than in their every day lives, where, you know, you're a little more defensive; you're a little more self preserving.

I think you're constantly assessing and looking for whether or not ... you shared [being queer] or not, would you feel safe? Would you feel that this is a safe place to do this?



I think my biggest issue with the medical system is that it, there is a feeling of invisibility. I mean, right now, it's not, my experience hasn't been outright animosity. But there is that feeling of 'Is it okay to say, like, am I okay in this space? Is this something I can bring up in this space?' versus 'Do I kind of just keep it to myself, unless explicitly asked?' I'd say that's one of my biggest issues there.

Several participants noted the necessary galvanizing, self-protection, and preparation undertaken in anticipation of oppressive healthcare practices or practitioners:

See, at [a medical site] I was really out of it ... you know what, my attitude was, 'She's my partner. If you can't, if you can't accept that, we're going to go full blown to the media.' And we were willing to do that.

I always go very well prepared. So ... we had typed out questions. We knew what we wanted to say. I, so she, and we have a copy for the doctor. And so, it would, and at some point in that process, we would identify ourselves as a partner, or she would, right at the beginning, say 'I want my partner, to come in and sit like this.' So, we'd be looking for the initial response. 'Where are we going to go with this, if the guy gets all upset or nervous or something?' I would say that there's very little in the healthcare system that makes it easy or comfortable, whether you're accepted for your same sex orientation or not. There's all the power issues of the doctor's knowledge, as there's a lot of mystique around it. Even with my professional background, I can be nervous, going in to talk to the doctor. But mostly because we both go very well prepared to the doctors, we come in in a, at least at an equal side. We're not sitting there waiting, like, for them to pronounce something.

One participant noted how the strategy they undertook to safely receive care had significant implications in the efficacy of the care they received: "I lie to my doctor slash omit information slash tell her basically nothing about my life. And if you don't, if your doctor doesn't have a good handle on your identity and your life and the way that you live, then, there's lots of stuff that they're not going to have a conversation about with you."

Ramifications of Oppression and Discrimination

Participants discussed a number of ramifications resulting from their experiences of underwhelming healthcare. Some participants, for example, reported avoiding necessary specialist care: "I can't bring myself [to see a specialist]. Because we, I'm moving in May, and with the stress of that big cross country move and everything coming up so quick, I can't put myself in a position where I'm going to cause any more turmoil to my life, right now. I just can't." Yet another participant stated:

[S]o I've had a horrendous time with docs, and docs that will actually take things seriously. So I've been without a practitioner for over fifteen years ... suffer through things [laugh], in other ways, right, too, where, I don't get sick that often, but I usually wait until it's really, when I know I really need antibiotics and then I go in ... Yeah, check it [laugh]. I don't have a practitioner, because of my experiences.



The emotional burdens of engaging with the healthcare system were another common theme. One participant noted the fear associated with deciding whether to disclose their identity to a practitioner: “for me not to be able to talk about my life, it takes so much energy, to shut yourself down, and to try and, you know, it’s like cutting off pieces ... It depletes you. It fills, there’s a sadness that comes with that, that you can’t actually be who you are. So, in a moment, if I was really ill, you know, I would need to be able to be fully there [regarding coming out to practitioners].” Indeed, emotional stress, anxiety, and fatigue were common themes among participants, with one reporting: “There’s actually a kind of feeling like you’re shrinking, cause it’s like, ‘There’s something wrong with you,’ or ‘You’re not wanted here.’ Like, you know, I don’t want to have to deal with you.’ Or, you know, those kinds of feelings, which I think, I mean, they’re just undermining to self esteem, and sense of self and stuff like that, right?” Another participant noted: “I was really anxious about increasing our interaction with the health system, in such an intimate time and like a, what’s the word, not fragile, but just, you’re exposed, right? Like, it’s such an intimate time in your life and [partner] was really anxious. She didn’t want to have a hospital birth, because she was really anxious of how she would be treated.”

Others found themselves angry, frustrated, or unwillingly cast as educator when receiving inadequate and uninformed care: “I got very annoyed. But I’ve also learned that instead of getting annoyed with people, sort of education, so I always feel like I’m trying to like [laugh], educate a doctor about how it’s not okay to make, you know, that LGBT is not a strange thing.”

Positive Experiences

Participants were eager to share positive experiences and noted appreciation for practitioners who demonstrated openness, respectful curiosity, and a willingness to ask questions of them:

Just previously with, especially being in a polyamorous marriage, I was married and so that even makes things more complicated, that sometimes, doctors make some assumption that you only have one partner. [Family physician] never did, for example, make that assumption. And so when he’d bring up, you know, questions about my sexual activity, he was always very general in how he asked it, and very gender non-specific and very kind of open to that response of there being multiple partners.

Some participants also noted how impactful physical indications of a medical site being 2SLGBTQIA+-friendly were for them in seeking care:

The pamphlets they have, actually, as well ... makes me feel, I mean, I don’t, I guess it’s subjective, because it’s how it makes me feel, but I feel like when there are pamphlets that are about, like, broader sexual health, or if people are questioning or stuff like that. Again, my frame of reference is kind of [a medical site]. Like, there, they’re really good. They have all kinds of pamphlets, and condoms out, like, stuff like that. So it’s also, I mean, in some ways, it’s not just that it’s a space where there’s stuff about sex, but it makes it feel okay to talk about sex and sexuality, because it’s already out in the open, versus becoming something very clean and sterile, where it’s not sure if it’s okay to talk about.



[Practitioner] had this lovely survey that you filled out, when you became a new patient, that asked all about your medical history but it also asked personal information, and so it gave you the opportunity to come out ... I think it's important to ask, like, because that's such a, because that is such a huge part of our community that is vulnerable and taken advantage of.

Lastly, participants noted that open and interactive practitioner approaches enabled a sense of agency in their own health and care moving forward:

So, what I really like about her is she always kind of like, asks for my opinion about what's happening. So I feel like she really involves me in my own healthcare. Whereas before, my doctors would kind of just like, prescribe medication to me. I feel like she's, like [sigh], this isn't, like, she'll say 'This is what I'm thinking we might do. What do you think about this?' And then she'll explain, like, if I'm going to go on an antibiotic, or if I'm going to use, like, just any sort of medication, she'll really explain to me what that medication is like.

When I think about what it is that makes [practitioner's] practice safe, it's, she doesn't hesitate to ask me whether I'm in a relationship. She doesn't use any stilted, awkward language. She's, there's no, there's nothing that flickers across her face, in terms of mild judgement. There's, it's just an absolute given for her, sort of, 'Why not?' Like, it doesn't even, it's just not anything –.

I mean, that's one of the other great things about my doctor, that I guess I'm just assuming. But that's what she does all the time. She always explains, kind of what, if she has any concerns about something, once we talk, what her concerns would be, what she wants to do about it, what that procedure and test will do, and then, based on that, what steps and choices are, right? So I mean, like, all of that. I mean, the point is that it's not one directional. This is, really, healthcare is about relationship and it's about shared responsibility. And how can I share our responsibility for my own health, if you don't actually act like a partner, and translate the parts for me that I need to understand that I can actually then have an impact and make positive change for myself, right?



"The risks of ignoring making a positive space - if you create an environment that's not hospitable to GLBTTQ - you're not just missing sexual health. You're missing mental health; you're missing abuse; you're missing a whole segment that's not even being measured in reports and in research and so on and so forth. Our voice isn't even being counted."

Quotations are those of study participants



Recommendations and Conclusions

Many participants were enthusiastic about the opportunity to help inform and improve 2SLGBTQIA+ healthcare moving forward and were keen to offer recommendations to accomplish this.

Acknowledgement of the lack of existing training and continuing education offered to practitioners, and the real need for that to change in order to facilitate meaningful 2SLGBTQIA+ healthcare, was a recurrent theme:

I think they just need to be, um, trained and aware and thinking about the diversity of sexual orientations and gender identity and experiences that people are going to have, and to be, kind of self reflective about, and kind of, like, seeing it as one of their roles to be critically engaged with what they're learning and what they have been taught and so that they can kind of unlearn the kind of heterosexist models that they have been taught. And so just to be, that first thing would just be that awareness and that critical, you know, for them to have that critical eye, and to just, and to see it as part of their, you know, responsibilities to be competent in this area.

That getting informed is so important. You know? Like, I don't think, I think a lot of healthcare providers really don't understand. And truthfully, if you don't have, if you don't live within that context, if you don't have a close friend, or as one of your family or something, some experience that makes you understand how important those respectful interactions are, then maybe you won't get it. But, um, you know, that experience with your healthcare providers is really a part of your overall well-being, and they have an obligation, I really do believe that as healthcare providers, we have an obligation to show everybody respect and empathy and care, and respecting and understanding somebody's queerness, whatever that means to that person, falls right into that. So, yeah, I think that some healthcare providers, they don't see it as being a big deal. I think that most would understand. I think some really can't be bothered, but I think that it's really important for everybody to make that push, so that everybody can get on board. That's all.

I think the most problematic experiences with medical professionals happen, for me, when there wasn't a box that they could check, and then just confusion and frustration and denial ensued. That and just because the queer community is not something that a heterosexual person would understand necessarily doesn't mean that it is wrong for that person to ask questions, if they are questions that are asked respectfully. So again, rather than just ignoring or overlooking or you know, picking one of the two options that you feel, or the medical profession, you know, would feel the most comfortable with, so for example, if I was a gender queer person, and I did not want to identify a gender - how



often does a medical professional would just pick one, based on their perception of what gender you're presenting? Probably more often than not, at least based on my experiences with how people have reacted to my appearance. It's, I think it's just really important to ask. It might be uncomfortable for some hetero medical professionals, but it's important. It's damaging to people when people who are in positions of power, like medical professionals are, to make, you know, really quick judgement calls or decide things about who I am, and who I've been, without acknowledging my opinion.

I think a curriculum needs to underline and outline the risks of ignoring making a positive space, that it doesn't just come down to whether or not I'm going to report the numbers of people that I've slept with, but that if you create an environment that's not hospitable to GLBTTQ that you're not just missing sexual health. You're missing mental health; you're missing abuse; you're missing risks that might occur outside of a committed relationship and that you're missing a whole segment that's not even being measured in reports and in research and so on and so forth, but they're not even, their voice isn't even being counted.

Lack of education and awareness placed participants in the uncomfortable position of decentring their own needs in appointments in order to "catch up" practitioners:

I, because I feel like when I have an appointment, I need to be the centre of that appointment. And so, I don't want it to be, like, teaching somebody something about, like, homophobia or about, ah, like, somebody, like an identity or something like that. And so, as I say that, I think, 'Oh, but I often feel like my doctor doesn't know, and she tells me, and I really like that she tells me she doesn't know.' And so, I think the difference is that in the past, when I've had to become, like, the person who's like 'Actually, what I mean is this. And this is why I mean that thing,' it becomes, like, 'Oh, I need to teach you this thing about my life.' But if I tell my doctor, I feel like she says 'Oh, I didn't realize that,' or 'I don't know what that means,' like and will do the things I mention, like, she'll get out a book or she's out the internet, and it becomes, like, learning, or, like, she's trying to understand, rather than I'm having to teach her. So I guess it's like the reluctance to what I'm telling someone, versus, like, 'I'm totally open to being wrong,' or being uneducated about something or just not knowing. And I feel like when she does that, she's like 'I actually want to know. Like, I actually want to learn. I don't want to just like, listen awkwardly to what is being told to me.' So, I guess, yeah, like, I think the difference is, like 'Oh, I actually want to know, so I don't make this mistake and so that I can be as accurate as I can and I want to learn with you,' versus, yeah, just like a more passive approach, so like, I'm teaching somebody something and they're passively listening. And I feel like 'Oh, this might not change anything.'

Although practitioner willingness to pursue necessary research and be open to learning and asking questions was repeatedly noted as significant, participants further clarified that relevancy, context, and transparency regarding why a question was being asked enabled them to feel secure in sharing:



[S]omething that makes me get my guard up is like, when I feel like they're being curious about me because they're curious, but not because it has anything to do with me. So, kind of like, over asking questions about like, coming out or that sort of thing. Like, not just to see, check on your mental health but to see, like, 'I want to know what it's like when you come out,' which is, like, a totally vulnerable question, because, like, some of us have horrible experiences.

Don't ask, don't ask it if it's not relevant, if you don't need to know.

[T]hat kind of context appropriateness is important. So, if comments seem to come out of left field, and I don't know where they're coming from, that can be sometimes a little bit off putting. Knowing why questions are asked or knowing the medical reason, or whatever it is, that those questions need to be asked.

More direct or practical recommendations included:

The other thing would, for sure, be language, using gender neutral language as much as possible, even when you're dealing with somebody who you know is straight. There's nothing wrong with then calling them, that person, 'their partner,' right? Like, it's, why risk making anyone uncomfortable, when you can make nobody uncomfortable by using gender neutral language? ... [H]eavily gendered language, that's automatically, like, one of those things that's, like, 'Okay, not necessarily going to be on board with me.' Right? Like, it's one of those, those clues that when somebody uses really good gender-neutral language, it's kind of like, 'Oh, well, they at least get that part of it.' And they understand that they shouldn't be making assumptions like that."

Other than [a medical site], or places like that, there's no places that have really great reputations. Like, we've thrown it out there on Facebook, like, me and a couple of our friends, like, 'Hey, who's got a really great doctor?' And 'No, not really.' As for like, really horrible reputations, I haven't heard anything either. But yeah, no, like, if there, like, if [we] had some kind of list, that said like, you know, 'These are great, queer friendly doctors' that would be great.

Even just like, a little rainbow flag, cause like, you know, cliché as that is, just having some sort of staff training and then once the staff awareness training has happened, then you put the little rainbow sticker on the door or something, and then, just that, you know if, it, it makes people who need it feel that much more safe there. But you can't just put a little sticker on the door and call it a day. Like, I think that there definitely needs to be, like, some training and awareness training with the staff, before, you, like, claim that it's queer friendly.

I think the really important thing about having gender inclusive bathrooms is it generally makes people feel freer, because you're not, then you don't have to worry about, 'Okay, this is my birth gender, versus the gender I interpret myself as. Which bathroom do I choose?' And I mean, it's also just practical, in terms of, 'I am a male parent with a small female child. Which bathroom do I go in?' or just generally



stuff like that. I mean, as long as everybody's clean, it doesn't really make sense to have bathrooms separated by gender, especially if they're just a single stall bathroom, which a lot of doctors' office bathrooms are.

[T]reat people like they're people; meet people where they're at ... you know, ask, be open and, and ask people, like, 'What do you want? Like, what do you see your care looking like?'

Based on participant responses, we recommend the following in order to work towards compassionate, competent care for 2SLGBTQIA+ communities in Manitoba:

1. Training in 2SLGBTQIA+ identities, health, and healthcare needs in rural and urban clinical sites in Manitoba. This training should be mandatory and could be administered through the health regions. Training should be provided to *every member* of the healthcare team who may interface with patients. Training should include how to appropriately use accurate pronouns and names and how to initiate discussions with patients about pronoun use.
2. Medical and nursing curricula in universities and colleges should include a *substantial* number of mandatory hours/credit hours dedicated to 2SLGBTQIA+ identities, health, and healthcare needs. These curricula should be community-based and comprehensive; that is, curricula need to *cut across all aspects* of student learning and also be founded in an intersectional understanding of medicine that de-centres the settler, white, heterosexual, cis, thin, and able body identity that typically founds medical knowledge.
3. Heterosexism and cis-sexism must be addressed within healthcare. Certainly, healthcare spaces are not only accessed by heterosexual and cis-gender people and services should not be provided with this assumption. To assume heterosexuality and cis-gendered bodies communicates that these are the only “normal” sexual and gender identities, and this prevents people who do not fit those “boxes” from accessing care.
4. All intake forms need to be reviewed and re-vamped to be inclusive in terms of sexuality and gender. We recommend allowing patients to “fill in the blank” on forms and use their own language pertaining to sexual and gender identities. If this is impossible, providing as many “check boxes” as possible, in consultation with the community, is another strategy. Any reference to next of kin should be gender inclusive and not assume heterosexuality.
5. “Safe space” material, such as rainbow stickers, posters, and reading material, can and should be used in healthcare spaces. However, such material should *not* be used if healthcare providers working within that space have not had training about 2SLGBTQIA+ identities and healthcare needs and policies are not in place regarding the safe provision of 2SLGBTQIA+ care. Further, “safe space” is in and of itself a



controversial term because a space that feels “safe” to one person may not feel “safe” to all. As such, a “safe space” for a white settler may not be “safe” for an Indigenous person, Black person, or Person of Colour. We therefore recommend anti-oppressive, anti-colonial, and anti-racist training alongside 2SLGBTQIA+ safe space training.

6. All clinical spaces should have gender inclusive bathrooms.
7. While many hospitals in Manitoba are funded in part by religious groups, it is important to note the high degree to which our participants found Christian iconography communicated a lack of safety in clinical spaces, which was due to a history of anti-2SLGBTQIA+ sentiment in some Christian denominations. We suggest, then, that clinical spaces in which Christian iconography is present work hard, through policy statements, press releases, and especially in practice, to communicate that they are committed to providing affirming 2SLGBTQIA+ healthcare. In these spaces, in particular, 2SLGBTQIA+-positive materials are imperative.
8. We recommend comprehensive, rigorous, and well-rounded 2SLGBTQIA+-related policy in every health region in Manitoba. These policies should be guided in part by the 2SLGBTQIA+ communities in which health regions are located.
9. We recommend the ongoing support of 2SLGBTQIA+-specific community clinics *in addition* to the development of accessible and affirming care *throughout all healthcare spaces* in Manitoba. While 2SLGBTQIA+ community clinics are integral to queer communities, the over-burdening of these clinics due to a lack of knowledge about or understanding of 2SLGBTQIA+ care in other clinical spaces creates conditions of inaccessibility as described by our participants.



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