

Healthcare access experiences and needs among LBQ women, trans, and nonbinary people in Canada

A Research Report



October 2023



Land Acknowledgement

We would like to begin by acknowledging that Egale is based on the traditional shared territories of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. The territory is protected by the Dish With One Spoon Wampum Belt Covenant, an agreement between the Haudenosaunee, Anishinaabe and allied nations to peaceably share and care for the resources around the Great Lakes. The concepts of gender, sexuality, and oppression that we often rely on in 2SLGBTQI advocacy work are largely based in white, Western, colonial systems of thought and do not represent the multitude of understandings of identity that exist outside of this viewpoint. Colonial violence created the foundations for the landscape of gender-based violence that we understand today. Indigenous communities and Two Spirit activists, scholars, writers, and artists have gifted us with ample tools to work with as we move toward the collective liberation of gender and sexuality minority people. We are grateful to carry these with us here and in our work beyond. The violence of colonialism is ongoing. So too are movements toward resisting this violence.

Acknowledgements

About Egale

Egale is Canada’s national 2SLGBTQI organization. Egale works to improve the lives of 2SLGBTQI people in Canada and to enhance the global response to 2SLGBTQI issues. Egale achieves this by informing public policy, inspiring cultural change, and promoting human rights and inclusion through research, education, awareness, and legal advocacy. Our vision is a Canada, and ultimately a world, without homophobia, biphobia, transphobia and all other forms of oppression so that every person can achieve their full potential, free from hatred and bias.

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Glossary

2SLGBTQI: Two Spirit, lesbian, gay, bisexual, trans, queer, questioning, and intersex. The order of acronym beginning with Two Spirit recognizes the presence of Two Spirit and Indigenous peoples across Turtle Island, and the historical erasure of Two Spirit people through settler colonialism and in mainstream queer organizing. For a full list of 2SLGBTQI terms and definitions, see: <https://egale.ca/awareness/terms-and-definitions/>

Ableism: Discrimination and exclusion based on one's abilities (mental, neurological, intellectual, emotional, and/or physical) and productivity. It often manifests as social stigma and the maintenance of physical and systemic barriers to resources and opportunities.

Ageism: Discrimination and exclusion based on one's age, particularly those deemed especially young or especially old. It tends to operate in ways that benefit working-age adults.

Fatphobia: Fear, hatred, or contempt for fat people and the stigmatization of individuals with bigger bodies. It often exhibits through the treatment of fat bodies as being in need of correction and discipline.

Racism: Ideas or practices that establish, maintain or perpetuate the racial superiority or dominance of one group over another.

Classism: A belief that a person's social or economic station in society determines their value in that society. Classism also refers to behaviour that reflects this belief, such as prejudice or discrimination based on class or socioeconomic position.

Sexism: Prejudice and discrimination against people based on their sex or gender, often based on the belief that male supremacy is a natural fact, and that biological differences in sex characteristics can and should dictate social status and gender(ed) roles (Krieger, 2020).

Heterosexism: Discrimination and prejudice in favour of heterosexuality. It includes the presumption that all people are heterosexual and produces barriers for anyone who fails to uphold dominant expectations of heterosexuality.

Cisheterosexism: Discrimination at the intersection of cissexism and heterosexism which privileges cisgender and heterosexual norms and identities, and punishes anyone who fails to uphold those norms.

Cisheteronormativity: A set of societal assumptions, norms, expectations, and beliefs that centers cisgender and heterosexual experiences. These beliefs and practices perpetuate the privileging of heterosexuality and binary, cisgender identities, and lead to stereotyping and policing of people, beauty standards, and relationships for 2SLGBTQI people and communities.

Pathologize: To pathologize means to treat people differently or mentally categorize someone as abnormal based on stereotypes, stigma, or prejudice. Pathologization can be in reference to medical or psychological symptoms, or in reference to someone's physical appearance or social standing.

Introduction

What priorities for health and healthcare access do women, trans, and nonbinary people who are lesbian, bi+,¹ or queer in Canada have? What actions can be taken across sectors to address these priorities?

Efforts to gain and maintain access to healthcare for 2SLGBTQI people in Canada have long histories and are ongoing. From efforts to decriminalize and de-pathologize homosexuality, to organizing for access to care and treatment for people living with HIV/AIDS, to fights for gender-affirming care and more, we know that equitable and affirming care for 2SLGBTQI communities in Canada is not easily won and is not guaranteed. While important gains have been made, there remains much work to be done to ensure equitable healthcare access for all 2SLGBTQI people. This includes for lesbian, bi+, and queer (hereafter “LBQ”) women, trans, and nonbinary people seeking care across care sectors .

Dismissal and invalidation of LBQ women, trans, and nonbinary patients’ healthcare concerns and issues are rooted in multiple social dynamics and systems of oppression, including gender bias against women (also referred to as sexism) (DiGiacomo et al., 2015) and against trans and nonbinary (hereafter, TNB) people (also referred to as cissexism) (Kattari et al., 2015). Canadian studies have documented the unique barriers that LBQ women face in accessing care across sectors, including but not limited to homecare (Grigorovich, 2015), sexual and reproductive healthcare (Flander et al., 2017; Tam, 2021; Yager et al., 2022), and HIV care and support (Logie et al., 2012), and have examined the different disclosure and navigation practices that LBQ women, trans, and nonbinary people engage in in medical settings (see also Fredericks et al., 2017). While minimal research has documented healthcare access experiences of LBQ nonbinary people (Burchell et al., 2023), Canadian studies have shown how trans LBQ individuals face numerous barriers to

¹ We used “bi+” in research recruitment materials as an umbrella term to unite signify plurisexual identities (e.g., bisexual, pansexual, queer, sexually fluid, omniseual, and more).

healthcare, including a lack of knowledgeable providers, denial of healthcare, and refusal to approve hormone therapy or gender-affirming care (Gahagan & Subirana-Maleret, 2018; Giblon & Bauer, 2017).

Together, this body of research shows how healthcare experiences among LBQ women, trans, and nonbinary people are often characterized by assumptions and judgments. Indeed, “health” itself can be understood as a term filled with value judgments and hierarchies (Metzl, 2010), and mobilized as part of ableist, racist, and classist ideologies that target disabled, neurodivergent, fat, poor, Indigenous, Black, immigrant, and racialized communities, among others (see Andrews et al., 2021; Berlant 2007). Despite efforts from individual healthcare practitioners and educators, critical research, and coalitional community organizing, we continue to see 2SLGBTQI healthcare needs go unmet, and the perspectives and priorities of LBQ women, trans, and nonbinary people go largely unheard.

To these ends, and building on foundational research and critical intersectional approaches, the aim of the Action Through Connection research project was to learn more about healthcare access experiences among LBQ women, trans, and nonbinary people in Canada and to amplify their perspectives and priorities when it comes to structural and systemic change across care sectors. To do so, through 2022–2023 we established and engaged three advisory committees, and conducted focus groups and interviews with 35 LBQ women, trans, and nonbinary people living in urban, rural, and suburban areas across Canada. Focus group and interview participants included LBQ women, trans, and nonbinary people 18–69 years old from nine provinces, with a range of gender identities and sexualities. Nineteen participants were Black, Indigenous, and/or people of colour, and 16 were white. Most participants (27 of 35) were born in Canada, while eight were born outside of Canada.

This report provides a high-level summary of the research findings and recommendations for change and collective action. It has three main sections: [Methodology](#), in which we describe the research process; [Findings](#),

in which we highlight and discuss participant experiences and perspectives; and [Recommendations](#), where we provide summary recommendations for education and training, healthcare practitioners, health systems change, and intersectoral action to improve healthcare access for LBQ women, trans, and nonbinary people in Canada.

Methodology

Collaborative Approach

The Action Through Connection research study was initiated, crafted, and conducted by, with, and for LBQ women, trans, and nonbinary research leads, advisors, and collaborators. The lived experiences and knowledge of the team shaped and grounded how we oriented the research, how we engaged with participants, how we interpreted the research findings, and our approaches and commitment to mobilizing these findings.

The research was led by Dr. Brittany Jakubiec, Dr. Celeste Pang, and Kim Seida. Through 2022–2023 we engaged three advisory committees to provide additional expertise and input on the study. This included an Academic Advisory Committee (made up of five academic and community-based researchers), Community Advisory Committee (made up of 10 community members identifying as LBQ women, trans, and nonbinary people); and a Community of Practice on LBQ Health (made up of 10 organization representatives and independent practitioners and researchers). Committee members provided valuable input to the research, including providing feedback on the focus group questions and supporting study recruitment. French-language focus groups and interviews were supported by Fondation Émergence.

Participant Engagement

We invited participants who self-identified as women, trans, and/or nonbinary people who were lesbian, bi+, or queer, or who resonated with these experiences (having personal lived experiences of moving through the world

as a lesbian, bi+, or queer person), were over 16 years old, currently living in Canada, and able to participate remotely (via phone or online) in ASL, English, French, or LSQ. Potential participants indicated their interest by completing a short registration form on Qualtrics (a survey software program).

Participants were recruited through a range of methods, including by sharing recruitment materials through the advisory committees and existing networks, direct emails to community groups, and through Egale’s social media platforms. Forty-four people expressed interest in participating in focus groups, and we sent participation invitations to 17 people. Additionally, when the Community Advisory Committee was fully established, we sent focus group invitations to those who had expressed interest in being on the committee to see if they wanted to take part in a focus group instead. Invitations to participate were sent to individuals based on criteria such as diversity of experiences, age, their geographical location (including if they were living in rural, urban, or suburban areas), and identity-based characteristics to help us address the underrepresentation of certain groups in 2SLGBTQI health research.

From September–October 2022 we engaged 35 participants in seven online focus groups (six in English, one in French) and seven individual interviews (six in English, one in French). Focus groups lasted between 72 and 125 minutes, while individual interviews lasted between 26 and 85 minutes. Each participant received a \$50 gift card honorarium. All were guided by the following questions:

1. What are three adjectives that you would use to describe your overall experience accessing healthcare in Canada?
2. Thinking about one of those words, can you tell us more about your experience?
3. What healthcare have you sought in the past five years? What barriers did you face? What went well?
4. From your perspective, how has your identification or how others see you impacted your access to healthcare?

5. How could healthcare access for LBQ women, trans, and nonbinary people in your region be improved?
6. Would you like to see more connection between different healthcare and social services? If so, what would you like to see?
7. What are your top three priorities for healthcare access?

Demographics

Participants ($N = 35$) in this study were between the ages of 18 to 69 (average age = 34), primarily from urban areas (see Table 1), and from nine Canadian provinces (see Table 2). Among the participants, 19 were Indigenous, Black, or people of colour (POC), while 24 individuals described having a disability. Most participants ($n = 27$) were born in Canada, while eight were born outside of Canada. Nearly all participants ($n = 31$) described their housing situation as secure or stable, and around half ($n = 19$) described their income as meeting their needs. Nearly all participants ($n = 32$) had some post-secondary education.

Participants provided their own description of their gender and sexuality and could use more than one label. In terms of gender identity, labels included woman ($n = 15$) and ciswoman ($n = 3$), nonbinary ($n = 10$) and trans nonbinary ($n = 2$), trans woman ($n = 2$), trans masc ($n = 3$) or trans guy ($n = 1$), as well as gender fluid ($n = 2$), gender queer ($n = 1$), gender nonconforming ($n = 1$), and gender questioning ($n = 1$). In terms of sexuality, labels included queer ($n = 14$), bisexual ($n = 11$), lesbian ($n = 9$), dyke ($n = 1$), femme-attracted ($n = 1$), pansexual ($n = 7$), Two Spirit ($n = 2$), gay ($n = 2$), homoflexible ($n = 1$), as well as polyromantic ($n = 1$), grey ace/grey asexual ($n = 2$), and grey aro ($n = 1$).

Table 1. Rural, suburban, and urban representation of participants.

Area	Count
Rural	5
Suburban	3
Urban	27
Total	35

Table 2. Provincial representation of participants.

Province	Count
Newfoundland and Labrador	1
Nova Scotia	4
Prince Edward Island	1
New Brunswick	3
Québec	6
Ontario	13
Manitoba	4
Saskatchewan	1
British Columbia	2
Total	35

While this is a qualitative study, and the participant sample is not representative of all LBQ women, trans, and nonbinary people in Canada, this snapshot helps to understand the range of who we heard from, and who we didn't. Limitations include no representation from the territories, lower participation in the Prairies, and fewer from non-urban locales. Strengths, in comparison to other research in this area, include the diversity of gender including a high number of nonbinary participants and the ethno-racial diversity among the participants.

In the findings sections below, we have assigned participants a pseudonym and will use a brief participant description when using a quote or relaying a participant's experience. To ensure participant confidentiality, we will report some of their demographic information (i.e., age range, gender, sexuality) and somewhat conceal other aspects (e.g., ethno-racial background, region) when introducing a direct quote. In this descriptive statement, when noting a participant's region, we will use "Atlantic Canada" for those from NL, NS, NB, and PEI to especially ensure participant anonymity from this region. When noting a participant's ethno-racial identity, we will use "white" or "BIPOC" as listing a participant's race or ethnicity alongside their age, sexuality, gender, location, and direct quote could risk their anonymity. We recognize there are some limitations in using the BIPOC acronym as a singular participant's

identifier. We have elected to use it to retain participant anonymity and confidentiality while still providing the reader with important demographic information to contextualize the participant’s perspectives and experiences.

BIPOC participants in this study experienced specific and compounding barriers when navigating healthcare settings and interactions with care providers due to systemic / institutionalized racism and being perceived as racialized within this system. We used “racialized” when reflecting on these harmful interactions within healthcare systems that speak to broader systemic issues, and we explicated processes of specific forms of discrimination (e.g., anti-Indigenous racism) to appropriately contextualize participants’ experiences.

Findings

Labour in Accessing Care

A prominent issue highlighted by research participants was that of the various forms of labour involved in seeking and accessing care. In this report, “labour” refers to the strategies participants used to advocate for themselves or on others’ behalf in efforts to access care and to improve the quality and access of care they received. Participants’ intense mental, emotional, and interactional labour was evident throughout what we call the “diagnosis and treatment arc” (see also Wiegand et al., 2023), beginning with initial efforts to access care (pre-diagnosis) through to diagnostic and treatment processes. The efforts and exhaustion in trying to access care that participants described often began before initial visits to care providers and had effects on their health and wellbeing beyond the end of medical encounters.

Existing research has illustrated multiple strategies that LBQ women, trans, and nonbinary people use to advocate for their own—or their loved ones’—needs in the face of invalidation, dismissal, ignorance, and incompetence. Specific strategies highlighted by recent studies include managing identity

disclosure, such as intentionally concealing identities to avoid discrimination (e.g., Carpenter, 2021; Hoffkling et al., 2017) or disclosing to correct assumptions (e.g., Soinio et al., 2019), advocacy and persistence in order to attain their needs (Seelman & Poteat, 2020), and online health information seeking (Eiduson et al., 2022).

These strategies to access healthcare and information are a consequence of and response to widespread dismissal of patients' concerns and experiences as well as invalidation of self-knowledge. In our research, participants described invalidation of their experiential knowledge through phrases like "people do not take me seriously," "I don't feel like I'm taken seriously," and "I have to fight to be taken seriously."

Participants felt that the dismissal they experienced was connected to ageism, racism, sexism, and cissexism in addition to their position as a patient in the power dynamics of a patient-provider encounter. Historically, sexism and cissexism have taken the form of diagnosing women and people from marginalized communities with "hysteria" (a diagnosis popularized in the early 20th century and defined as the conversion of emotional distress into physical symptoms) as way to dismiss patients' health concerns and control them through pathologizing diagnoses (see Grose, 2016). To this day, both implicit and explicit gender biases influence healthcare providers' behaviors and treatment approaches, leading to discrimination and reinforcing health inequities. For example, a 2018 study found that doctors often view men with chronic pain as "brave" but view women with chronic pain as "hysterical" or "emotional" (Samulowitz et al., 2018). This study also found that doctors were more likely to treat women's pain as a product of a mental health condition, rather than a physical condition, while another survey found widespread beliefs among dentists and physicians that women exaggerate their pain (Wesolowicz et al., 2018). Our research echoed these findings, with Siobhan [20s, white, grey ace/bisexual genderfluid woman, urban ON] sharing with us their experience battling dismissal in efforts to get an endometriosis diagnosis:

“

Over the past five years, I have been dealing with a lot of chronic pain. So now I'm looking at getting diagnosed with endometriosis. I've been fighting for that for years and the biggest barrier is just getting someone to take me seriously. It's so, so hard advocating for yourself and trying to express to people how much pain you're in because it's not a physical thing [...] I have to communicate constantly. And I have to get really good at my communication skills.

”

The dismissal and invalidation our participants described has been coined “medical gaslighting” (Fetters, 2018). Medical gaslighting is often most evident in interpersonal exchanges between providers and patients, but “it is the result of deeply embedded and largely unchallenged ideologies underpinning healthcare services” (Sebring, 2021, p. 1951). These ideologies continue to privilege biomedical expertise over people’s lived experience (Sebring, 2021) and in so doing erase people who understand and communicate their health-related needs to providers through their lived experience. Further, gaslighting causes patients to question their own experiences and may lead to healthcare avoidance and delays.

Some participants, like Annette [30s, white, lesbian woman, urban QC], explicitly linked dismissal of health concerns to misogyny:

“

I'm going to come back to misogyny. The fact that I look like a woman, I feel that I am taken less seriously. If I say things to my doctor, or regardless of if I go to the drop-in clinic or whatever, it's as though people didn't believe me. No matter [how] I explain how my body is functioning or how I know that something's wrong, they don't believe me. And it's hard to say whether that would have been different if I had been perceived as a male, but every time, that's the feeling I get. That no

matter what I say about my own knowledge of my own body, what I say is always questioned. (Translated from French)

”

Beyond gender bias, other biases such as those relating to ethnicity, disability, and age, have also been shown to create inequitable healthcare interactions and outcomes (White & Stubblefield-Tave, 2017; Marcelin et al., 2019). The ideological structures guiding western medicine frame women, transgender, intersexualized, disabled, racialized, and queer individuals as ‘bio-Others’ (Sebring, 2021). ‘Bio-Others’ are those who are constructed as inferior through medical and scientific discourse (an exercise of power Foucault [2008] refers to as ‘biopolitics’), as compared to the cisgender, straight, white, and able-bodied male subject on whom medical knowledge often focuses (Sebring, 2021). Such exclusionary and “othering” frameworks have been used to pathologize, marginalize, and control different groups in society. These ideological frameworks have also led to medical gaslighting and have deepened healthcare access barriers experienced by those who fall outside of “normative” social parameters. As Parker [20s, BIPOC, gender nonconforming lesbian, urban ON] and Jyoti [20s, BIPOC, nonbinary lesbian, urban MB], respectively, explained:

“

I know that particularly for fat folks it’s really hard to advocate for themselves. Poor folks who don’t have this language, [it’s] really difficult to advocate for themselves. Trans folks who don’t pass as a binary gender, also really difficult to access care and to be thought of as valid. (Parker)

”

“

My healthcare experiences, they’ve not been the same over the course of my life. And how I’ve presented to the healthcare system and how the

healthcare system [has] reacted to me as like a BIPOC trans person who has disabilities. Some healthcare providers have been really positive. And I've had really good experiences. And then, in other systems, like emergency care, I've had less than good experiences [...] So I would say varied, because there's been really positive and also negative experiences. (Jyoti)

”

In the Canadian context, settler colonialism and white supremacist logics continue to create health disparities and shape healthcare access. Indigenous LBQ women, trans, nonbinary, and Two Spirit people face distinct access barriers rooted in the historical role of medical institutions as instruments of the colonial state (Schreiber et al., 2021). In medical settings, the manifestation of viewing and treating Indigenous care seekers as bio-Others has included forced sterilization, birth alerts,² and perceptions of them being drug-seekers or drunkards (Schreiber et al., 2021). Health authorities have also been complicit in separating Indigenous children, elders, and adults from their families (e.g., see Ducsharm et al., 2022; Stevenson 2012), and deep disparities continue to exist in access to basic healthcare in rural, remote, and northern communities (e.g., Leader et al., 2023). Anti-Black racism also takes particular forms in Canadian settler-colonial society, impacting health and health outcomes as well as care access for Black communities (Dryden & Nnorom, 2021). Black people continue to encounter stereotyping and provider bias (Black Health Alliance, 2020), while systemic anti-Black racism in admissions policies and racist treatment from peers, superiors, and patients, have excluded Black Canadians from equitable health professions training, employment, and leadership opportunities (Joneja, 2022; Kalifa et al., 2022).

These systemic barriers directly impact access to affirming care for Indigenous, Black, and other racialized LBQ women, trans, and nonbinary people, and the

² A birth alert is when a social worker or child welfare agency shares private information of an expectant parent (often without their consent) whom they deem “high risk” with a healthcare provider or other social service worker (Hwang, 2022). Birth alerts are rooted in racist assumptions about risk as well as the characteristics of a “fit parent.”

additional layers of labour they must perform in attempts to secure needed care.

Another systemic and damaging issue prompting the need for patient and care seeker advocacy is that of provider incompetence and ignorance, which leads to inaccurate information regarding sexuality, health risks, and screening needs as well as feelings of isolation and confusion among LBQ women, trans, and nonbinary people (Rabbitte & Enriquez, 2023). The various advocacy strategies that study participants employed were not only geared toward maximizing their quality of care but also holding service providers accountable to address their incompetence. Although the onus should certainly not be on patients to become experts in their own healthcare, participants did this work in order to fill in the gaps caused by providers' knowledge gaps.

One of the main ways in which participants advocated for themselves in healthcare settings was by pushing back against problematic healthcare dynamics or against providers' dismissive or invalidating behaviors and decisions. However, participants like Siobhan [20s, white, grey ace/bisexual genderfluid woman, urban ON] described the process of pushing back against power and knowledge imbalances between provider and patient as a careful balancing act. This balancing act may, for example, involve guiding a healthcare provider toward diagnostic or treatment options while maintaining expected knowledge and power differentials by acting as if the provider inherently knows more about the patient's body and their issue than they do. As Siobhan explained, the degree to which one is believed, and their wishes respected, during this balancing act is dependent on one's privilege:

“

I mean, self-advocacy, and somehow getting the right formula, has been the reason I've considered myself lucky, like, somehow managing to balance [...] “Hey, I'm noticing the symptoms, I see it's linked with this, I already have these,” but still being able to at least pretend that well, maybe you know more than me, whether they do or not. Or being like,

“It seems like it could be something related to this, but I’m willing to be wrong.” Like basically, kind of telling them what’s wrong with me, subtly pointing them in a direction and then saying, “Well, maybe not.” But I know some of that benefit comes from my own whiteness that I can be seen as a reliable narrator on my body [...] my privilege absolutely plays a massive role in it [...] even when I was diagnosed with depression, when I said I was hesitant about taking an antidepressant without some more treatment, they actually were pretty okay with that, even though it was pretty obvious they wanted to put me on something.

”

Indeed, multiple participants brought up their own privileged social locations when discussing their self-advocacy and advocacy for others. For example, Sidney [60s, white, lesbian/dyke woman, urban BC] noted:

“

You need to be well enough to be an advocate because even if you could speak for yourself, if you’re really sick you don’t necessarily have that wherewithal to speak in this system that is not about you.

”

Queer, trans, and nonbinary people may also experience more pressure to advocate for others, knowing that nobody will fill this role if they do not, as well as knowing the harm that ‘staying silent’ could cause their loved ones. It is important to recognize, then, the precarity of advocacy in healthcare spaces. Broader power structures impact how patients and service seekers are able to get their concerns heard and their needs met.

Other participants described the mental labour involved in developing a strategy prior to even setting foot into a healthcare setting and the ways in which they used what Shim (2010) terms “cultural health capital” to improve their healthcare experiences. Cultural health capital is the “repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and

interactional styles [that] may result in more optimal health care relationships” (Shim, 2010, p. 1). For Riley [30s, BIPOC, Two Spirit lesbian woman, rural Atlantic Canada], this health capital comes from working in healthcare, while for Rita [50s, BIPOC, bisexual woman, urban ON], it is rooted in speech patterns and stated personal affiliations (e.g., coming from a family of medical professionals). In each case, participants wielded this capital in efforts to improve their healthcare experiences:

“

I’m kind of coming into most interactions as a bit of a double agent ‘cause my training is [in healthcare]. So I kind of have an idea of what questions are going to be asked or what information that my health professional might be looking for. I tend to spend a lot of time before appointments or referrals almost problematically ruminating over what’s going to come up and what they’re going to ask, rehearsing answers, and trying to figure out how I’m going to get my needs across based on what they’re going to be asking me [...] I find professionals are receptive when I use my knowledge of the system. And I kind of treat it like a strategy game [...] I try to be overly humble, almost downgrading my own experience, but just asking things as questions, so I’m not stepping on any toes, because I’m trying to tell them I know what I’m talking about, without making them so offended that they’re gonna stop treating me well, if it makes any sense. (Riley)

”

“

I’m really good at being an advocate everywhere I go. I always feel like I have to have this toolkit of knowing exactly what my rights are, wherever I am, that I will smash over your head if I need to, so I can get what I need [...] whenever I have to go get any kind of health care. And part of the reason is because I’m not white, and so they don’t take me seriously. And then you add menopausal and instantly you go off in another category

[...] But if I go in, and I've got my suitcase, and I'm prepared with all the knowledge that I have, and I'm gonna lay it out on the table for you before you get to start talking. I'm going to tell you what I think is going on, why I think it's going on, these are the symptoms, and then I'm going to wait for you to respond [...] And one of the first things I always say to any doctor is, "I need you to understand one very important thing about me, one, you're going to have a conversation with me, I come from a family of medical professionals. So I'm not playing around with you." And the minute you say that, it switches to a different level. (Rita)

”

Other forms of advocacy (for self and for others) which participants described included being persistent, changing their language (e.g., how they describe their symptoms, the jargon they use, the tone of their voice), asking a lot of questions, and making concerted efforts to communicate their needs in efforts to receive appropriate and adequate healthcare. This is also an example of using cultural health capital to try to optimize interactions with providers and, ultimately, health outcomes.

All of these self-advocacy strategies discussed above take an emotional toll: participants discussed feeling exhausted, frustrated, anxious, fearful, and uncomfortable seeking care. For example, Taylor [50s, white, queer woman, urban ON] shared the emotional toll that advocating takes:

“

When I get home, I'm a wreck, I'm exhausted, I could sleep for days [...] the exertion it takes just to advocate for yourself and others you love, I find that incredibly difficult.

”

Some individuals seeking care may even blame themselves for not advocating well enough for themselves, despite knowing it is not their fault. As Mary [30s, white, lesbian trans woman, rural Atlantic Canada] shared:

“

Sometimes I blame myself for not being good enough at being an advocate for myself, which is kind of ridiculous. It's not on me, that's the system I'm interacting with, really. So my hope is that I would like to move towards a future where people don't have to work so hard to do that self-advocacy. And that's not their takeaway from interactions, how hard they're having to advocate for themselves.

”

The mental and emotional labour and strategic navigation of patient-provider interactions participants described highlights their awareness of the importance of not “stepping on providers’ toes” and not damaging providers’ egos in order to protect their quality of care. Participants’ need to navigate these interactions is rooted in broader pressures to perform “patienthood,” which is “marked by passivity and deferring to the doctor’s expertise” (Sebring, 2021, p. 1956). Importantly, and as Rita’s experience above illustrates, this navigation is particularly complex for those who experience intersecting forms of discrimination such as ageism, sexism, and racism.

As this report will illustrate, the multiple barriers that LBQ women, trans, and nonbinary people face at all stages of seeking and accessing healthcare and the labour required to access healthcare and to try to ensure positive health outcomes are rooted in sexism, cisheterosexism, racism, colonialism, ableism, and other axes of discrimination and marginalization.

The following sections, which focus on specific healthcare domains (primary care, sexual and reproductive care, transition-related care, and mental healthcare), will explore the various advocacy and self-advocacy practices of LBQ participants as they navigated cisheteronormative and exclusionary healthcare interactions within each of these healthcare settings.

Accessing Primary Care

Participants discussed their experiences accessing primary care at length. This included reflections on trying to find and interacting with primary care physicians or family doctors, cost-related barriers, and the use of emergency room care. Participants shared how impeded access to primary care affected their health and wellbeing, options they would like to see (including coverage for dental care and other services), and specific practices they used to try to cover care gaps. Throughout these discussions, they reflected on how their intersecting social locations fundamentally shaped their primary care experiences, and on the systemic changes needed to increase access to competent, affirming, and affordable healthcare.

As has been well-documented in research among 2SLGBTQI communities—including with regards to access to primary healthcare (e.g., Gahagan & Subirana-Malaret, 2018; Giblon & Bauer, 2017; Logie et al., 2019)—LBQ women, trans, and nonbinary participants described access barriers to primary care that were affirming of their gender identities and expressions, sexualities, and relationships. In light of intersecting forms of oppression they faced in their everyday lives, and both negative and positive experiences in healthcare settings, participants related their desires to find primary care providers who would take them seriously, consider their needs and health histories holistically, pursue appropriate treatments, and be willing to work one-on-one with them over time. However, difficulties in finding primary care providers who actually did these things caused participants intense frustration. Kalani [20s, BIPOC, queer, nonbinary, urban Atlantic Canada] described struggles with both accessing a primary care provider and with medical incompetence while seeking care for chronic health concerns related to ovarian cysts:

“

It’s frustrating [...] the amount of struggle that it is to actually see a doctor. Because I have a family doctor, I’m fortunate to have one but she’s on vacation every other week. And is gone for long periods at a time that I’m

dealing with [...] issues in my stomach and everything [...] I still never got an official diagnosis of PCOS or anything, which is what I'm considering is probably what I've been dealing with for a while [...] It's just been a lifetime struggle, honestly.

”

TNB participants expressed particular concerns about not knowing if care providers would be consistently and respectfully gender-affirming (e.g., using their pronouns and names, especially when different from legal documents). The cisheterosexism TNB people face in healthcare settings influences their future use of care, uptake of treatment, and can lead to delayed or avoidance of care seeking (Boyer et al., 2022; Ziegler et al., 2020). Participants described avoiding or “putting off” healthcare because of this lack of certainty, and the various practices they engaged in to try to determine in advance what a care encounter might be like. As Mary [30s, white, lesbian trans woman, rural Atlantic Canada] described:

“

Just being trans always makes me really anxious anytime I have a first interaction with someone because I don't know how they'll treat me as a trans person. A lot of the time, it helps if I can Google them, and like, see that I can expect to have positive interactions because they look like they're queer positive for whatever reason. But that's rare that you can look ahead of time, usually you're just put into the system, you have no idea who you're going to be interacting with. So, I'm always just constantly worried how I'll be treated beforehand. Which makes me a lot more hesitant to seek care, because I'm worried that I won't be treated.

”

Experiences of sexism, racism, ageism, and medical gaslighting also informed how participants approached care encounters, and what they looked and hoped for in primary care providers. Meera [30s, BIPOC, bisexual cis

woman, urban ON] had had several primary care physicians over her life, and mixed experiences with care providers taking her and her family history and symptoms seriously. After having her symptoms ignored and being misdiagnosed, in adolescence she found a family doctor who was willing to work with her and pursue treatment for her health concerns. Now looking for a new family doctor, after the most recent one moved her practice, Meera's experience with a competent doctor made her realize she deserves a family doctor who cares.

“

I started seeing a doctor that my cousin was seeing. And when she took me on, she understood what I was going through because she had seen similar symptoms with my cousin and listened to me, and was willing to try treatments with me rather than decide what was wrong with me and tell me how I was feeling [...] That experience gave me the foundational understanding that I deserve to have a care provider that listens to me and has the expertise to try to figure out what's wrong with me if the first diagnosis doesn't stick [...] I deserve to have a primary care physician that cares for me primarily. And I like to keep that in mind as I look for a new one. I don't know how long it's going to take, but I want that standard of care for myself, even if that means having to advocate for it and trying other doctors until I find one.

”

This demand for competent care and for being respected by primary care physicians was a common theme in focus group discussions. At the same time, the issue of having access to a primary care physician or family doctor at all was top of mind for many participants, let alone access to one affirming and familiar with 2SLGBTQI communities and healthcare issues. In 2019, approximately 4.6 million Canadians (14.5% of people over age 12) did not have a regular healthcare provider, with the largest lack among people aged 18–34 (Statistics Canada, 2020). While analyses of root causes differ,

retirement or relocating (Statistics Canada, 2020), a downward trend in people entering family medicine (Smart, 2022), a shortage of medical school and family medicine residency spots (Li et al., 2023), and barriers to licensing and placement of internationally trained medical professionals (e.g., Purewal et al., 2023) have all been recognized as contributing to this shortage.

Siobhan [20s, white, grey ace/bisexual genderfluid woman, urban ON] discussed her short-term use of her university's health clinic and described finding a new family doctor upon graduation as a "gamble":

“

I had a family doctor when I was going to university clinics. But my family doctor was atrocious. So I forwarded all my care to the university. And then when I graduated, I realized I was going to be going without, so I [...] looked around and eventually figured out the right keywords to find a brand-new doctor, just graduated, and then to find someone with an opening. Thankfully, my gamble paid off.

”

The characterization of finding a family doctor as a “gamble” highlights the uncertainty and care disruptions that LBQ women, trans, and nonbinary people can face and resonates with other Canadian research that has documented the precarity 2SLGBTQI people of all ages face when it comes to securing a family doctor (e.g., Pang & Maclennan 2023).

This situation also speaks to the privileges of priority access to family doctors, and to other primary care providers. For Siobhan, and other participants who were recent graduates, it was through student status and university affiliation that they had previously had steady access to primary care physicians and other primary care services. Losing access to university health clinic providers meant finding themselves without a family doctor while at the same time entering a new stage of life, seeking work, and aging out of other forms of privileged access (such as parents' private workplace insurance).

While Canada purports to have a universal healthcare system, this issue of privileged access— whether it be through student status, private healthcare insurance coverage, or ability to pay for private clinical care out-of-pocket— shows how access to care can indeed hinge on affiliation and/or ability to pay. This state of affairs was not lost on participants, including participants who had private healthcare insurance coverage through their full-time jobs. As Jessi [30s, BIPOC, queer cis woman, urban QC] reflected:

“ I’m quite fortunate that I can afford private care because I work as an engineer and my profession allows me to be able to access. I have private healthcare coverage with my employer, so it makes things a lot easier to find the doctor and the care that I want, and that I need for my particular situation [and that] understands my background. In that domain, had I not gone to engineering school, or graduated, I don’t think I would have been able to have the means to afford private care. ”

Those without private healthcare insurance coverage and/or the ability to pay out of pocket discussed how cost was a barrier to accessing a range of needed services, from seeing clinical practitioners such as physiotherapists and dentists, to paying for items such as prescription medications and eye glasses. Siobhan [20s, white, grey ace/bisexual genderfluid woman, urban ON] further discussed the impact of no longer having student status on her ability to pay for prescription medications, and her efforts in trying to navigate different coverage options and secure needed medications while still meeting other basic needs.

“ Now I’m off my university insurance, I’m trying to get the spoons together to have a conversation with my pharmacy and say, hey, I’m under 25. So I fall under that drug benefit plus that the government has, but I’m not on school insurance anymore. How long is it going to take to flip that

because I am on EI [Employment Insurance] at the moment due to a summer contract ending, and I get paid slightly more than Ontario Works [a social assistance program]. So like, what if I can't necessarily pay for my medication outright, and then have it back? Like, that's gonna be like a week's worth of income, even if it's \$100.

”

Ontario's "OHIP+" program, which provides coverage for some drug products for people aged 24 years and younger with OHIP coverage but no private plan, was one specific program that participants discussed and shared information about. While those in their early 20s saw this as a benefit, they were acutely aware of imminently "aging out" of the program and other age-exclusive forms of access (e.g., parent's private healthcare insurance), as well as the challenges in navigating access and having to come up with new solutions for paying for medication after they turned 25.

Alongside care navigation and disruption, participants also described cost-related care avoidance. Here, dental care—which is not included as a medically necessary and covered form of care under the Canada Health Act—emerged as a particularly pertinent area for discussion. Annette [30s, white, lesbian woman, urban QC] described her care decision-making process, and the irony that while many women and LGBT people work in care professions this doesn't necessarily translate into them being able to access care themselves.

“

I'm lucky to have the RAMQ, so certain healthcare services are free for me [...] I work for a non-profit organization, so often you don't have private insurance either, that would allow you to access healthcare. For example, sometimes I say to myself, I'll go to the dentist, but is it really an emergency? I wait until the last minute when I'm in pain, and I say, okay, now I'll pay the \$1000 that I don't have, because I have no choice. But it's taking into consideration where you come from, and I find that,

I don't want to make generalizations either, but often, women, LGBT communities work a lot in care provision, caring for people, and that's something, like, pretty insecure. Sometimes that limits access to health care because if something's not reimbursed by the RAMQ, well you can't necessarily afford it. (Translated from French)

”

Participants' frustrations about costs of care, and concerns about their health and ability to function in the day-to-day as a result, were summed up by Preeti's [20s, BIPOC, queer woman, urban ON] statement:

“

Everyone talks about how Canada has free health care , but like, actual Canadians know that it's not inclusive health care. There's this exclusion of going to the eye doctor, or getting an eye exam; dental isn't covered, mental health care isn't covered [...] I don't understand, are eyes not part of our bodies? I don't really get it.

”

Finally, participants described their experiences seeking care in emergency departments, in the absence of access to a family doctor and in crisis circumstances. According to the Canadian Institute for Health Information, emergency and ambulatory care is one of the largest-volume patient activities in the country (Canadian Institute for Health Information, 2023a), with almost 14 million unscheduled emergency department visits in the last 12-month count (Canadian Institute for Health Information, 2023b). With overwhelming demand and staffing shortages, Canadian health systems and emergency departments are facing a crisis, with patients and communities across the country facing lengthy wait times and closures (e.g., see Miller & Bamaniya, 2023).

The experience of one participant, Emma [60s, white, lesbian cis woman, urban Atlantic Canada] and her wife Tammy highlights how critical access to emergency department care is, and how multiple assumptions and prejudices

on the part of care providers can impact access to care, with harmful and dangerous consequences for patients and their health:

“

The healthcare system makes...well people will assume things [...] Several years before Tammy passed, and about six or seven weeks after she had the triple bypass, she started to have chest pain. And I brought her to the hospital that night. She woke me up, and basically I just threw on a pair of sweats and put on a baseball cap because my hair was crazy. And we went to the hospital and they brought her in, hooked her up to the ECG. And then she never really presented with like, a typical ECG in one who's having a heart attack. And the doctor on-call came in after a while. She was in a lot of pain. And the doctor, her first question was like, do you guys, do you both, you take drugs? Well, obviously [wife] takes prescription drugs. But no, it was like, no, she says, "You don't snort cocaine?" I was like, "What? What?" I was like, "Whoa, where's this coming from?" And she was like, "Well, you're not having a heart attack." She looked at Tammy and she said, "You're not having a heart attack." [...] So they let her sit there in pain, and the nurses kept coming in saying they wanted to wait a while for a further ECG. And when they did the second one, she was having a heart attack. And I tell you, after they took the second one, they came in and everything was flying, I got kicked out, cuz they needed to deal with that right away.

”

When Emma and Tammy complained to the hospital and the incident was investigated, they were told that at the time there had been a “major drug problem” in a nearby area that it had been assumed by their look that they were there for drugs. While measures were taken to try to ensure this wouldn't happen again, it did. As Emma related:

“

After that, they put a major, like a big note on her file. But even about five or six years later, she still encountered [it]. I wasn't there with her at this time. She went into the emergency room, and basically, they accused her of trying to get some narcotics [...] They assumed we were looking for drugs and they withheld medication until they let her suffer.

”

This experience points to several failures in care, and several social attitudes and prejudices which directly harmed patients' health and wellbeing. Classist and sexist assumptions informed how Emma and Tammy were read. Care was denied to them based on profiling of how they were dressed and under the assumption they were seeking narcotics; assumptions and treatment that further reveals the social stigma associated with substance use and addiction and the discrimination and barriers that people who use substances face in healthcare settings (Chan Carusone et al., 2019; Lang et al., 2013).

This situation also speaks to the many instances of medical gaslighting that participants related. While younger LBQ women, trans, and nonbinary participants pinpointed cisheterosexism and ageist discrimination against them as young people as part of the reason primary care practitioners did not believe them or take their concerns seriously, older participants noted the added irony of being dismissed by practitioners they had just met while having decades of accumulated knowledge about their bodies and health conditions. This dismissal led participants to engage in various self-advocacy strategies, and to avoid or delay seeking care. Together with barriers related to the availability of primary care physicians and the costs of care, uncertainty about gaining access to needed care, and exhaustion about this uncertainty and self-advocacy needed, characterized primary care access experiences.

Sexual and Reproductive Healthcare

Participants in this study sought sexual and reproductive healthcare for a multitude of reasons, and experienced various barriers and challenges in receiving the care they desired. Nearly all participants shared a negative experience—or several—regarding their effort to have their sexual and/or reproductive care needs met by healthcare providers (e.g., primary care providers or family doctors, gynecologists, etc.).

For some participants, a barrier to accessing desired healthcare services was the negotiation of sexual and/or gender identity disclosure. Participants were unsure whether to disclose this information, and if it would be received with care. For example, after disclosing she was a lesbian, Emma [60s, white, lesbian cis woman, urban Atlantic Canada], experienced a shift in how her doctor treated her:

“

More than five years ago, I was referred to a gynecologist because during a pap test, they found some irregular cells, and they just wanted to have me checked out a little closer. When I went to see this gynecologist, and of course, they asked you your sexual history and he mentioned, do I have a husband or boyfriend? I was like, “No, I don’t, I’m gay and lesbian.” And the reaction was, “Oh,” and immediately, his body language and his tone of voice changed. And he looked at the stuff and he said, “Well, I don’t think there’s anything more we have to do here.” He just basically dismissed me, and I walked out of there.

”

As such, Emma’s healthcare was negatively impacted after disclosing her sexual orientation to her doctor. This experience importantly captures the risk that LBQ women, trans, and nonbinary people face in navigating identity disclosure in a healthcare setting: do they risk disclosing their identity and experiencing dismissal, and do they risk discrimination and stigmatization?

Overall, previous research has found that healthcare seekers with minoritized sexual identities are often reluctant to disclose their identities due to possible stigmatization and discrimination, even though they know disclosure is integral to holistic care, and this lack of disclosure can impact their overall sexual health and wellbeing (Law et al., 2015; Soinio et al., 2019).³

Even when there are visual signals of inclusivity in the space (e.g., rainbow stickers, pride flags), those seeking sexual healthcare cannot guarantee their experience will be positive and affirming. For example, Jace [20s, BIPOC, lesbian woman, urban Atlantic Canada] shared her experience at a women’s clinic, where she experienced stigma through persistent rejection of her queerness when her healthcare providers referred to her wife as a support friend—a denial of her lesbian relationship as a real relationship—and questioned her wife’s participation in her healthcare:

“ The journey started at the women’s clinic, which was a terrible experience—and I will tell anyone the reason why it was terrible—because there are of course rainbow stickers in the lobby and pride flags, and then the nurse practitioner and the doctor referred to my wife as my “support friend.” And they asked me why I needed my emotional support friend, even after me repeatedly explaining to them that she was, in fact, my wife, and she was present because she has half the information associated with the hell that is happening [to me].

”

Like these participants, those with minoritized sexual identities can feel invisible or invalidated within healthcare settings due to heteronormativity and assumptions about identities, relationships, and sexual behaviors. For example,

³ These impacts on sexual health and wellbeing can be serious and life threatening. For example, due to encountering sexual stigma—or fear of being stigmatized—in healthcare settings, LBQ women, trans, and nonbinary healthcare seekers can experience barriers in maintaining positive sexual health (Flanders et al., 2017), are less likely to receive appropriate cancer screening (Ragosta et al., 2023), have lower rates of pap testing and subsequent late detection of cervical cancer (McIntyre et al., 2010), and have lower use of early detection screening for breast cancer (Lacombe-Duncan & Logie, 2016).

Serina [20s, BIPOC, pansexual cis woman, suburban ON] shared her experience of heteronormativity within a healthcare setting:

“ The doctors usually say, “Are you sexually active?” And I’ll say yes. And they’ll say, “Okay, are you using condoms?” I’ll say, No. And they’re like, “Are you trying for a baby?” No. They’re like, “Okay, so you’re having unprotected sex?” And so I’m like, oh, sorry, I’m having sex with a cis woman right now. Like, it’s just all very heteronormative. ”

As highlighted by these participants’ experiences, lesbian and plurisexual⁴ women seeking sexual healthcare are often met with heteronormative biomedical understandings of sexual health for women (Munson & Cook, 2016) and a denial of lesbian sex as “real” sex (Lacombe-Duncan & Logie, 2016). These assumptions can even impact sexual health testing. For example, for Corinne [20s, BIPOC, bisexual woman, urban ON] this meant healthcare providers conducting an incomplete, or partial, panel of tests for STIs:

“ So this sexual health clinic that I found, I had actually found it for a male friend of mine. And he went and he told me that they swabbed his throat, they asked him if he wanted his anus swabbed. It was like, what? I’ve never heard that before, and I’m [in my 20s], I’ve been going to my doctor for paps and STI checks since I was 15 or 16. And I’ve never had my throat swabbed or anywhere else done. Like, I didn’t know that the panel was like that, and I was shocked. And I had mentioned it to her. And she basically said, “because you’re straight” kind of thing. Like, “because you don’t have those risks,” but who says that gay women aren’t having anal sex? ”

⁴ By plurisexual we mean sexual identities that are not solely based on attraction to one gender (e.g., bisexual, queer, pansexual, sexually fluid).

Beyond the erasure and invalidating experiences described above, bisexual and plurisexual women can also experience binegativity, bi erasure, and biphobia⁵ within sexual healthcare settings, wherein they can experience disease narratives (e.g., are assumed to be vectors of disease), hypersexuality narratives (e.g., are assumed to want sex with everyone/be interested in sex with everyone), and heterosexism (e.g., devaluation of same-gender relationships, assumption of heterosexuality) (Flanders et al. 2017). Further, sharing sexual history information with a healthcare professional is a vulnerable action, one that LBQ women, trans, and nonbinary people don't take lightly. For Lou [30s, white, queer/bisexual nonbinary, urban QC], their doctor made several comments about their sex life, and the participant perceived these comments as a personal judgement, reflecting:

“ I was talked to as if I were a “poor woman who doesn't know how to control her body. (Translated from French) ”

Meera [30s, BIPOC, bisexual cis woman, urban ON] shared her experience of these harmful biases and her sense of feeling judged:

“ The doctor asked how many partners I had, and if I had multiple long-term partners—which I did—and then started to talk to me about having less sex and being very careful about using protection with my partners [...] in part of that conversation with my health care practitioner, I said, “My partners are also men and women.” And that changed the tone of the conversation. When I disclosed to the doctor that I was bi, they said, “Well, that means you're having even more sex, then.” That's not what that means at all. It was really annoying to hear that because it

⁵ Binegativity is the prejudice and discrimination targeting bisexual people, and bi erasure is the systemic denial of bisexuality (see Flanders et al., 2017). Biphobia is defined as fear or hatred of bisexuality, often exhibited by name-calling, bullying, exclusion, prejudice, discrimination, or acts of violence (see Egale's 2SLGBTQI terms and concepts glossary at <https://egale.ca/awareness/terms-and-concepts-updated/>).

was untruthful and judgmental. And then the tone of the conversation changed completely to “if you don’t take care of yourself and start making better choices, your life is going to turn out really badly for you.” [...] I felt so targeted and felt so judged for a question that might have had something to do with the outcome of my healthcare, but when I answered honestly and identified myself as being a bi person I was met with judgement and recrimination.

”

This participant’s reflections of her experiences directly reflect these narratives around bisexual and plurisexual people being a ‘vector for disease,’ and the sexual stigma associated with bisexuality and the assumption of hypersexuality or having more sex. This type of stigma can impact healthcare seekers on an individual level, but also at a systematic or institutional level, and can create barriers to accessing holistic and appropriate sexual healthcare for bisexual and plurisexual women, trans, and nonbinary people.

This shaming and blaming of minoritized sexual identities and behaviors was not uncommon for participants. For Parker [20s, BIPOC, gender nonconforming lesbian, urban ON], this sexual shaming was tied up with racism, resulting in layered or intersectional stigma:

“

Because I’m Asian, and because there is a racial component to how sexuality—especially queerness—is very much whitewashed and is very much gentrified, the way that my physician has asked me questions, especially when it comes to sexual health, have been very targeted. I can give you one example. When I went in to get a cervical exam to screen for a pap smear to screen for cervical cancer, my physician asked me why. And I was like, “I’m 21. This is the time that we should start getting them.” And he’s like, “Yeah, but like, have you had sexual partners?” I’m like, “Yes,” and said how many, and he was like, “Wow, that many?” and I was like,

bro, like, fuck off. Like, first of all, that's just really, really disrespectful, that's so condescending. That's so rude.

”

Parker shares here not only an experience of sexual stigma by their doctor, but also a reflection of the role of race, sexuality, and gender in mediating healthcare experiences. Further, Parker's comment about the “whitewashing” of queerness speaks to how queer racialized people navigate their sexuality in institutions such as healthcare, where the pervading norms dictate heterosexuality and whiteness. As noted by Worthen (2020), this tension “affects the ways LGBTQ people of colour see themselves and the processes involved in their stigmatization” (p. 29).⁶

Whether participants experienced discrimination, invalidation, or stigmatization due to their sexual or gender identities, or feared being discriminated against on these grounds, these participant perspectives importantly shed light on what it means to navigate the sexual healthcare system as an LBQ woman, trans, or nonbinary person. From navigating disclosure with healthcare providers—and the aftermath of disclosure—to experiencing stigmatization for one's sexual behaviors, practices, and relationships, participants in this study experienced erasure, layered or intersectional stigma, and encountered harmful narratives (e.g., disease and hypersexuality narratives). Ultimately and across the board, participants experienced significant barriers in maintaining positive sexual health (Flanders et al., 2017).

LBQ women, trans, and nonbinary people seeking fertility and reproductive healthcare can also experience harms as a result of cisheterosexism in these healthcare settings, as well as the lack of culturally competent care from providers. Participants in this study who were seeking fertility and reproductive healthcare were met with harmful assumptions and stereotypes about their sexuality and gender, and that of their partner's. For example, one participant

⁶ The authors of this report will expand on these connections in a forthcoming paper.

shared her experiences of seeking to conceive with her partner, and when she attended appointments alone, she would often be met with cisheteronormative assumptions that her partner was a man. Another participant remarked that their identity is invalidated frequently at a fertility clinic that advertises itself as “inclusive.” Lou [30s, white, queer/bisexual, nonbinary, urban QC] shared that due to anticipated stigma, they don’t disclose their gender identity in reproductive healthcare settings:

“ I won’t go telling the insemination clinic that I’m a nonbinary person, you know, I have a uterus, I have a girlfriend, I want to be inseminated and all the rest, I have no choice but to just not talk about it out of fear that it will be a hindrance because it’s too complicated and that’s it, I want to achieve my goals much more than to have my gender identity respected, sadly. (Translated from French) ”

Often times, the perception of services at fertility clinics can be seen as targeting heterosexual women and couples due to a lack of information (e.g., on websites) for queer, trans, and nonbinary people. For Quinn [30s, white, queer/gay woman, urban Atlantic Canada], the lack of available information was a barrier to receiving her desired reproductive healthcare:

“ Recently, I’ve looked for family planning and support with reproductive health, and I feel like it is pretty much nonexistent in [my province] [...] the one fertility clinic that we did have access to didn’t accept our referral. So, when I went back to my family doctor and asked for more resources, she just said, “I don’t know where to send you or what to do, that was kind of the only place to go.” We have one fertility clinic in [my province] and when you look on the website, they don’t even have a page of resources for the LGBTQ community, they don’t state that as a reason that you would need to go access treatments. ”

For trans and nonbinary people, other factors impact their experiences of fertility services, or access to those services, such as the cost of fertility preservation—such as sperm or egg banking (Guss et al., 2021). For example, one participant noted that access to fertility preservation is expensive and a privatized service, therefore inaccessible to many trans people. Trans participants seeking fertility and reproductive services—and participants in relationships with trans partners trying to conceive—in this study experienced varied cost-related barriers. Mary [30s, white, lesbian trans woman, rural Atlantic Canada] shared:

“ In particular to this region, I feel like better access to reproductive health services would be nice. We have one clinic here, so as a consequence, waitlists are a problem. Also, in terms of reproductive health, it can be really cost prohibitive, especially as a trans person. When I was starting my transition, I was the opposite of financially stable. So, anything cost prohibitive was a total barrier to me. So early on in transition is when you’re making those decisions about securing your reproductive health, and a lot of the time, it’s not even a decision really, it’s just “Well, I just can’t afford that.” It’s not just a barrier. It’s like, it’s just no. ”

Cost is also a barrier for those who do not have access to insurance or provincially sponsored health coverage. For example, Zehra [40s, BIPOC, queer woman, urban ON] did not have access to provincially funded reproductive healthcare for many years because they were an immigrant to Canada. Zehra shared the intersecting stigma associated with being an older, racialized, immigrant woman trying to conceive:

“ When I was with my partner, and we wanted to have a kid, I didn’t want to have to make any attempt before I had a more secure status and access to health care , just in case for complications or anything else. And ”

that brings me to [an age in her 40s]. Which means that if you're a little bit, you know, aware of reproductive health, pregnancy, and there are those things, like, even after 35, everyone looks at side-eye, let alone at 40. Most of my interactions and encounters were with midwives. I also had to briefly deal with—before I got pregnant—the fertility clinics, just to make sure that that was something feasible for me, and ageism and ableism are the biggest two factors. Racism, yes, xenophobia, yes, they were all impacted. But at that point, ageism was the biggest, particularly when we were trying to get pregnant. And the other reason I avoided was also, obviously, that fertility clinics or anything to do with pregnancy is extremely based on heteronormative assumptions. I'm a queer woman, [my] partner's a trans person. So even that brief encounter to just get a few tests done was extremely stressful, because we were surrounded by assumptions and attitudes.

”

Participants in this study shared experiences of fatphobia, or weight bias, when seeking out sexual and reproductive healthcare. Weight bias is pervasive in healthcare settings and in provider-patient encounters, resulting in experiences of prejudice, dehumanization, and discrimination for larger patients. For many participants, the discrimination or bias they faced by medical care providers was a barrier to experiencing their desired healthcare outcomes, resulting in harmful and distressing healthcare experiences. For example, Tori [30s, BIPOC, Two Spirit, bisexual, genderfluid, urban MB] experienced fatphobia by her doctor who only focused on her weight as the root to all of her problems, including polycystic ovary syndrome (PCOS) and her reproductive issues. In self-advocating for a hysterectomy, she was turned down and told to lose weight. She shared:

“

He constantly tells me that I'm morbidly obese and that I need to lose weight, and all of my medical issues, which are like, reproductive issues,

are all because I'm fat [...] I understand that my weight coincides with my reproductive issues to a point, but I guarantee that my ovaries not working at all has not everything to do with my weight [...] When I talk to him about PCOS, or what that might look like for me, or any of those concerns around it, he's like, "no, no, no, no, it's just your weight." I'm like, that's not valid, that's not correct.

”

Annette [30s, white, lesbian woman, urban QC] had a similar experience:

“

You can be subjected to fatphobia, like “You have such and such problem, maybe you should start by losing weight” and in the reproductive procedures I went through, I wasn't required to see a nutritionist, but they recommended I do. (Translated from French)

”

The push to lose weight, exercise, and even see a nutritionist was not unfamiliar to other participants. Jace [20s, BIPOC, lesbian woman, urban Atlantic Canada], after weeks of her pain not being taken seriously by doctors, had to have immediate surgery to remove a part of her reproductive system. Despite asking her healthcare providers to investigate whether she had endometriosis—a diagnosis she had been seeking for several years—at the same time as her surgery, they did not look into this during her surgery, and referred Jace to an endometriosis clinic in a neighboring province. When Jace looked into this option, she realized it would never be an option:

“

[The clinic] has decided they're not taking referrals, but that's not true, they're taking certain ones [...] If you look at the demographics of who they are taking, it is white women between the height and weight of da-da-da, and it's controllable variables, they are not actively engaging in

work with larger bodies or women of colour at all, at all. [...] They're like, oh, we don't know what to do with your Black genetics, so we're not going to risk our trial in our study on figuring that out.

”

Later, when Jace was recovering from surgery and asking her doctor for help managing knee pain (related to a chronic health condition), she was told to lose weight, despite Jace saying that exercise wasn't possible post-surgery, and she was eating in a very healthy way. The participants' experiences are a perfect example of “fat broken arm syndrome” is where a healthcare provider would attribute a fat patient's health concerns to their weight, similar to how “trans broken arm syndrome” is when a healthcare provider attributes a trans patient's health concerns to their transness (Paine, 2021). Healthcare providers are not able to see past the patient's weight.

As a whole, participants desired sexual and reproductive healthcare that was free from judgement and discrimination, and for patient-centered care that was accessible, affordable, timely, and culturally safe. Instead, their experiences were overwhelmingly challenging and fraught with cisheteronormativity, biphobia, sexual shame, racism, and fatphobia. While affirming experiences were less frequently shared, these experiences were marked by providers respecting, listening to, and believing care seekers, and affirming their multifaceted identities and lived experiences.

For those seeking sexual and reproductive healthcare, their experiences of harm, perceived lack of service options, and lack of culturally competent care is documented in extant literature (e.g., Carpenter, 2021; Corbett et al., 2013; Luxion, 2020; Yager et al., 2022). Participants also experienced medical paternalism which was enacted via the dismissal and denial of their own body knowledge and self-understanding of the issues that brought them to seek care, as well as medical pathologization via fatphobia or weight bias (McPhail & Bombak, 2015; Paine, 2021). Due to systemic challenges in our

current healthcare system or a lack of available services, participants were not always able to access the sexual and reproductive healthcare they needed and wanted. When they were able to access care, their sexual and reproductive healthcare trajectories and experiences were impacted negatively by cisheterosexist assumptions about their identity, behaviors, and relationships.

Gender-Affirming and Transition-Related Healthcare for Trans and Nonbinary People

In this project, approximately half of participants were trans, nonbinary, or gender nonconforming. Many of these participants reflected on whether their healthcare was gender-affirming, and some who sought out transition-related healthcare (e.g., surgeries, procedures, HRT) experienced challenges and barriers. In the literature, it has been reported that TNB people face myriad barriers in having their primary—and for some, their transition-related—healthcare needs met. Some barriers are systemic. For example, TNB people in Canada are less likely to have a family physician or primary care provider (Scheim et al., 2021; Ziegler et al., 2020). Other barriers are related to negative interactions with care providers, such as experiencing marginalization, stigmatization, and discrimination, or in the lack of available services (Boyer et al., 2022; Ziegler et al., 2020). It can also be difficult as a TNB person to find an affirming and competent healthcare provider as there is a limited number of practitioners who are adequately knowledgeable⁷ (Holloway et al., 2022; Ziegler et al., 2019; 2022) in transition-related or gender-affirming healthcare. The pandemic has also intensified these healthcare barriers. For example, it has impacted access to hormone therapy, caused delays in gender-affirming surgeries, and decreased access to healthcare providers (Grey et al., 2023).

When TNB people navigate healthcare settings, they are often up against a cisheterosexist system. From intake onward, healthcare forms and electronic medical records often force TNB people into a binary sex essentialist system,

⁷ Here, adequately knowledgeable is about being aware of relevant medical aspects and procedures (including but not limited to transition-related healthcare) for trans and nonbinary care seekers. It can also include cultural competency, sensitivity, and awareness of health issues and priorities for TNB care seekers.

not allowing name updates and pronoun indication, and using highly gendered language (Gómez et al., 2022; Hurren et al., 2023; Ziegler et al., 2019; 2020). This often leads to misgendering, deadnaming, and harmful interactions with healthcare providers and staff. For example, Claude [50s, white, nonbinary, femme-attracted, rural QC] shared:

“ It’s at intake, the first thing is when you’re a person who is starting their gender affirming care process or who is in transition, to get people to use your chosen first name and your pronouns, the way you want to be gendered, it’s an ongoing battle [...] even though you make notes on the papers and forms and all that, they’re always mixed up, they tell you, “We can’t use your first name, because it’s not the same as the one on your health card” [...] it adds anxiety and pressure to the whole situation. (Translated from French) ”

Several participants also spoke about the struggle for the healthcare providers and staff to use non-gendered pronouns like “they” and “iel.” Max [30s, white, pansexual, trans nonbinary, urban QC] shared:

“ In my case, I use the pronoun “iel” so sometimes, before they call out my name, they call me ‘Mr.’ when I am waiting somewhere. I’ll often go tell people, and it’s not always respected. (Translated from French) ”

Dion [18, BIPOC, pansexual, nonbinary, rural MB] shared:

“ I’m nonbinary, no one ever uses my pronouns in the hospital [...] there are so many confused looks, especially because it’s not like traditional pronouns, it’s not common enough, I guess, but using “them” seems to be harder for people for some reason. ”

Trans and nonbinary people report anxiety around gender identity disclosure in healthcare settings, noting fear of discrimination, expectations of negative experiences, and feeling unsafe (Gómez et al., 2022; Ziegler et al., 2019; 2020). Many TNB people avoid seeking healthcare due to negative experiences and anticipated discrimination. Specifically, lived experiences of invalidation, misgendering, deadnaming, mistreatment, non-affirming care, verbal harassment, and victimization within the healthcare setting are directly associated with care avoidance for TNB people (Boyer et al., 2022; Eiduson et al., 2022; Goldberg et al., 2019; Kattari et al., 2021). Participants in this study described feeling anxious, uncomfortable, fearful, intimidated, stressed, and worried about accessing care as a TNB person. Claude [50s, white, nonbinary, femme-attracted, rural QC] said it simply:

“

Accessing healthcare services is intimidating for gender diverse people.
(Translated from French)

”

These fears and anxiety are not groundless. TNB people report that providers lack understanding and are not informed about trans and nonbinary identities and healthcare needs (Goldberg et al., 2019), that TNB people are misgendered and deadnamed by healthcare providers and staff (Boyer et al., 2022; Eiduson et al., 2022), and for nonbinary care seekers in particular, that their healthcare needs are framed within a binary trans framework, often leaving their unique healthcare needs unaddressed (Lykens et al., 2018). For example, Spencer [30s, white, queer/grey ace, transmasc nonbinary, rural Atlantic Canada] shared:

“

I'm constantly misgendered, there's not one single space I can walk into without being misgendered, which is incredibly difficult. It makes me not want to access any care.

”

Mary [30s, white, lesbian trans woman, rural Atlantic Canada] explained their hesitancy to seek care because of their fear of poor treatment:

“ Just being trans makes me really anxious anytime I have a first interaction with someone, because I don’t know how they’ll treat me as a trans person. [...] I’m constantly worried how I’ll be treated beforehand, which makes me a lot more hesitant to seek care, because I’m worried that I won’t be treated well. ”

KT [30s, BIPOC, queer/pansexual, nonbinary, urban ON] shared that it’s stressful to seek out care because of anticipated discrimination or negligent healthcare experiences rooted in “trans broken arm syndrome.”⁸ They shared:

“ It’s so stressful to go and seek out health care, sometimes just because you run that risk of being deadnamed, and you run the risk of being misgendered, and disrespected. Not even being able to access the care because of trans broken arm syndrome or just the care provider’s ignorance and not really being able to provide competent care, especially if it’s gender-affirming care that you’re seeking. ”

Because of practitioners and staff being generally uninformed about TNB healthcare needs, some trans and nonbinary care seekers take on the burden of educating their healthcare providers (Boyer et al., 2022; Holloway et al., 2022; Ziegler et al., 2019; 2020)—a role that is particularly taxing when one’s healthcare concerns are unrelated to gender identity (Goldberg et al., 2019) or when you are TNB and navigating “women’s” health care settings (Gómez

⁸ Trans broken arm syndrome is when a transgender or nonbinary patient’s symptoms are misattributed to their transgender status (Wiegand et al., 2023) or when “trans people seek care for a health concern unrelated to gender, but providers dismiss the concern as a consequence of being trans” (Paine, 2021, p. 4). An example from Wiegand et al. (2023) was when a nonbinary patient’s pain was attributed to their hormone replacement therapy.

et al., 2021). For example, Denver [30s, white, queer/gay transmasc/trans guy, suburban MB] shared:

“ My family doctor has fortunately been supportive, but I was the one who had to point out to her all the resources that were available for starting me on hormone therapy, she didn’t know any of that before. ”

Having uninformed healthcare providers could also lead to providers doing harm to TNB patients. Spencer [30s, white, queer/grey ace, transmasc nonbinary, rural Atlantic Canada] shared that their health was put at risk by having health care providers that were uninformed:

“ There were several times where my health was put at risk, because it turns into this thing, where, as a trans person, you have to advocate for yourself, you almost have to know more than the doctors know. ”

Lastly, Finn [30s, white queer, transmac/genderqueer, suburban Atlantic Canada] used a good analogy when rightly pointing out that physicians can’t claim ignorance for other health concerns such as diabetes:

“ Say you were a new physician, and you said, I was recently diagnosed with diabetes, and they reply “I never dealt with diabetes before, find someone else” you know that wouldn’t be right. You can’t do that. If you’re lacking knowledge, you are the healthcare provider responsible for finding that knowledge. It shouldn’t be up to patients or organizations to develop resources. ”

Another barrier—often exacerbated by one’s geographic location—includes the need to travel for transition-related care, if one can afford to. Many TNB people need to travel out of province, or long distances to access their desired healthcare and gender-affirming care (Holloway et al., 2022; Ziegler et al., 2019; 2020); due to a lack of available clinics performing life-saving gender affirming care, some even have to travel out of the country (Koch et al., 2020). In Canada, several provinces and territories either have only one trans health clinic, or in some cases, TNB people must travel out-of-province to access gender-affirming care. Spencer [30s, white, queer/grey ace, transmasc nonbinary, rural Atlantic Canada] shared that, because they lived in a rural part of their province, it was difficult for them to get access to a specialist (as part of their gender-affirming care team). Spencer shared:

“ It’s a five-hour trip, one way, into the city; I don’t drive, so it’s a financial barrier, it’s access to transportation, there’s all kinds of issues. ”

For participants who had to leave their province or territory, there were out-of-pocket costs for care. For example, Finn [30s, white queer, transmac/ genderqueer, suburban Atlantic Canada] had to leave their province to access gender-affirming care. At that time, their provincial care insurance did not cover these costs, so Finn had to pay out of pocket. Further, with the troubling trend of privatized healthcare, some participants feared not being able to access gender-affirming care due to financial barriers. Anusha [30s, BIPOC, pansexual/bisexual trans woman, urban ON] shared:

“ I haven’t had access to healthcare because it seems like there are a lot of services that I need that are privatized [...] I don’t have access to [OHIP] and I don’t have access to health benefits. ”

For those who can access transition-related healthcare, there are often long wait lists (Ziegler et al., 2019; 2020) and unexpected costs when procedures are not covered by one's province or territory (Koch et al., 2020). Several TNB participants shared their experiences with long wait times for gender-affirming care, from taking months to get a call back from a clinic, to waiting years for surgery or hormone replacement therapy (HRT). Participants shared that these long wait times were demoralizing, made them feel hopeless, and it had a negative impact on their healthcare and mental health. Claude [50s, white, nonbinary, femme-attracted, rural QC] shared:

“ It took four months for the first clinic to call me back. That's too long. When you've gotten to that point, when you are at the point of wanting to get health care related to your gender identity, it's not in six months, a year—that just makes suicide rates go up—it's right then that you need treatments, but it seems it's not important, it's like, not important enough. (Translated from French)

”

Jyoti [20s, BIPOC, nonbinary lesbian, urban MB] shared that they had been waiting two years for gender-affirming surgery and is expecting to wait another two more years. Jyoti said:

“ I think it does have real impact on people's mental health, even for myself.

”

For Anusha [30s, BIPOC, pansexual/bisexual trans woman, urban ON], she had been passed from provider to provider, and had been waiting a long time to start HRT. She said:

“

It's been really stressful because I need these surgeries to be able to go on, day to day. It's a time sensitive thing, it's not something I can really just like wait for months and months and months.

”

The COVID-19 pandemic has had a global impact on healthcare services and care seekers (e.g., avoiding primary care, see Tami et al., 2022). The pandemic also increased the availability of and access to virtual or telemedicine for Canadians, and TNB people—particularly those with chronic health conditions and anxiety—preferred virtual care over in-person care (Navarro et al., 2022). In the current study, a few participants spoke to the positive benefit of accessing healthcare over the phone—a new option since the onset of the pandemic—and how this removed several healthcare barriers. For Spencer [30s, white, queer/grey ace, transmasculine nonbinary, rural Atlantic Canada], this meant not having to travel to appointments a great distance away, as well as avoiding fat shaming that could occur in in-person appointments. He shared:

“

On the plus side, my endocrinologist who is five hours away, I haven't seen in person with COVID, so those [appointments] got to be phone calls, which is great for me because it meant I wasn't paying for shuttle service back and forth to the city and having to pay for accommodations. It also cut out all the other fun little nuanced things that I had to deal with at those appointments in person, you know, like fat shaming.

”

For Denver [30s, white, queer/gay transmasculine/trans guy, suburban MB], virtual care options meant convenience and flexibility as someone working full-time. They shared:

“

As someone who has to work full time, eight hours a day, to afford my living space, I do appreciate how virtual appointments offer a bit more convenience and flexibility [...] not having to take all that extra time out of my already very busy day when I'm already exhausted. It's one good thing that's come out of COVID.

”

Therefore, while the pandemic has had myriad negative impacts on the healthcare system, it did also enable new options that increased access to healthcare for TNB and other participants in this study.

Altogether, negative experiences and anticipated discrimination leading to care avoidance, or delay in seeking care, have a huge impact on the health and wellbeing of TNB people. One's healthcare experiences—as well as the anticipation of poor or harmful healthcare interactions—has a negative impact on future use of care and the uptake of medical treatment. Further, that TNB people as a whole are less likely to have a family physician or primary healthcare provider, as well as the general lack of services for gender affirming-care, means that their primary and gender-affirming healthcare needs are not being met. TNB people also report additional barriers to accessing healthcare, such as long wait times, limited specialists, having to travel for transition-related healthcare, and the increasing out-of-pocket costs and the privatization of transition-related healthcare. TNB people accessing care also report anxiety around gender identity disclosure, experiences of being misgendered, deadnamed, and discriminated against, the challenge of having care needs met with uninformed healthcare providers and bearing the burden of educating practitioners and staff. All of these factors compound and intersect in ways that produce an inaccessible and harmful healthcare system for trans and nonbinary care seekers all across Canada.

Mental Healthcare

A growing body of research shows that LBQ women, trans, and nonbinary people are disproportionately affected by mental health burdens (Dürrbaum & Sattler, 2020; Hatzenbuehler, 2009). For instance, studies indicate higher rates of posttraumatic stress disorder (PTSD) among plurisexual women (Walters et al., 2013) and transgender and nonbinary people (James et al., 2016). These populations also experience higher rates of anxiety and mood disorders (Borgogna et al., 2019), substance use disorders (Whitehead et al., 2016), body image concerns (Mason et al., 2018), eating disorders (Watson et al., 2016), and suicidality (Dunlop et al., 2020). Some of the main reasons for these mental health disparities are discrimination and stigma (Hsieh & Shuster, 2021), with plurisexual LBQ folks facing unique forms of stigma, such as binegativity and monosexism (Schulman & Erickson-Schroth, 2019) as well as harmful stereotypes (e.g., that plurisexual people are sexually promiscuous) (Brewster & Moradi, 2010). Stigmatization can lead to higher rates of poor mental health among plurisexual people relative to heterosexual and gay/lesbian (i.e., monosexual) individuals (Ross et al., 2018; Salway et al., 2019). Similarly, racialized—particularly multiracial—LBQ individuals experience negative mental health outcomes as a result of intersecting marginalization and invisibility (Felipe et al., 2022). Compounding these stereotypes are barriers LBQ women, trans, and nonbinary folks face when seeking or accessing mental healthcare, including fears of being denied mental healthcare or mental healthcare providers' lack of education about their needs (Schulman & Erickson-Schroth, 2019).

Participants' experiences seeking and accessing mental healthcare in many ways mirrored their experiences with primary, sexual, reproductive, and transition-related care. The main issues highlighted by participants when sharing mental healthcare experiences were widespread dismissal of their mental health concerns, inaccessibility of mental health services, and the damaging impacts of mental healthcare that is rooted in paternalistic,

biomedical, and colonial frameworks. One of the most cited issues in participants' discussions of seeking and/or accessing mental healthcare was not being taken seriously or of being dismissed. For example, Anusha [30s, BIPOC, pansexual/bisexual trans woman, urban ON] shared that she often felt like mental healthcare providers were uninformed about her needs and, as a result, felt like they wanted to "shoo [her] away and refer [her] to someone else." Anusha went on to describe how it took her a long time to realize she needed and would benefit from mental healthcare. However, when she finally accessed care, her mental health concerns were dismissed as simply the result of a busy school schedule or work-related. Naomi [30s, BIPOC, queer woman, urban ON] also felt that her mental health concerns would not be taken seriously unless a healthcare provider decided that they were serious, creating labour for her to "perform" the seriousness of her concerns to ensure that she received treatment:

“ I found a lot more barriers in terms of accessing mental health services, in [that] it just kind of feels like there's a lot of hoops to jump through. And it has to be something that's critical, where you're literally calling either—whether your doctor, like for example, decides that you cannot be left alone. So it has to be something that you have to perform, or you have to actually be a danger to yourself before it's actually taken seriously. ”

Providers' stigma toward those with mental health concerns also factored into participants' experiences of being dismissed. Claire [20s, BIPOC, bisexual/pansexual trans nonbinary, urban BC] shared how a previous hospitalization due to a mental health crisis had "followed her," creating barriers for every subsequent health visit, even if it was for an unrelated issue. She noted:

“ I was actually hospitalized for a very long time due to my mental health. And after this whole thing of being diagnosed, it's followed me every

time I seek health care . So even though I'm going to the emergency for something totally unrelated, like, I was having chest pains, [but] because they saw my history of being in the hospital and having all of these mental illnesses and whatnot, they didn't take it seriously. So there's this barrier that follows me everywhere, like no one takes me seriously anymore [...] because of my diagnosis, it just follows me everywhere. ”

Claire's experience highlights how medical gaslighting, as discussed earlier, intersects with mental health stigma to create compounding barriers for LBQ individuals living with mental health concerns. Indeed, she went on to describe how she was concerned that healthcare providers' interpretations of her as 'mentally unstable' was connected to her sexual identity, sharing that after she had come out to providers, they did not take either her identity or her mental health concerns seriously. Supporting this connection Claire made, previous research has similarly found that stigmatization due to sexual identity and mental illness are interrelated (Kidd et al., 2011). Specifically, pathologizing 2SLGBTQI identities may lead providers to conflate them with mental health problems, leading to ineffective and damaging treatment (Hudson-Sharp et al., 2016).

Inaccessibility was the second concern raised by participants in their discussions of mental healthcare. The unaffordability of most mental healthcare was a commonly noted access barrier, with multiple participants discussing the high cost of mental healthcare (alongside costs of dental and vision care, as highlighted in the 'primary care' section). Affordability-related barriers seemed to intensify with age, as both Anusha [30s, BIPOC, pansexual/bisexual trans woman, urban ON] and Emily [20s, BIPOC, bisexual/pansexual woman, urban ON], respectively, discussed:

“

I don't really get health benefits or anything like that. So every dollar kind of counts, [...] especially when it comes to mental health care and things like that. Once you're past 30, it seems like not a lot is available to you, for free at least. (Anusha)

”

“

Therapy is not covered by our healthcare, and it's so fucking expensive... so expensive. And I've been pretty lucky in the past, that my parents have been able to pay for that for me, but now, going forward as an adult, I would have to pay for that. And it's literally something that I can't really afford at all. [M]y university pays for like, four sessions per year [but] I need more than that. (Emily)

”

A lack of 2SLGBTQI- responsive and -affirming services was another access barrier to mental healthcare. Worsened by fragmented approaches to care, the lack of affirming mental healthcare put the burden on participants to navigate the system as best they could. These navigation practices required significant emotional and mental labour and came with a mental health toll. Sofiane [20s, white, bisexual, nonbinary, urban QC] when asked to describe their experiences accessing healthcare, shared the retraumatizing effect of psychiatric approaches to gender:

“

For me, the words that came to mind were winding, like a road [...] you really have to learn to navigate different resources that are unconnected, whereas they should be. [F]or example, in psychiatry, gender issues are not taken into consideration at all; there are some retraumatizing experiences that are never really taken into consideration.

”

Similarly, Lou [30s, white, queer/bisexual, nonbinary, urban QC] described avoiding any mention of their gender and sexuality in interactions with psychologists in efforts to avoid being pathologized (i.e., having their gender or sexuality be framed as the ‘root cause’ of their mental health concerns):

“

[F]or a long time I completely avoided the subject of gender orientation and identity because that wasn't why I was seeing a mental health professional and I didn't want them to tell me that I was unhappy because I wasn't affirming myself sufficiently in my gender or [...] to push the consequences of what I was experiencing onto the wrong cause. So, this meant that I was so afraid of that happening or, among other things, through bad experiences, that I flat out avoided that issue in my interactions with psychologists, so that it wouldn't become—I don't know how to explain it—an easy solution for them to say, “Ah, you're fine, but because you don't assume your identity enough, it's because you aren't comfortable with your bisexuality, it's because you aren't comfortable with your gender identity,” whereas that had nothing to do with it, that wasn't at all the reason that I wasn't doing well. You know, hiding part of yourself, when you're navigating the health care system, becomes an automatic reflex.

”

Even participants who would presumably have fewer access barriers due to self-described economic privilege had experienced difficulties finding 2SLGBTQI-affirming services. For instance, Quinn [30s, white, queer/gay woman, urban Atlantic Canada], who despite working in government mental health services herself, shared:

“

I found it really hard to find someone to talk to that could understand where I was coming from, [and] the issues that I was facing.

”

Another participant, Alyssa [30s, white, queer/lesbian cis woman, urban Atlantic Canada] repeatedly highlighted her privilege in having the funds to access queer-friendly mental healthcare online, given the lack of competent providers in her area:

“

I was also finding there's no queer service providers around [who] are queer friendly [...] they're friendly, but it doesn't mean that they can understand your experience or what you're there to talk about, or the barriers you are facing, you know, they're empathetic, but they might not get it. So, yeah, unfortunately, I've had to use that privilege to source out queer therapy that is online, and it's through a practitioner in the States.

”

Like Alyssa, Emily [20s, BIPOC, bisexual/pansexual woman, urban ON] contended that her economic privilege was not enough to access some of the mental healthcare she was seeking:

“

It's still not super easy to get diagnostic testing for things like ADHD, that's something I wish I could get, but I don't have like \$1,200 lying around.

”

Dallas [30s, white, queer, nonbinary, urban SK] also noted how despite psychiatry being very inaccessible in their province, their profession granted them privilege in both access to and quality of mental healthcare:

“

In my province, psychiatry is very inaccessible to a lot of people. And I recognize that, based on the work I do, that [it] brought me some privilege and connecting with somebody just because I myself also work in healthcare. And that provider has always been quite respectful, [when] I've talked about anything regarding my gender or my sexuality; [they] were ecstatic when I got a new girlfriend. It was nice to have that actual

relationship, where a provider could be happy about that and celebrate that with you.

”

While it is promising that some participants had positive mental healthcare experiences, framing high-quality mental healthcare as a privilege rather than a right reflects broader structural problems, such as federal underfunding of mental healthcare (Raycraft, 2023) and widespread views that mental health is less important than physical health (Ollivier et al., 2021). In fact, some participants referenced these structural access barriers, which compounded cost-related barriers. Such issues included a lack of investment in mental healthcare, a lack of resources, difficulty finding mental healthcare providers, and long waitlists, as Denver [30s, white, gay/queer trans masc/trans guy, suburban MB] described:

“

I do wish that mental health was more of a priority because the healthcare system in general, like in [small town in Atlantic Canada], to get mental health care , it's something that you really have to seek out yourself. And it's often difficult to find the therapist, and their waitlists are often very long [...] it's something that's so difficult to access and often overlooked and never even suggested by a lot of healthcare providers. [A] lot of the time, people here have to pay out of pocket, and if it was more accessible, that would be good.

”

Another structural access barrier emerges from the relationship between primary and mental healthcare: as described earlier in this report, primary care providers are often gatekeepers to other forms of healthcare, including mental healthcare. For some participants, such as Anusha [30s, BIPOC, pansexual/bisexual, trans woman, urban ON], primary care gatekeeping, combined with

gaps in referral processes, heightened barriers to obtaining necessary mental healthcare:

“ [Doctors] sometimes would say things like, ‘Okay, if you really want, we could refer you to a psychiatrist’. And I’d say, ‘Sure, let’s try that’. And then I would never get a call back from those referrals. And sometimes I would talk to doctors who would say they don’t want to help me because I needed a family doctor because I didn’t have a family doctor at the time. ”

Difficulties in accessing mental healthcare described by participants is troubling, as research has found that the lack of access to inclusive mental health services—particularly for trans and bisexual women and gender diverse people—are a contributing factor in elevated levels of depression, suicidality, and other mental health concerns (Steele et al., 2017; Cronin et al., 2021).

A third theme emerging from participants’ reflections on their mental healthcare experiences was how paternalistic, colonial, and biomedical approaches to mental healthcare created intersecting and compounding barriers to care. Just as in primary care settings (see also Boyer, 2017), participants highlighted how mental healthcare replicated racist assumptions of racialized patients as simultaneously “weak” while also “supernaturally strong”. The assumption about racialized patients as weak is based on paternalistic racism which frames racialized groups as inferior and in need of “saving” (see Gebhard et al., 2022), while the latter assumption stems from providers’ biases regarding higher pain thresholds among racialized patients (e.g., beliefs that Black people have less sensitive nerve endings, thicker skin, and stronger bones, see Jones et al., 2020). An experience shared by Preeti [20s, BIPOC, queer woman, urban ON] highlights these paradoxical biases against racialized folks seeking care, and how ignoring the role of colonization in shaping racialized clients’ experiences of mental health and healthcare simply perpetuates these biases:

“

[B]eing a racialized woman, or racialized, disabled person, there are certain images of what the quintessential patient looks like [...] So I feel like sometimes there's an assumption that I am, especially in mental health spaces, in need of a certain kind of saving. Or I remember I was talking to this RN about ADHD, and I was talking about the history of mental illness in my family. And I was like, 'Oh, I personally think there is, but because of the stigma of it, lots of folks don't talk about it. [But] I'm able to identify patterns, now that I'm older and able to reflect on how folks have grown up. And I'm able to make assumptions about patterns of depression or anxiety or PTSD, whatever that might be'. I had mentioned this candidly, that folks don't talk about it [...] And I think this nurse was just not really thinking about what she was saying, but she was like, 'oh, yeah, I can definitely see how different cultures might have different ways of talking about it'. And I was like, 'Okay, please do not get it twisted. This is absolutely because of colonization, and not an inherent thing in racialized communities'. So I think little things like that, there's really a lack of cultural competency [...] it's really a reality of living in a post-colonial world. I think it's so vast and often really contradictory. I feel like there's often this stereotype of supernatural strength, but also incredible weakness and how that especially is navigated [...] It's not logical, but I think it's often contradictory, which I think makes it even more difficult to navigate, because I think sometimes you don't really know what to expect, because you don't know what end of that stereotype or bias you're gonna experience.

”

The stereotypes and biases which racialized 2SLGBTQI people encounter when accessing mental healthcare create uncertainty, frustration, and worsen mental health outcomes (Bastos et al., 2018). For example, encountering racism or racial bias has been shown to significantly predict barriers to accessing and maintaining mental healthcare by causing distrust and fear of further

discrimination (Dawes et al., in press). This relationship illustrates the necessity of explicitly anti-racist approaches to 2SLGBTQI mental healthcare.

Even when not explicitly linked to colonialism, some participants' experiences clearly revealed how biomedical approaches created unsafe and harmful mental healthcare environments. For instance, Tori [30s, BIPOC, Two Spirit, bisexual, genderfluid, urban MB] described their experiences in a crisis center:

“ [T]hey keep you in a room for 24 hours [...] And then they put you into a stability unit. But it looks and feels like a hospital, and you have a locker and a really awful bed, and a really awful room. You're there for about a week, [...] there's a whole bunch of other very unstable people there with you while you're feeling rather vulnerable and unstable. It's just messy and it doesn't feel nice, [and] it doesn't feel like a safe place to restabilize, regroup, and recenter. It's homophobic and fatphobic at the same time as well. ”

Experiences like the one Tori shared illustrate how biomedical approaches to mental healthcare can worsen, rather than improve, feelings of instability and vulnerability. Homophobia and fatphobia in crisis centers intensify these feelings of vulnerability. As a result of intersecting forms of discrimination, as well as pathologization of 2SLGBTQI identities in mental healthcare settings (see Rees et al., 2021), participants like Annette [30s, white, lesbian woman, urban QC], described anticipatory anxiety when entering mental healthcare spaces:

“ The symbolic associations surrounding mental health and hospitals trigger [my] anxiety beforehand [...] they had brought up my sexual orientation. I can't quite remember the words, but there was something that bothered me about the doctor, something that he said. I don't know, it's as though, like, my sexual orientation was synonymous with instability. ”


As participants' experiences shared above illustrate, accessing mental healthcare has unfortunately been characterized by dismissal, intersecting stigmatization, inaccessibility, and a lack of safety. These negative experiences are in large part why LBQ women, trans, and nonbinary people delay or avoid mental healthcare (Matouk et al., in press). Ongoing discrimination and stigmatization within mental healthcare settings amplifies the mental health disparities these groups already experience.

Complementary & Alternative Medicine and Mutual Aid

Taken together, the LBQ women, trans, and nonbinary people with whom we spoke with shared healthcare experiences characterized by emotional and mental labour, medical gaslighting, inaccessibility, and lack of safe, affirming care. Participants also shared numerous examples of stigmatization, marginalization, and discrimination from providers in various healthcare settings (e.g., primary care, sexual healthcare, reproductive healthcare, transition-related care, and mental healthcare). These structural issues and systemic failure serve as “push factors,” influencing LBQ women, trans, and nonbinary people to turn toward complementary and alternative medicine (CAM), community-based care, and mutual aid networks to seek information and healthcare (Goldberg et al., 2018). The total frustration regarding the inability of ‘the system’ to meet their needs is exemplified by Sidney’s [60s, white, lesbian/dyke woman, urban BC] poignant statement:

“ This is really about systems. But if we wait for the systems, I’ll be long dead, and I need it to start working for me now. ”

Although participants in this project did not speak at length about CAM or community-based care such as mutual aid, previous research has shown that 2SLGBTQI people seek care and services outside the mainstream healthcare system in efforts to increase their access to queer-informed providers and



to gain control over their care (see Carpenter, 2021). LBQ women, trans, and nonbinary people who are racialized may be especially likely to look outside of the healthcare system, given the historical and ongoing role of biomedicine as an instrument of colonization and the resulting damage inflicted on racialized communities (Cerezo et al., 2021). However, since CAM is infrequently covered by insurance providers (again, a byproduct of colonial systems), access to these services requires significant out-of-pocket expenses. Like advocacy, then, being able to navigate care outside of established channels and settings is dependent on one's socioeconomic privilege and social locations.

Beyond considering access barriers to CAM and community-based care, it is important to reflect on what pushes people away from “mainstream” (i.e., western, biomedical) healthcare in the first place. This report has highlighted access barriers and difficulties obtaining affirming, high-quality care, but it is likely that at least some LBQ women, trans, and nonbinary people—particularly those who are racialized—consciously avoid western biomedicine because of the harm it has caused them and their communities. Consequently, the recommendations we put forward below stem from an explicit acknowledgment and criticism of the ways in which healthcare systems can perpetuate structural racism by stigmatizing and discriminating against intersectionally marginalized LBQ women, trans, and nonbinary individuals. Further, any adequate intersectoral action to improve access to healthcare for these populations requires critical reflection on how systems of oppression (e.g., racism, sexism, cisheterosexism, and ableism) intersect to shape access to and experiences of healthcare.

Recommendations

Stigma and minority stress experienced by LBQ women, trans, and nonbinary individuals occur on individual, interpersonal, and structural levels (Hatzenbuehler & Pachankis, 2016), creating healthcare access barriers. Participants in this study shared countless examples where their access to—or experiences of—healthcare services were problematic, harmful, and discriminatory. Altogether, participants shared nearly one hundred recommendations for change or action (see Figure 1). Further, we organized them thematically and have put forward multi-level recommendations to address these healthcare access barriers for LBQ women, trans, and nonbinary people in Canada.

Figure 1. Participant recommendations.

- Inclusive forms and IT systems
- Pronouns on name badges
- Safer waiting areas
- Anti-misogynistic healthcare
- Stigma-free healthcare
- Anti-racist policies
- Anti-transphobic policies
- Ask for and use our pronouns
- Check your assumptions
- Incentivized training
- Comprehensive training
- Shame-free sexual healthcare
- More robust medical school training
- Strengths-based education and training
- Queerness as health-promoting
- Better asexuality education for healthcare providers
- Healthcare free from weight bias
- Greater access to inclusive information and resources
- Access to translators in healthcare settings
- Universal access to healthcare regardless of citizenship status
- Greater access to trauma-informed mental health services

- Reduced wait times for all forms of care
- Reduced wait times for gender-affirming care
- Greater access to inclusive reproductive services
- Healthcare navigator roles
- Investment in community clinics and centers
- Recruitment and retention of bipoc and 2slgbtqi people
- Increase supply of physicians, family doctors, nurse practitioners
- Address healthcare provider burnout
- Recognition and valuation of non-western medicine

Multi-Level Recommendations

For Education & Training

- Include mandatory content on LBQ women, trans, and nonbinary health in health professions education curriculum, including in medical schools and nursing, social work, midwifery, and personal support work programs.
- Include mandatory training content on how systems of domination (e.g., racism, fatphobia, and cisheterosexism) are interrelated, and provide actionable strategies on how to combat these systems at multiple levels (e.g., interpersonal, organizationally, and structurally) in healthcare and other service settings.
- Mandate training and ongoing professional development for all in-practice healthcare providers and staff working in frontline roles. This includes healthcare settings in areas related to 2SLGBTQI health generally, but also sexual, reproductive, and mental health services specifically relating to and/or addressing LBQ women, trans, and nonbinary needs in these areas.

- Develop, implement, and incentivize comprehensive training for doctors and other medical practitioners to understand and become competent in providing affirming transition-related healthcare.
- Develop, implement, and incentivize comprehensive training for doctors and other medical practitioners to understand and become competent in providing affirming care to nonbinary and gender nonconforming people.

For Healthcare Practitioners

- Recognize patients as true partners in their healthcare: listen to and take seriously their concerns and experiences.
- Seek out ongoing learning opportunities specific to 2SLGBTQI health generally, and also specific to health needs of LBQ women, trans, and nonbinary people (e.g., transition-related care). Where these opportunities are lacking, advocate for them.
- Do not make assumptions about people's gender identities, sexualities, or family structures, their sexual and reproductive healthcare needs, desires, or their relationship types or behaviors.
- Check preconceptions based on people's age, ability, size, ethno-racial background, socioeconomic status, or other grounds. Implicit biases harm patients and reduce access to care; explicit discriminatory actions and prejudicial statements not only undermine care but can contravene professional codes of ethics.
- Embrace anti-racist and anti-oppressive practices and values at the organizational level, clearly communicate these values, and support and promote such practices among staff.

For Health Systems Change

- Ensure that healthcare in Canada remains true to standards of a universal, publicly funded system, as access to healthcare is currently

fragmented within and across provinces and territories. This includes advocating against efforts to privatize healthcare.

- Take immediate action to increase the supply of and access to primary care physicians and nurse practitioners and improve continuity of care.
- Extend public funding for essential primary care services, including eyecare/vision care, dental care, and mental healthcare for people of all ages.
- Increase affordable access to and funding for fertility, reproductive, and transition-related healthcare services.
- Update health information policies and practices to be inclusive of diverse genders and sexualities, and to maintain the confidentiality of patient records.
- Develop and increase care seeker access to 2SLGBTQI-affirming and inclusive sexual, reproductive, fertility, and transition-related healthcare information and resources.
- Increase support to recruit, train, and retain 2SLGBTQI and Indigenous, Black, and racialized health professionals who can become leaders in their fields.
- Increase support for critical health research that can continue to document and examine health and healthcare access disparities and promising practices.
- Encourage—and offer viable opportunities for—healthcare providers to learn about and implement anti-racist, anti-oppressive, and social justice-oriented approaches to service provision. Doing so would position healthcare providers as active agents in combating racism, fatphobia, cisheterosexism, and other systems of oppression.

Conclusion

What priorities for health and healthcare access do women, trans, and nonbinary people who are lesbian, bi+, or queer in Canada have? What actions can be taken across sectors to address these priorities?

The answer is many. As this report explores, LBQ women, trans, and nonbinary people's healthcare access experiences are varied and mixed, with significant barriers to accessing affirming, timely, and affordable care. Across all types of healthcare, participants highlighted:

- a. The labour required to access care in the face of dismissal and invalidation of their concerns and self-knowledge
- b. The impact of having no or limited access to primary care physicians
- c. The impact of postponing seeking healthcare for fear of discrimination or poor care
- d. Cost-related barriers in accessing healthcare due to affordability or transportation reasons
- e. Harmful interactions and discrimination rooted in sexism, racism, weight bias, medical gaslighting, ageism, and cisheterosexism.

In light of these experiences and a desire for improvement in our health systems, participants provided many recommendations for action. Some of these recommendations are aimed at particular groups (e.g., educators, healthcare practitioners, policymakers), others apply to specific sectors, while still others are a call to action for sectors to work together to improve healthcare access for LBQ women, trans, and nonbinary people in Canada. It is our hope that the experiences and perspectives so generously shared by participants will be taken up by those with the privilege and responsibility to implement these recommendations in order to ensure that healthcare is accessible, equitable, and comprehensive for all 2SLGBTQI people.

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