

Treading water: Healthcare Experiences of Racialized Queer and Trans Young Adults

**by
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Abstract

Research suggests that racialized, queer, and trans communities experience significant health inequities. This study explored the lived experiences of four racialized, queer, and trans young adults who have engaged with healthcare services in British Columbia. Data was collected using semi-structured interviews, lasting approximately 45 minutes. Data analysis employing hermeneutic phenomenological analysis indicates several barriers to accessible healthcare. Identified themes include several challenges encompassing system navigation, limited and unavailable practitioners, financial barriers, interpersonal and medical incompetence, discrimination, and disjointed care. Participants connected these themes to negative affect, lack of motivation to seek care, and unattended health concerns. Themes revealed a subset of positive experiences relating to competency and choice of practitioners. Additionally, participants shared strategies to safeguard themselves and navigate current healthcare challenges, along with their hopes for improved services. This study also informs several areas of future research, community initiatives, and counselling practices to better advocate for and facilitate positive healthcare experiences.

Keywords: Health equity; healthcare; race/ethnicity; sexual orientation; gender orientation; intersectionality

Dedication

For those who search for possibilities,

For those who resist,

For those who are vulnerable enough to care,

For those who have lost hope,

For those who carry it,

And for those who dream of collective liberation for all.

This is for us.

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List of Acronyms

2SLGBTQ+	Two-Spirit, lesbian, gay, bisexual, transgender, queer, and other terms
AR	Action Research
ADHD	Attention-deficit/hyperactivity order
B.C.	British Columbia
HPA	Hermeneutic phenomenological analysis
HRT	Hormone replacement therapy
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, and other terms
MSM	Men who have sex with men
MSP	Medical services plan

Glossary¹

Cisheteronormativity	As defined by LeMaster et al. (2019), “the systemic normalization and material privileging of bodies, identities, and subjectivities that most closely align with white cisgender and heterosexual cultural expectancies” (p. 367)
Gender affirming care	A variety of social, psychological, behavioral, and/or medical supports intended to affirm one’s gender. Gender-affirming care is often associated with gender-diverse folks. However, cisgender folks also access these services (e.g., rhinoplasty, makeup, hair transplants, laser hair removal), often without equivalent controversy
Masking	Hiding or suppressing neurodivergent traits to adapt to societal expectations
Non-binary	A term for gender identities that exist beyond the gender-binary
Queer	Describing sexual and/or gender identities that are non-heterosexual and/or non-cisgender
Race/ethnicity	As defined by Mutaner (1999), “a set of social relations that are a subset of the structure of a social system: a hierarchical relation between white and non-white populations that produces ill health among [non-white people] through economic, political, and cultural relations” (p.123)
Racialized	A term referring to non-white people that recognizes that race is a social construct
Trans/transgender	An umbrella term for gender identities that do not align with assigned gender at birth
Two-Spirit ²	A term that includes a range of sexual, gender, cultural, and/or spiritual identities and expressions within some Indigenous communities across Turtle Island, colonially known as North America. In some societies, Two-Spirit people also hold specific ceremonial, spiritual, and healing roles. Two-Spirit as a concept or experience

¹ The definitions of identities provided in this glossary are approximations rather than definitive or exhaustive descriptions. Identities can be defined and experienced in unlimited ways, varying from person to person. Additionally, it is important to recognize that language is fluid, dynamic, and evolves over time and contexts.

² The description of the term/identity Two-Spirit is informed by Harlan Pruden and Se-ah-dom Edmo’s presentation “*Two-Spirit People: Sex, Gender & Sexuality in Historic and Contemporary Native America*” and Marie Laing’s zine, “*Two-Spirit: Conversations with Young Two-Spirit, Trans and Queer Indigenous People in Toronto*”.

existed pre-colonialism. The need for a pan-Indigenous term arose in response to colonial violence and targeting of Two-Spirit individuals and their communities. Two-Spirit may be used as a “placeholder term” as individuals search for more accurate words in their Indigenous languages (Laing, 2017, p.4)

Preface

Like many other racialized queer and trans³ folks, much of my life has been dedicated to supporting family, friends, and community members access healthcare. This study was born out of the need for underserved communities to get the care we want and need- in the ways we want and need it. This thesis was written while translating medical diagnoses in patchwork Mandarin. It was written while facilitating access to hormone replacement therapy, abortions, and affirming counselling. It was written while providing palliative care for a family member. It was written while grieving and dreaming of a future of medical advancements and accessibility.

I wrote this thesis knowing that isolated change among individual practitioners or within the medical system is not enough. Without replacing the systems that are oppressing us and making us sick, there is no sustainability. This paper does not aim to cover all the possible ways practitioners could treat us better. Rather, this is a paper that offers a platform for people to share their stories, dream of better care, and perhaps for practitioners to listen. With that in mind, this paper has been written with that purpose in the forefront.

I invite you to reflect on your own experiences of care, and in the words of Zena Sharman⁴, imagine a world where racialized “queer and trans people loved going to the doctor”. What would change? What becomes possible?

³ In this thesis, I use the umbrella terms “queer” and “trans” in lieu of 2SLGBTQ+. This reflects common practices within the community. Notably, individuals have varying relationships and histories with these terms. Individuals who are a part of the 2SLGBTQ+ community may or may not identify with the terms queer and/or trans.

⁴ Zena Sharman's *The Care We Dream Of* is a beautifully written, comprehensive collection of stories, interviews, research findings, history, essays, and poetry on liberatory and transformative approaches to LGBTQ+ health. It informs much of my work in the field of healthcare accessibility, including this thesis.

Chapter 1.

Introduction

Access to health is a fundamental human right. Healthcare offers the opportunity to maintain and improve the health and well-being of individuals and our communities. Despite this, many communities have complicated relationships with healthcare systems. Healthcare, as a science and practice, is situated within surrounding social, cultural, political, and economic contexts. Therefore, it is susceptible to and bi-directionally informed by narratives about normality, superiority, health, and worth. Healthcare is often researched, defined, and delivered in ways that exclude and exploit marginalized groups⁵. In a Western context, this includes but is not limited to Indigenous, Black, migrant, disabled, queer, and trans communities (Agénor et al., 2022; Disability Alliance BC, 2022; Doyle, 2020; Leason, 2021; Morales & Yong, 2020; Ventriglio et al., 2021).

A legacy of this continuing history, health disparities among marginalized communities remain a challenge for the Canadian healthcare system (Adjei et al., 2020; Craig et al., 2020; Lasser et al., 2006; Logie et al., 2018a; Miconi et al., 2021; Siddiqi et al., 2017; Toombs et al., 2022; Veale et al., 2017; Veenstra, 2019; Veenstra & Patterson, 2016a; Veenstra & Patterson, 2016b; Veenstra et al., 2020). Research has documented persistent healthcare barriers for racialized, queer, and trans⁶ communities in Canada (Clark et al., 2018, Mahabir, 2021). These communities are often underserved and face immense barriers to accessible, safe, and affirming care. Among these challenges are a lack of culturally competent care, discrimination, gaps in practitioner knowledge, and up-front costs (Boukpassi et al., 2021; Clarke, 2016; Logie et al., 2018b; Salam et al., 2022; Tang et al., 2015; Zhao et al., 2021). Members of these communities can be less likely to seek medical care when needed (Boukpassi et al., 2021). This can lead to unaddressed health concerns and widened health disparities. Through this thesis, I aim

⁵ The Flexner Report is a particularly relevant example of this. I encourage readers to explore the origins of this report, including the funders' motivations.

⁶ I deliberately use punctuation for phrases listing “racialized”, “queer”, and “trans” throughout this paper. The term “racialized, queer, and trans” are used to refer to distinct communities, while “racialized queer and trans” denotes intersectional identities.

to explore the often-complicated relationships racialized queer and trans young adults have with healthcare services.

1.1. The Research Phenomenon

Despite the growing research on healthcare inaccessibility, research and initiatives have often focused on racialized, queer, and trans communities as distinct, separate groups (Giritli Nygren & Olofsson, 2014). Critically, this does not account for the intersections between ethnicity and sexuality. Intersectionality recognizes that various social identities can simultaneously influence our experiences through systems of power and oppression (Crenshaw, 1989). When applied to health research, intersectionality provides a framework to understand differences in health outcomes and relationships with healthcare systems (Dhamoon & Hankivsky, 2011). In this thesis, I incorporated intersectionality to highlight the nuances of seeking and navigating healthcare as racialized queer and trans young adults.

The present study focuses on young adults aged 18 to 29. Generally, young adults as a collective have relatively lower illness rates (McMurdo, 2000). However, research suggests that this age range is a significant time frame to develop health-related habits and outcomes (Lawrence et al., 2017). By focusing on young adults, this study aims to provide insight into the early healthcare experiences of racialized queer and trans individuals. Given the need for more intersectional research, this thesis serves as an exploratory study. In this study, I documented youths' experiences with the Canadian healthcare system in British Columbia. In doing so, I aimed to identify gaps in healthcare provision and possible areas for future research and initiatives. While this thesis primarily focuses on interactions between participants and healthcare providers, I will also briefly address desired changes participants hope to see within the healthcare system.

1.2. Healthcare

To understand the cultural context of this thesis, I will provide an overview of the healthcare system and structures across Canada and within British Columbia. The following sections provide insight into the structural, organizational, financial, and systemic factors that influence healthcare systems and experiences.

1.2.1. Canada's Healthcare System

The Canadian healthcare system is an accumulation of several interdisciplinary and interdependent subsystems. Each level of government (i.e., federal, provincial, and territorial) contributes to healthcare facilitation (Government of Canada, 2019). Financially supported by the federal government, provincial and territorial governments fund and provide administrative structures for services (Marchildon, 2008). Provincial and territorial governments determine healthcare priorities and manage available resources (Government of Canada, 2019). However, as Marchildon (2008) notes, provincial and territorial governments are relatively removed from the pragmatics of healthcare delivery. Provincial and territorial governments also grant authority to regulatory colleges to oversee the actions of their members (e.g., registered social workers under the British Columbia College of Social Workers and doctors under the College of Physicians and Surgeons of Nova Scotia). The government and regulatory bodies expect practitioners to follow the general guidelines provided.

Canada Health Act

The federal government of Canada established the Canada Health Act in 1984 (Minister of Health, 2015). The Canada Health Act was created in response to the accumulating financial barriers to healthcare, such as up-front costs for patients (Minister of Health, 2015). Under the Act, the Canadian healthcare system aims “to protect, promote and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (p. 3). While guided by values of equity and solidarity, the Canada Health Act primarily focuses on finances (Minister of Health, 2015). Specifically, this legislation determines requirements for provincial and territorial governments to receive the entirety of their federal healthcare funding (Minister of Health, 2015).

As per these requirements, insured health services must follow five principles, including public administration, comprehensiveness, universality, portability, and accessibility (Minister of Health, 2015). Public administration refers to the requirement that a province or territory's public health authority facilitates their health insurance coverage under a non-profit model. Comprehensiveness denotes that such health insurance includes “all insured health services provided by hospitals, physicians, or dentists” (Minister of Health, 2015, p. 4). Universality allows insured residents to have

equal access to this health insurance, while portability supports timely and continuous insurance coverage for residents moving between provinces and/or territories (Minister of Health, 2015). The final criterion, accessibility, can be understood as insurance coverage that enables equal “reasonable access” (p. 3) to insured health services. This means that patients accessing covered services should be able to do so equally, without additional barriers (e.g., cost, discrimination, etc.). The Minister of Health (2015) provides clarity into the use of the term “reasonable access” with the “where and as available rule” (p. 4). Critically, the accessibility criterion does not require that all residents can access all services. Instead, residents must have equal access to insured services where they exist and are available (Minister of Health, 2015). Across Canada, there can be many variations in practitioner competency and availability. This means that some residents may not be able to access services depending on their location and the capacity of service providers.

All provinces and territories provide insurance coverage for all “medically necessary hospital and doctors’ services” (Government of Canada, 2019, p. 1). Provinces and territories determine which services are deemed medically necessary and control the extent of financial support (Mikkonen & Raphael, 2010). For example, the Canadian Health Act requires that all pharmaceutical prescriptions obtained through hospitals are offered at no-cost to patients (Government of Canada, 2020). However, coverage for all other prescriptions (e.g., from family doctors, walk-in clinics, dentists) depends on the individual province and territory.

British Columbia

The publicly provided health insurance plan in British Columbia is the Medical Services Plan, MSP (Government of British Columbia, n.d.). MSP applies to all eligible British Columbian residents and pays for medically necessary services from select practitioners. MSP also covers the costs of diagnostic services (e.g., x-rays and blood work) and a subset of services for some populations (e.g., eye exams for specific age groups and orthodontic services for specific conditions). MSP has limited coverage for

prescription pharmaceuticals (Government of British Columbia, 2023), though some residents may be eligible for additional coverage⁷.

1.2.2. Healthcare Access

The following section discusses access to understand how logistical components of the healthcare system impact patient experiences. Access to healthcare is a determining factor in healthcare outcomes. Research on healthcare access has the potential to inform health policy, thus influencing individual healthcare experiences and overall population health. While “access” can be considered a colloquial word, healthcare access has various definitions (Levesque et al., 2013). In the following section, I will present a comprehensive and patient-centered model of healthcare access by Levesque et al. (2013).

Levesque et al. (2013) reviewed existing conceptualizations of healthcare access. Researchers selected high-impact publications and those with clearly defined dimensions and determinants of access. Levesque et al. combined aspects of these publications to introduce a comprehensive and patient-centered definition of access and accessibility. Levesque et al. defined access as “the opportunity to reach and obtain appropriate health care services in situations of perceived need for care” (p.4). In other words, when we feel we need and want care, we can experience access when we find and receive the appropriate services.

⁷ Eligible B.C. residents may apply for additional prescription coverage through 12 PharmaCare plans. The most generic plan available is the Fair PharmaCare Plan, where coverage is income-dependent and subject to deductibles and limitations.

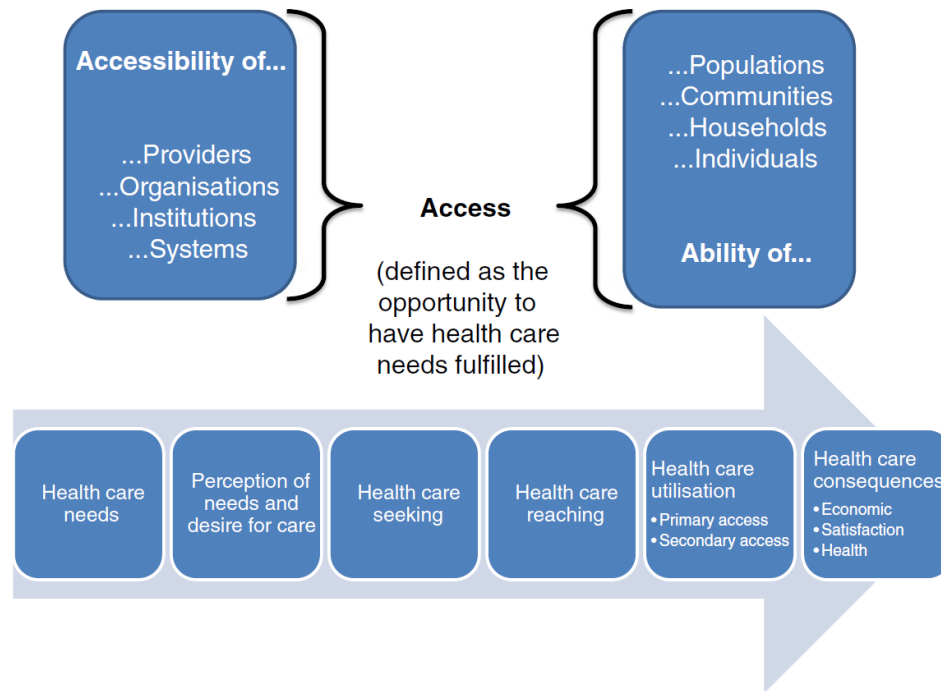


Figure 1. Levesque et al.'s (2013) depiction of access to health care.

Levesque et al.'s (2013) model begins with a healthcare need. As seen in Figure 1, individuals need to recognize this medical need and want to seek out healthcare. They also need to search for, contact, and receive services that apply to their needs. By this definition, access depends on a variety of abilities of potential patients. It also relies on the characteristics and responses of the healthcare system. This relates to the concept of accessibility. Levesque et al. distinguish access from accessibility, where accessibility is a feature or quality of healthcare services that facilitates access (e.g., financial accessibility and physical accessibility). By defining access in this way, Levesque et al. recognize that access extends beyond the first point of service contact. Access is relevant "each time a person tries to access a source of care" (p. 4). This definition also provides opportunities to identify access barriers and improve accessibility throughout the process of obtaining healthcare.

As seen in Figure 2, Levesque et al. (2013) elaborate on this model by incorporating five dimensions of accessibility (i.e., features of healthcare services) and five corresponding dimensions of patient abilities. The five dimensions of accessibility include 1) Approachability, 2) Acceptability, 3) Availability and accommodation, 4) Affordability, and 5) Appropriateness, while the patient abilities include 1) Ability to perceive, 2) Ability to seek, 3) Ability to reach, 4) Ability to pay, and 5) Ability to engage.

In the following sections, I will provide descriptions of each dimension of accessibility and the corresponding patient ability. I will also situate Levesque et al.'s model (2013) using research on the experiences of racialized, queer, and/or trans people. Despite well-documented health disparities, there is a lack of research on the healthcare experiences of racialized Canadians (Mahabir et al., 2021). Consequently, there is very little literature on the experiences of racialized queer and trans Canadians. It is also worth noting that I explore generalized healthcare experiences in this thesis. These healthcare experiences include but are not limited to gender, sexual and reproductive-related care. However, much of the existing research on queer and trans communities focuses on these sub-domains of healthcare. Thus, several examples used throughout this section reflect these limitations.

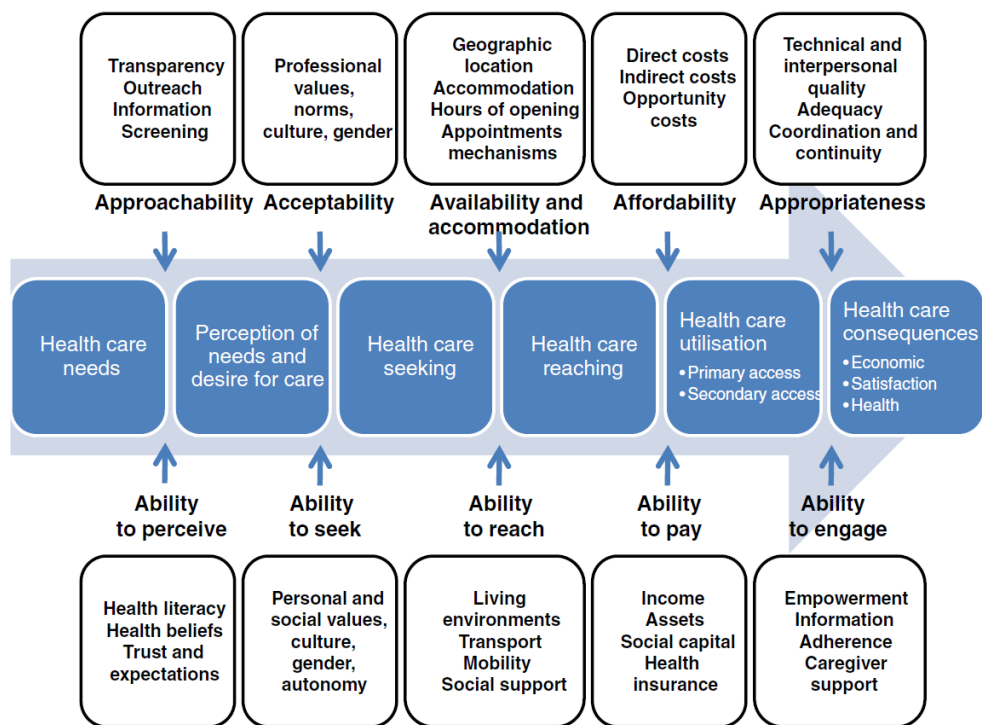


Figure 2. Levesque et al.'s (2013) depiction of conceptual framework of access to health care.

Approachability & Ability to perceive

Healthcare approachability depends on three requirements. First, people need to be aware of the existence of a service. Levesque et al. (2013) do not require that people are able to identify the specific treatment. Instead, people must be aware that “some form” of support is available (p. 5). Second, people must be aware that a service has the potential to offer them health benefits. Lastly, the service must be reachable. People

may not want to seek care that is out of reach, even if they know the service exists. Healthcare structures can make services more approachable in a variety of ways. As noted in Figure 2, this can include increasing transparency (e.g., public reports of healthcare treatments and outcomes), sharing information about treatments (e.g., pamphlets), and outreach activities (e.g., health fairs and public service announcements).

Research with queer and trans populations has found significant challenges to the approachability of healthcare. Bauer et al. (2009) explored trans participants'⁸ experiences in Ontario. Bauer and colleagues stated that healthcare research and services are often based on cisheteronormative assumptions. Bauer et al. note that this results in informational erasure. There is insufficient trans-inclusive knowledge and the “assumption that such knowledge does not exist even when it may” (p. 352). Participants also had significant challenges with denial of care based on their gender. These experiences limit access to information on relevant health concerns, services, and health benefits. Bauer et al. also found that participants often had to travel to find providers that are aware of trans people (not necessarily affirming or medically competent). This raises concerns about the approachability of services for individuals who do not have the resources and/or capacity to travel. This example offers insight into some approachability challenges queer and trans folks may experience when considering healthcare.

Service approachability interacts with a person's capacity to notice their health needs and want healthcare (Levesque et al., 2013). This capacity is termed the “ability to perceive” (p. 5) and is influenced by personal, social, and cultural factors. Levesque et al. offer a non-exhaustive list, including health literacy, health beliefs, trust, expectations, and health knowledge. Research on these domains suggests that the ability to perceive may be especially relevant for racialized, queer, and trans communities. As such, the following sections will discuss these domains within the context of racialized, queer, and trans populations.

⁸ Bauer et al. (2009) did not provide specific details about participants' racial/ethnic backgrounds and birth countries. The authors did share that “participants were born in a range of countries” and that the majority (84.6%) were Canadian citizens.

Health literacy

Health literacy is the ability to acquire, process, understand, and act on health information in ways that provide health benefits (Ratzan & Parker, 2000). Health literacy depends on an alignment in skills and abilities between patients and the “demand and complexity of information and services” (Parker & Ratzan, 2010, p. 28). Research suggests that 60% of Canadians above the age of 15 do not have sufficient health literacy levels (Canadian Council on Learning, 2007). Rates of health illiteracy are highest among Indigenous populations, recent newcomers, individuals with lower formal education levels and/or lower proficiency rates of English or French, and people using social assistance. While there can be overlap between these groups and racialized queer and trans young adults, there is currently a dearth of intersectional health literacy research for this demographic (Lee-Foon et al., 2020). However, community consultations with LGBTQ adults identified health literacy as a contributor to one’s overall health (Copitts & Gahagan, 2016). Participants shared that mainstream health information tends to be based in heteronormativity and the gender-binary. This presents challenges for developing one’s health literacy. One study explored young Black gay and other MSM’s evaluation of sexual health information in Toronto (Lee-Foon et al., 2020). This research found that some participants may struggle to identify and access applicable and credible sources of health information. Challenges in this aspect of health literacy may reduce individual’s access to relevant and accurate health information. Under Levesque et al.’s (2013) model, lack of health literacy may limit a patient’s ability to perceive their health needs.

Health beliefs

Health beliefs refer to the attitudes, perceptions, and definitions people hold about health, illness, and the factors that influence them (Misra & Kaster, 2015). Health beliefs can significantly impact health behaviors, including engagement with services (Boukpassi et al. 2021; Whitley et al., 2006). Studies on non-European Canadian immigrant populations have found that some individuals may be less likely to engage with mental health services. While engagement is also influenced by other factors, research suggests that health beliefs play a significant role (Boukpassi et al. 2021; Whitley et al., 2006). For example, patients may have negative perceptions of medications and prefer other forms of treatment (Whitley et al., 2006). Respect for patients’ health beliefs can support patients’ comfort in participating in the treatment

process (Baig et al., 2016). This research suggests that health beliefs are essential to understand an individual's perceived need and desire for healthcare.

Trust and expectations

Individual patients and their corresponding communities can have varying and dynamic relationships with healthcare systems. Historical and current instances of medical abuse, neglect, and experimentation have been well-documented among racialized, queer, and trans Canadians (Mahabir et al., 2021; Henriquez & Ahmad, 2021; Clark et al., 2018; Colpitts & Gahagan, 2016; MacDonald et al., 2014; Bauer et al., 2009). Negative experiences with the healthcare system can result in mistrust and low expectations for healthcare providers (Logie et al., 2019; Bauer et al., 2009). These findings highlight how relationships with healthcare systems can impact one's desire to seek care.

Health knowledge

Health knowledge encapsulates a wide range of information. This can include medical information about conditions and treatments, preventative health, healthcare information, and patient rights (Trevethan, 2017). Following Levesque et al. (2013), health knowledge may impact an individual's ability to notice health-related concerns. Racialized queer and trans Canadian young adults may face unique challenges in obtaining relevant health knowledge. Research suggests that mainstream health information is often non-inclusive of queer and gender-diverse communities. Lee-Foon et al. (2020) found that racialized queer youth and adults may deem such information irrelevant, opting for information from peers and community members.

Acceptability & Ability to seek

Under Levesque's et al. (2013) model of access, the next feature is acceptability. When healthcare services are acceptable, patients are more likely to feel comfortable with components of a service (e.g., type of treatment and practitioner identities). Acceptability helps patients feel that seeking care is the right choice. Levesque et al. state that cultural and social factors highly influence acceptability. These factors can include "professional values, norms, culture, and gender" (p. 5). Acceptability also applies to the type of healthcare service. People can have varying perspectives on

treatments and approaches (e.g., medications, blood transfusions, and counselling interventions).

As an example, social work originated in the 1800s (O’Neil, 2016). Social work was established according to the norms at the time. These norms included the professional value of chastity and opposition to sex work. O’Neil writes that these early norms have continued legacies within social work, limiting social workers’ abilities to normalize sexuality and support sex workers. As a Black queer sex worker, Gwendolyn (2023) critiques the approachability of social work. Gwendolyn (2023) provides examples of whorephobic policies that restrict services to active (i.e., practicing) sex workers. Gwendolyn also highlights practices, such as mandated reporting, that can further endanger sex workers, particularly racialized, queer, and trans individuals. Following this example, healthcare systems can increase acceptability by addressing the values, norms, and culture that dictate policies (e.g., mandated reporting) and service delivery. Services can improve acceptability by offering providers, treatment options, and approaches that correspond to what is acceptable to patients. In this way, increased acceptability of a service supports people’s alignment with it, thus improving accessibility.

Acceptability corresponds to patients’ ability to seek services (Levesque et al., 2013). “Autonomy and capacity” enable individuals to pursue healthcare (p. 5). This can be culturally influenced by social identities, personal values, and societal norms. For instance, acceptability may be complicated for minors seeking gender-affirming care. While they may want gender-affirming services, unsupportive legal guardians may restrict a minor’s ability to seek them (Puckett et al., 2018).

Availability and accommodation & Ability to reach

Available and accommodating services help patients get healthcare when they need it. The number of healthcare resources and their ability to keep up with demand determine a service’s availability (Levesque et al., 2013). The number of adequate facilities, equipment, and practitioners with relevant qualifications can vary across time and location (Malko et al., 2017). Healthcare systems can make services more available and accommodating by using different modalities, such as telehealth platforms, offering services at various times of the day, and policy changes (Clark et al., 2018).

Past research has found that a lack of service availability can result in gender-diverse youth abstaining from primary healthcare (Clark et al., 2018). Youth shared that they did not access care when services were unavailable in their area and wait times were “unacceptably long” (p. 304). Researchers have also examined the wait times for gender-affirming care within British Columbia. Gender-affirming practitioners are inconsistently available throughout Canada (Clark et al., 2018). The availability of gender-affirming healthcare can be a challenge for youth in rural and remote regions. Wait times can have significant medical and social consequences for patients. Clark et al. (2018) demonstrated how this impacted one non-binary young adult who shared the following statement:

In my own experience the system seems more like it's designed to gate keep people than it is to help them. By the time I get cleared to have the surgery I need, it may be too late. I'm afraid that I'll take my life before I can get the surgery to help me, because it's such an arduous and unnecessarily difficult path. I just want to live. (p. 305)

According to Frohard-Dourlent et al. (2017), there can be a significant range in wait times between initial referrals and surgical assessments. Wait times ranged from one day to five years. Wait time variability was even greater between assessments and surgeries, ranging from one month to nine years. Participants attributed wait times to insufficient health system capacities. Critically, this study featured predominately (i.e., 80%) white participants and focused on gender-affirming surgeries.

Availability is a particularly relevant concern to current healthcare access in Canada. Canada has been experiencing a physician shortage for several years, particularly in rural regions (Malko et al., 2017). This physician shortage stems from policies, insufficient primary care student enrollment, and decreased physician productivity. COVID-19-related practitioner strain and early retirement rates have exacerbated the lack of available physicians (The College of Family Physicians of Canada, 2022). While primary care physicians are one possible access point for healthcare, there is no known literature on how current physician shortages directly impact racialized, queer, and trans communities' access to general and specialized healthcare services.

The ability to reach relates to a person's ability to attend services (Levesque et al., 2013). To reach services, patients need access to resources and information. For in-

person services this can include transportation (e.g., access to and funds for a vehicle and public transport), mobility support (e.g., walkers, wheelchairs, and support people), and information on how to find and get to the service. To reach virtual appointments, patients may need access to devices (e.g., phones and computers), telecom services (e.g., Internet and phone plans), and digital literacy. Levesque et al. (2013) highlight that ability to reach may be a particular challenge for those with rigid or demanding schedules (e.g., work, caring for family members).

Affordability & Ability to pay

Affordability refers to how financially accessible services are. Levesque et al. (2013) break down affordability into three costs. This includes direct, indirect (e.g., transportation and child-minding fees), and opportunity costs (e.g., lost income). Clark et al. (2018) state that while MSP covers some medical services, youth often face out-of-pocket costs for private services, travel, and medication. Clark et al. highlight that the inconsistent availability of gender-affirming healthcare can result in additional travel costs. These financial barriers can result in gender-diverse youth abstaining from healthcare and seeking alternative forms or sources of care. Clark et al. (2018) report that these alternatives can include accessing unprescribed hormones from “off the street” (p. 304) sources.

The ability to pay refers to a patient’s ability to gather enough financial resources to afford services (Levesque et al., 2013). Some individuals have access to supplemental private health insurance, which can reduce the financial strain on patients. When service costs match with patients’ abilities to pay, patients can begin the initial stages of accessing healthcare. Levesque et al. note that patients experiencing poverty, social isolation, and debt may have limited ability to pay for services. This is particularly relevant as racialized Canadians are more likely to experience income inequality relative to their white counterparts (Block et al., 2019). Kia et al. (2020) documented this trend within the queer and trans community, where racialized queer and trans people are more likely to experience wage disparities compared to white queer and trans folks. These financial trends have real implications for individuals’ abilities to access care. Clarke et al. (2018) provide examples of gender-diverse youth who could not afford services and were forced to abstain from care.

Appropriateness & Ability to engage

Appropriate services are comprehensive, effective, and culturally attuned (Levesque et al., 2013). The type of intervention and its delivery influences appropriateness. Practitioners need to take the time and effort to understand the unique needs of their patients and tailor their care accordingly. Appropriateness extends beyond medical concerns and incorporates interpersonal interactions between patients and practitioners. In the following sections, I discuss appropriateness as it relates to racialized, queer, and trans populations. I do this by presenting research on practitioner competency. Afterwards, I will provide a description and examples of the ability to engage.

Practitioner Competency

[Racialized populations](#)

The presence of systemic racism often influences the appropriateness of healthcare services. Systemic racism can present in a multitude of ways. For instance, commonly used medical textbooks lack images showing how health conditions present across skin tones (Louie & Wilkes, 2018). The lack of representation can lead to missed diagnoses and inadequate treatment for racialized patients. In this case, the lack of applicable medical knowledge can threaten patients' access to appropriate care.

Racism can also impact provider-patient interactions, resulting in inappropriate service delivery. This is well documented among racialized communities seeking healthcare (Browne et al., 2011; Duong, 2021; Rouse, 2009). In a Canadian context, Indigenous patients have reported a wide range of discriminatory interactions with healthcare providers (Browne et al., 2011). Such discrimination can have significant implications and have led to the preventable deaths of several Indigenous individuals (Duong, 2021). One Indigenous woman shared her experiences with racism in the emergency hospital. She noted that providers treat Indigenous people differently, particularly individuals living with HIV. The participant stated, "people assume you're still using drugs. They assume that's how you got [HIV], so it's assumptions, assumptions." Experiences of discrimination have been documented among several different racialized groups across Canada, with similar consequences to patient health outcomes (Mahabir et al., 2021).

Queer and trans populations

Canadian medical schools and licensing do not have national standards for queer and trans healthcare training (Wyton, 2021). While more than 95% of Canadian medical students endorse the importance of trans health, only 67% reported being introduced to the topic (Chan et al., 2016). An even smaller subset of students, 27%, believed that the curriculum was proficiently taught. The lack of consistent and sufficient training on trans health may explain why less than 10% of students reported competency in this area. Researchers also assessed students' understanding of basic trans health using seven "True or False" questions (e.g., cancer screening recommendations and contraindications for hormone replacement therapy). They found that accuracy for only 1 out of 7 questions showed significant improvement from students' first to the fourth year of studies. This finding suggests a lack of improvement in students' knowledge of trans health as they progress through their training.

The lack of medical training can contribute to practitioners being unable to provide appropriate healthcare for queer and trans patients. Research has documented various negative experiences among queer and trans patients in Nova Scotia (Colpitts & Gahagan, 2016). According to participants, practitioners lacked medical knowledge of queer and trans-related healthcare, leading to inappropriate medical advice and judgments. Participants expressed how these experiences de-motivated them from seeking routine and preventative healthcare. Instead, participants delayed seeking medical care until they were ill. These negative experiences extend to interactions with non-medical staff and cisheteronormative intake forms. This study is one of few that highlights primary healthcare experiences of queer and trans Canadians. The authors noted that the participants were predominantly white. However, no further information is offered (e.g., percentages and specific racial/ethnic groups). Though the authors discuss intersectionality, there are no specific mentions of racialized participants' experiences.

Interpersonal competency is also necessary for high-quality and affirming care. Social skills are often discounted, especially in comparison to biological-based sciences (Wyton, 2021). This stands, even though medical and interpersonal challenges often come hand in hand. Challenges with interpersonal aspects of care are well-documented among queer and trans healthcare patients. Documented examples have included practitioners making assumptions about patients' relationships and genders, making

discriminatory statements, using incorrect pronouns and terminology, and invasive and unnecessary questioning (Henrique & Ahmad, 2021). One gender-diverse patient in Nova Scotia shared that medical incompetency is often exacerbated by apathetic providers that are unwilling to learn (Bauer et al., 2009).

I've had more issues with lack of knowledge, having to [educate] my GP [general practitioner] and my [gynecologist]... Not only do they not have the knowledge, but they have no interest to learn. You can give them information, you can offer them resources, but they cannot be bothered. So they would much rather pass you off and get you out of the office—'pass the tranny'. (p. 353)

This is one of many instances where a provider's lack of medical and interpersonal skills renders services inaccessible. Patients may be able to notice their health needs and then seek, reach, and pay for care. However, if providers cannot offer appropriate care, services are still not accessible.

Corresponding to appropriate care, the ability to engage involves “the participation and involvement of the client in decision-making and treatment decisions” (Levesque et al., 2017). Patient empowerment, information, and adherence can support a patients' ability to engage, thus improving motivation (Levesque et al., 2017). Healthcare engagement can be challenging for patients seeking queer and trans-related healthcare as there is a lack of medical information, particularly longitudinal data, available (Bauer et al., 2009). Patients may also need social support and networks to engage with their treatments (Levesque et al., 2017). A lack of accepting and affirming relationships can result in patients abstaining from treatments (Puckett et al., 2019). Puckett et al. offered examples of participants who could not engage in gender-affirming care due to unsupportive family and potential consequences. Lack of support may be particularly relevant for individuals whose treatments require lengthy or intensive recovery (e.g., surgery).

Summary

Service accessibility can be understood through five service characteristics: approachability, acceptability, availability and accommodation, affordability, and appropriateness (Levesque et al., 2017). Services that embody these characteristics can be more accessible to patients. These characteristics correspond to five patient abilities: the abilities to perceive, seek, reach, pay and engage. These abilities enable patients to

advance through the stages of healthcare access. This model recognizes that both healthcare and patient-related factors can facilitate and inhibit access to care. Levesque et al.'s model provides several opportunities to understand healthcare access for racialized queer and trans patients. While Levesque et al. note that population-based factors of accessibility (e.g., low income) can be changed, resource characteristics are the most responsive to immediate change. This emphasizes healthcare systems' responsibilities to improve access to care through individual (e.g., practitioners seeking additional training) and systemic changes (e.g., policy and funding).

Chapter 2.

Methodology

2.1. Research Purpose & Questions

There is a need for a greater academic understanding of the healthcare experiences of racialized queer and trans young adults. Thus, I sought to explore the following questions: 1) What are the lived experiences of racialized queer and trans young adults in seeking out and receiving healthcare? 2) What are the recommendations of racialized queer and trans young adults for improving the quality and accessibility of healthcare services?

2.2. Research Design

2.2.1. Research Paradigm: Social Constructionism

This research is founded on social constructionism. Under social constructionism, reality is subjective and contextual (Guba & Lincoln, 2005). Truths are considered inseparable from the individuals who experience them and the circumstances that shape these truths (e.g., time and culture) (Guba & Lincoln, 2005; Heppner et al., 2008). In other words, social constructionism recognizes how social, cultural, political, and historical factors continuously shape our experiences and identities.

Social constructionism is well-suited for understanding the healthcare experiences of racialized queer and trans young adults. This paradigm recognizes how social categories, such as race, gender, and sexuality, influence our experiences. Despite their constructed nature, these categories have real-world implications for the lived realities of individuals and communities. As such, social constructionism offers a way to understand how racialized queer and trans young adults understand their identities and experiences within healthcare and broader societal contexts. The emphasis on contextual factors recognizes how social and structural factors shape our relationships and experiences with healthcare.

2.2.2. Theoretical Framework: Intersectionality

There is an abundance of research documenting Canadian health disparities (Bauer et al., 2009; Frohlich et al., 2005; Logie et al., 2018a; Veale et al., 2017; Veenstra et al., 2016a). However, the current body of research primarily focuses on health experiences pertaining to one aspect of identity (e.g., ethnicity, citizenship, disability, gender, or sexual identity). To acknowledge the impact of overlapping identities, the current research incorporates intersectionality as a theoretical framework.

Intersectionality recognizes our abilities to simultaneously hold multiple social identities (e.g., race, ethnicity, age, disability, and citizenship) (Crenshaw, 1989). It also recognizes that systems of power shape our experiences of these identities. In a monumental paper, Crenshaw (1989) used intersectionality to analyze Black women's experiences of discrimination. Specifically, Crenshaw called attention to the intersections of racism and sexism. While Black women's experiences can overlap with Black men's experiences of racism and white women's experiences of sexism, Crenshaw described how Black women also experience discrimination that cannot be explained by racism or sexism alone. In other words, those of us with multiple marginalized identities can experience unique forms of discrimination that are specific to the identities we hold.

Intersectionality suggests that our experiences are tied to our social, political, cultural, and economic environments. In this way, intersectionality offers a framework to understand the daily realities of marginalized communities and better inform our organizations, policies, practices, and research. Dhamoon and Hankivsky (2011) propose that an intersectional approach to health research offers a more complex and thorough understanding of health inequities. Chen et al. (2006) note that intersectional data analysis can enrich the understandings of health outcomes. This further aligns with community-based research recommendations on LGBTQ health, calling for more intersectional research (Colpitts & Gahagan, 2016).

In the context of this thesis, intersectionality provides a meaningful way to understand how racialized queer and trans young adults experience healthcare. The use of intersectionality as a theoretical framework reflects my commitment to understanding

the identities and experiences of participants in a nuanced and holistic manner. Following recommendations by the above-mentioned authors, I incorporated intersectionality throughout the methodology, analysis, and writing of this thesis. In doing so, I aim to provide a comprehensive understanding of how intersecting identities and broader social contexts result in unique experiences within existing healthcare structures.

2.2.3. Phenomenology: Hermeneutic Phenomenological Analysis

Phenomenology is a philosophical movement that revolves around the study of subjective experiences (Kafle, 2011; van Manen, 2016). It aims to understand how individuals perceive the world and the meanings that people attach to these experiences (Langdrige, 2007). Heideggerian phenomenology is a branch of phenomenology. It recognizes that individual and contextual factors shape people's perceptions (Heidegger, 1962; Langdrige, 2007). Examples of these factors can include past experiences and cultural background. As such, people's experiences of the same event or object can vary (Langdrige, 2007). Under Heideggerian phenomenology, language, in the form of discourse and conversation, provides access to the world and influences our experiences (Heidegger, 1962, Langdrige, 2007). Hermeneutic phenomenology builds on Heideggerian principles by emphasizing the role of language and interpretation (Langdrige, 2007). According to Gadamer (1975), language plays a critical role in understanding. Gadamer (1975) proposed that conversation enables participants to develop a mutual understanding of a particular topic and one another. This understanding of language lends well to hermeneutic phenomenological analysis, HPA.

The current study uses HPA to explore lived experiences. HPA is based on hermeneutic phenomenological principles (Langdrige, 2007). It explores how people use language to understand events (van Manen, 2016). HPA also considers the historical, physical, and temporal contexts that shape experiences (van Manen, 2016). As this is an exploratory study, HPA is particularly useful. HPA enables the identification of themes relevant to participants' experiences of healthcare. HPA also considers the impact of participants' social locations. This is essential to exploring and understanding the experiences of racialized queer and trans young adults.

Sample Size

The samples sizes used in phenomenological research can vary from upward of three participants (Polkinghorne, 1989). HPA does not require a large and representative sample, as the purpose is not to create generalizable information (van Manen, 2016). In alignment with van Manen, I argue that information that is not generalizable should not automatically be deemed insignificant. Following the aforementioned guidelines and resources available, I aimed to collect stories from approximately five racialized queer and trans young adults. This sample size is appropriate as the focus of this study was gathering in-depth and rich understandings of participants' experiences.

Reflexivity

HPA provides considerations for a researcher's self-reflections. HPA involves a reflexive study of experiences, assuming that realities and knowledge are inherently subjective co-constructions (Kafle, 2011). Knowledge cannot be separated from its historic, physical, and temporal contexts (van Manen, 2016). It also cannot be separated from the people who co-construct it (e.g., researchers and participants). Thus, researchers are not assumed nor required to be objective and detached (van Manen, 2016). As such, this research and its findings are inherently connected to my identities, general and healthcare experiences, and community connections. From an ethical and methodological standpoint, I believe this incorporation of my positionality enriches my understanding of the topic, supports rapport development, informs safety considerations, while informing the collection, analysis, and reporting of data. To support reflexivity, I journalled my reactions, thoughts, and perspectives. I also engaged community members in discussions about my healthcare experiences to better understand my reactions to participants' stories.

2.2.4. Action Research

This study incorporates aspects of action research, AR. AR generally features a researcher working with community members to address a social issue, collaboratively create scientific knowledge, and pursue social transformation (Greenwood & Levin, 2007). Through democratic collaboration with stakeholders, AR recognizes the importance of community wisdom and experience-based knowledge (Greenwood & Levin, 2007). AR's emphasis on incorporating community-based knowledge challenges

traditional views on expertise and researcher-participant power dynamics (Greenwood & Levin, 2007).

AR is flexible in its implementation and can involve working with community members in various ways. This may include, but is not limited to, working with community members to identify research focuses, make decisions, and share knowledge (Greenwood & Levin, 2007). In this project, I consulted racialized queer and trans community members to inform the research process. Following guidelines from Neufeld et al. (2019) for ethical community research, I facilitated consultations with four stakeholders (i.e., four racialized queer and trans individuals, among them were three individuals under the age of 30, one individual between the ages of 30-35, three facilitators of community programming for racialized queer and trans youth, and two healthcare providers). Community members provided feedback on the research and interview questions, interview process, honorariums, and safeguards.

In alignment with AR principles, I also conducted this research in partnership with a British Columbia-based non-profit organization, YouthCO HIV & Hep C Society (YouthCO). YouthCO provides a wide range of social and medical support resources for youth across British Columbia. The organization focuses on reducing the impacts of HIV and Hepatitis C stigma and facilitates programs for racialized, queer, and trans youth (i.e., individuals under 30 years of age). I have described further details on my partnership with YouthCO below.

2.3. Study Procedures

2.3.1. Ethical Considerations

I submitted the research protocols to the SFU Research Ethics Board (Study number: 30001436). The current study explores the healthcare experiences of racialized queer and trans young adults. Participation in this study automatically involves a level of disclosure about one's identities. Additionally, during the questionnaire and the interview, I asked participants to share their experiences with healthcare. These experiences can be emotionally challenging to discuss. As such, I incorporated several safeguards throughout the study to ensure that participants were supported, respected, and could provide informed consent. I emailed the informed consent form to all participants ahead

of time so that participants had sufficient time to read it and ask any relevant questions. Before the interview, I reviewed the details of the study and asked if participants had any questions about the consent form or research process. I checked in with participants after the interview and member-check to assess for safety and comfort with participation. If any participants requested additional support after any part of the study, I provided applicable resources.

2.3.2. Recruitment

To incorporate local knowledge and relationships, YouthCO assisted in recruiting participants by sharing the recruitment poster on their website and with their program attendees. I asked YouthCO staff to recruit participants that could provide detailed or distinct perspectives on healthcare experiences. Five racialized queer and trans participants indicated interest in participating. After completing the eligibility assessment, one individual had to withdraw from this study due to other professional commitments. As a result, I recruited a total of four racialized queer and trans participants. I compensated participants in exchange for their time, efforts, and knowledge. Participants received incremental honorariums (i.e., \$15, \$15, and \$10 CAD for completing the questionnaire, first interview, and follow up interview, respectively).

Inclusion Criteria

The following inclusion criteria is based on guidance from stakeholders. The inclusion criteria are as follows:

1. Participants must self-identify as a racialized person, person of colour, and/or member of the global majority.
2. Participants must self-identify as a member of the 2SLGBTQ+ community.
3. Participants must be between the ages of 18 to 29 at the time of the interview.
4. Participants must have considered and/or received healthcare services within British Columbia.
5. Participants must demonstrate the capacity to understand and provide informed and voluntary consent.

6. Participants must consent to be interviewed with audio recording, transcription, and translation for data collection purposes.
7. Participants must be available and consent to be recorded during their interviews.
8. Participants must consent to review themes and quotes selected from their interviews.

Exclusion Criteria

The exclusion criteria have been derived from the above inclusion criteria and are as follows:

1. Participants who do not self-identify as a racialized person, person of colour, nor member of the global majority.
2. Participants who do not self-identify as a member of the 2SLGBTQ+ community.
3. Participants who are not between the ages of 18 to 29 at the time of the interview.
4. Participants who have not considered and/or received healthcare services within British Columbia.
5. Participants who do not demonstrate the capacity to understand and provide informed and voluntary consent.
6. Participants who do not consent to be interviewed with audio recording, transcription, and translation for data collection purposes.
7. Participants who are unavailable and/or do not consent to be recorded during their interviews.
8. Participants who do not consent to review themes and quotes selected from their interviews.

2.3.3. Site Selection

To support participant recruitment across British Columbia, I interviewed participants via Zoom. Participants attended the session in a location of their choice. When scheduling their interviews, I offered information about choosing an interview location. This information included considerations for feasibility, privacy, confidentiality, and interruptions.

2.3.4. Data Collection

Data collection took place between March and April 2023. To understand participants' lived experiences, I focused on gathering participants' stories. Through email, I asked participants to independently complete a 20-minute written questionnaire with open-ended questions about their identities and experiences. I designed the questionnaire to encourage active reflection on past experiences. I asked participants to share detailed experiences with various aspects of healthcare. Participants were given approximately one week to complete the questionnaire and submit their answers through email.

After participants completed and submitted their questionnaires, I uploaded them into NVivo (version 12 Plus) for data management and analysis. I reviewed their questionnaire answers and identified areas for follow-up questions and further discussion. I individually invited each participant to participate in a 45-minute audio recorded interview via Zoom. The interviews were semi-structured to allow participants to provide detailed information about their experiences. Some participants took more time to complete the interview. The interview times ranged from 47 minutes to 57 minutes.

Following guidance from van Manen (2016), I approached the interviews in a conversational manner. I offered opportunities for participants to share details, feelings, and thoughts as they happened during their original healthcare interactions. For instance, one participant shared experiences of tension with other patients in waiting rooms. After they discussed the cause of this tension, I responded with a prompt for more details (i.e., "I'm curious if are there particular feelings or physical sensations that come up when you're in that spot."). When participants offered generalized information

on their questionnaire or during their interview, I prompted for specific examples. While the main purpose of these interviews was to clarify and expand on questionnaire responses, an interview script was also available to explore additional content. All the interviews were audio recorded. After each interview, I listened to the audio recordings twice to transcribe each interview verbatim and review it for accuracy. I then uploaded the transcribed interviews into NVivo.

After I analyzed each session, I wrote a summary of each participant's questionnaire and interview, including themes and quotes. I invited all participants to a 10-minute individual member check interview via Zoom. The final member check times ranged from 13 minutes to 18 minutes. van Manen (2016) recognizes that descriptions of events are inherently different from the experience itself. According to van Manen, the perceived experience of an event is more important than objectivity. In other words, the quality of these analyses depends more on how representative they are of participants' subjective experiences. As such, during the member check, I focused more on how well my interpretations aligned with participants' perspectives and intended messages, as opposed to verifying the accuracy of participants' stories. I screen-shared the summaries and read out each theme and quote for participants. Through conversation and feedback from participants, participants and I assessed how accurately the themes and quotes reflected participants' intentions and experiences. I gave participants time to share their thoughts, feelings, and feedback. Participants were given multiple opportunities throughout the session to clarify, edit, and/or remove any analyses to reflect their experiences. I also encouraged participants to edit statements to reflect their positionality, perspectives, and comfort with inclusion. I worked with participants during the session to make any requested edits. I also gave participants options to include their quotes verbatim or to select versions that I edited for conciseness (e.g., removing fragmented sentences and filler words). Participants had the option to review these edits and all four chose the edited versions.

To ensure that participants had sufficient time to review this document and multiple avenues to provide feedback, I offered to send a digital copy. All participants accepted this offer. I gave participants one week time to send requests for edits. This time also served as an additional opportunity for participants to share their perspectives without my immediate presence. The combination of the guided member check and independent document review provided time and multiple avenues for participants to add

contextual information. It also provided various occasions for participants to assess and discuss their comfort and safety with the included themes, quotes, and analyses.

2.4. Data Analysis

After the member-checks, I used van Manen's (2016) approach to phenomenology to analyse the data. I first listened to, read, and repeatedly re-read the questionnaire and interview transcripts to familiarize myself with the data. In alignment with van Manen (2016), this supported my orientation to participants' stories. To analyse the data, I followed principles of hermeneutic phenomenological analysis (van Manen, 2016). van Manen suggests that descriptions of lived experiences can be used to identify key themes within those experiences. While there are no set approaches to HPA, van Manen (2016) offers three approaches to identify themes. The first is wholistic, where the reader considers the text in its entirety. The reader then selects a phrase to represent the "fundamental or main significance of the text" (p. 93). In the selective approach, the text is reviewed multiple times to identify sentences and phrases that are "particularly essential or revealing about the phenomenon" (p. 93). For the detailed approach, the reader carefully considers every sentence and sentence cluster. The reader asks, "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (p. 94).

2.5. Conditions of Research

There are various approaches to conducting qualitative research (Kafle, 2011). In this project, I incorporate van Manen's (2016) four conditions⁹: 1) orientation, 2) strength, 3) richness, and 4) depth. Below, I describe these four conditions and explain how I incorporated them throughout this study.

⁹ These conditions are not explicitly considered quality criteria. I found that van Manen's four conditions incorporated and expanded on Lincoln and Guba's (1985) quality criteria for trustworthiness. I also found that these conditions aligned with my values and perspectives on community research. As such, I focus on van Manen's conditions in this section.

2.5.1. Orientation

van Manen (2016) advocates for the importance of oriented research. Oriented research is designed and presented in ways that intertwine theoretical knowledge and practical applications. van Manen (2016) speaks of researcher tendencies to detach ourselves from the “everyday lifeworld” (p. 134) and the lives of our participants. Instead, van Manen proposes that our research represents our values, beliefs, and perspectives and cannot be separated from life. To create oriented research, I reflected on how I wanted to uphold every day lived experience throughout my thesis. My research is oriented in that it is primarily guided by community knowledge. My research is inspired and informed by numerous books, articles, conversations, podcasts, and pieces of art. I also drawn on my experiences as a racialized queer and gender-diverse individual as well as my professional and personal support roles. I am tempted by convention to list all my professional roles relating to racialized, queer, and trans health. However, I know that these roles do not provide enough insight into the nature of my community connections. Further, much of this thesis has been informed by everyday relationships, knowledge, and practices. Therefore, I will focus on where I have learnt the most about racialized, queer, and trans health.

I began as a translator kid. Alternating with my siblings, I interpreted (and still interpret) healthcare information to my parents. This involves on-the-spot translations and pre- and post- appointment Google translating. I offer hopeful approximations despite my gaps in vocabulary and medical understanding. In my twenties, I connected with local racialized queer and trans youth who have transformed my understanding of care, community, sustainable advocacy, and liberatory action¹⁰. In more recent years, my learning has been heavily informed by the writings of Adrienne Maree Brown and Zena Sharman and several online workshops and webinars. My research is informed by my own healthcare experiences and those of loved ones. It is inseparable from the stories that community members have entrusted me with. My experiences enable me to better understand how we, as individuals and collectives, navigate health, well-being,

¹⁰ Aspects of this section are inherently vague. My learning has come from late-night phone rants about transphobic nurses, book groups on *Emergent Strategies*, counselling sessions, discussions with chosen family about value-driven healthcare, and more. While I cannot summarize every interaction that has connected me to the everyday lives of my racialized queer and trans kin, I hope the listed examples offer some insight.

and the healthcare system. These experiences inform my approach to research, chosen theories, methodology, analyses, language, and writing style. My understanding of the social and historical contexts supports me in conducting research that centers respect, ethics, and community safety. It also allows me to incorporate community knowledge that has yet to be represented in formal academic literature.

In further recognition that community and research are not distinct entities, I invited community members to inform the research process through community consultations. I also sought out research that documented how racialized, queer, and trans individuals want research to be conducted and incorporated those perspectives. In conducting the literature review, I intentionally featured qualitative research with quotes. I did this to orient my research, infusing it with the “day to day” knowledge and perspectives of various racialized, queer, and trans individuals.

2.5.2. Strength

According to van Manen (2016), orientation and strength are related aspects of research. When a researcher is strong in their orientation, they focus on the research phenomenon. The current research includes a wide range of communities, experiences, and fields of healthcare. To strengthen my research, I constantly considered the scope of this project. I routinely returned to my main focuses: “*What are the lived experiences of racialized queer and trans young adults in seeking out and receiving healthcare? What are the recommendations of racialized queer and trans young adults for improving the quality and accessibility of healthcare services?*” I questioned how different approaches addressed or strayed from this question. I sought support from my supervisor and other graduate students to specify the parameters and limitations of my study.

Strong research produces a thorough, truthful, and unique understanding of a phenomenon (van Manen, 2016). It avoids assumptions and surface-level descriptions. To address this, I conducted a thorough reading of existing academic and community literature on healthcare for racialized, queer, and trans individuals. This allowed me to witness a wide range of experiences with healthcare. It also revealed how people have varying priorities when accessing care. I then questioned my assumptions about what racialized queer and trans young adults may define as affirming, safe, and desired care.

To incorporate this consideration, I focused on open-ended interview questions and encouraged participants to define and/or provide more information about the terms they used.

2.5.3. Richness

Richness involves exploring phenomena from various perspectives and considering what is not immediately noticeable (van Manen, 2016). Rich descriptions offer a comprehensive understanding of a phenomenon. To encourage richness, I incorporated various ways of gathering data. By engaging participants in written responses and interviews, I created opportunities to develop a rich understanding of experiences. During the interviews, I noted the nuances, details, and verbal and non-verbal communication- paying attention to what was said and how. I also read and re-read the data with multiple different focuses to encourage a variety of perspectives. For instance, I read each interview transcript from the perspective of a service recipient, provider, and researcher. Each time, I documented different notes and observed the differences between these perspectives.

2.5.4. Depth

van Manen (2016) notes that there is unavoidable ambiguity and unknown in research. Deep research provides insight into this unknown. As with richness, researchers can create deep understandings by pushing past immediate observations. To encourage depth, I prompted participants to provide more information and examples when they initially answered with generalizations. At times participants would need more time to think. I encouraged participants to take their time and answer when they were ready. During the analyses, I considered how my research addressed gaps in the existing literature to create depth of knowledge. van Manen notes that deep text should be engaging for readers while centering participants' voices. During the next chapter, I incorporate participant quotes and use participants' chosen language. My use of participants' direct words fosters depth while offering irreplaceable insight into participants' perspectives of healthcare.

Chapter 3. Results

In this chapter, I aim to provide comprehensive descriptions of participants' experiences. I will explore key themes, share meaningful quotes, and comment on the similarities and differences between participants' experiences. To begin this section, I will introduce readers to each participant individually.

3.1. Introduction to Participants

During the questionnaire and interview, I offered participants opportunities to share any relevant social locations, characteristics, and events that contextualize their healthcare experiences. Participants shared a variety of backgrounds and health concerns. In the following section, I summarize each participant's background and experiences. Each summary is titled according to the wholistic theme derived from the participant's questionnaire or interview. These introductions serve multiple purposes, all of which contribute to the richness, depth, and ethical integrity of this thesis. I offer these summaries as a way for readers to "meet" each participant and become familiar with their unique stories, perspectives, and personalities. Additionally, these introductions offer contextual information that enhances understanding of the subsequent themes discussed in this chapter. Moreover, I offer these introductions to center and amplify the voices of participants who have generously and vulnerably shared their experiences.

3.1.1. AC's Experiences: Testing the waters

AC (they/them) is a 1.5 generation Taiwanese Canadian immigrant. AC is genderfluid, queer, mid-sized, and neurodivergent. AC's relationship with healthcare is characterized by high levels of worry, anxiety, and hesitancy. AC has experienced a variety of negative interactions with healthcare providers and other patients. These experiences revolve around denial of care and stigmatization connected to their identity as a visibly racialized, queer person in a bigger body. AC notes that practitioners tend to compartmentalize their identities and address them as separate units. However, AC notes that their identities are "*baked into*" every part of their care. In response to these challenges, AC has developed a wide range of skills and strategies to reduce contact with healthcare practitioners when possible. These can include lifestyle changes,

extensively searching for relevant information online, and self-medicating. When AC does seek out healthcare, they “*test the waters*” by strategically disclosing information, observing practitioner behaviors, and leveraging their medical knowledge as a veterinarian.

AC notes that choosing practitioners as a racialized queer and genderfluid person feels like “*having to choose [their] poison.*” In the absence of practitioners who are visibly racialized and queer, AC must often choose between racialized or queer practitioners. In doing so, AC feels they risk different “*flavor[s] of -phobia.*” AC notes that their family doctor has been a surprising and welcome exception to the stress of accessing care. AC chose their current family doctor as she is also East Asian. AC hoped that this would help their doctor understand the cultural aspects of their needs. AC has since found out that their doctor is also queer, information AC gained when they started asking about hormone replacement therapy, HRT. While AC’s doctor is new to supporting patients with HRT, she is patient, transparent, prompt, and enthusiastic to provide support. This has fostered a collaborative and trusting relationship. In reflecting on this, AC emphasized that luck has played a “*HUGE factor*” in their “*relatively smooth interactions with the system.*”

3.1.2. Tea Rosa’s Experiences: Left to deal with it on your own

Tea Rosa (they/them) has maternal roots in the Squamish Nation. Their paternal lineage is of mixed European settler heritage. Tea Rosa is Indigenous, queer, non-binary, and Two-Spirit. They live off-reserve and relocate often. For centralized records and financial accessibility, they rely on accessing care through the Squamish Nation’s health coverage. This presents its own challenges as practitioners who are eligible for direct billing are often not physically accessible to Tea Rosa.

Tea Rosa has a difficult relationship with help seeking. This is due to repeated invalidation and shaming from caregivers and family. This is reinforced by service providers who have consistently invalidated and ignored Tea Rosa’s chronic pain, gender, pronouns, and stated medical preferences. When Tea Rosa can access healthcare, they describe it as overwhelming, draining, not beneficial, and alienating. Tea Rosa has faced years of invalidation, denial of care, and cisheteronormativity from healthcare providers. These experiences have made it challenging for Tea Rosa to self-

advocate, self-validate seeking care, and feel deserving of quality care. In the past, Tea Rosa has accessed two practitioners who have validated their needs and treated their symptoms holistically. However, constant staffing changes and practitioner shortages have interrupted Tea Rosa's access to these practitioners and consequently, treatments and accommodations. Now, Tea Rosa does not have access to a practitioner who is authorized to facilitate the support they need, leaving them in "*survival mode*". Tea Rosa notes that they have largely been going without care unless their body is exhibiting concerning symptoms.

3.1.3. Orbit's Experiences: We go to practitioners to receive help, but we aren't treated like we need it

Orbit (they/them) is 19 years old, East Asian, queer, trans, and disabled. Orbit immigrated to Canada 15 years ago and is currently a university student. Orbit has Tourette's syndrome. While trying to get a diagnosis and support, Orbit found that most practitioners were unaware of their symptoms and unable to provide information. Rather, Orbit faced recurring and intersecting ableism, ageism, racism, and queerphobia. Orbit noted that practitioners were skeptical of providing support, given the recent increased awareness of Tourette's among youth. Unprompted, practitioners have also associated Orbit's Tourette's with their queerness- an association echoed by other providers who have assumed Orbit has a range of other mental health diagnoses (i.e., anxiety, depression, and ADHD) based on Orbit's sexuality. Without a concrete diagnosis, Orbit could not seek academic accommodations and social support. Orbit currently has a letter of diagnosis, a process that took over two years to complete. However, their university deemed the letter too vague, disqualifying Orbit from accommodations.

Orbit feels angry and hopeless because of repeated discrimination. Practitioners have questioned Orbit's requests for mental health support and non-binary identity¹¹ based on their appearance. They have also invalidated Orbit's experiences by downplaying the significance of their self-harm scars and insinuating that Orbit's queerness is a result of TikTok over-exposure. Additionally, Orbit has been forgotten by staff, waiting over an hour for appointments. These experiences, in addition to financial

¹¹ Orbit's family is unsupportive of their gender expression. As such, Orbit presents "very feminine" or "cis-passing".

barriers, waitlists, disrespect, and language barriers have reduced Orbit's access to healthcare and "[ruined] their faith" in the healthcare system. Out of frustration and hopelessness, Orbit has "[given] up" on multiple treatments and instead deals with the corresponding mental and physical health consequences.

3.1.4. Alia's Experiences: Stranded here, treading water

Alia (she/her) is 20 years old, South Asian, Brown, Tamil, Hindu, and queer. Alia is the child of refugees and grew up lower middle class. Alia shared healthcare experiences involving her invisible disabilities and neurodivergence. Alia often cannot afford fee-based healthcare treatments (e.g., private counselling) and will ration her treatment (e.g., medication) or go without. These financial barriers interact with the unpredictable nature of her health. Flare-ups in symptoms can interfere with her ability to physically access treatment and diagnostics. This can result in cancellation fees, amplifying financial inaccessibility. Alia also experiences a lack of safety and stability with her healthcare providers. She is aware that any helpful practitioner can easily be "*ripped away*". Alia has had positive experiences with a private counsellor. However, as a student, Alia has had to prioritize tuition and rely on public counselling services. Long waitlists and poor fit with assigned practitioners have left Alia questioning the purpose of seeking care.

When Alia can access services, she is often dismissed by practitioners. Alia points out the irony of being expected to trust adults, yet constantly being invalidated by them. In high school, practitioners discounted Alia's suicidality, dismissing her as a hormonal teenager who should instead uphold her academic performance. As an adult, Alia continues to struggle to access healthcare. Alia routinely faces lengthy wait times and continuous referrals. If any care is given at all, Alia is often rushed by practitioners who focus on fast and temporary solutions. Despite recurring and severe physical pain, Alia chooses to stay home, avoiding the realistic potential of being dismissed again. Alia acknowledges that her pain impacts her academic career, however, she no longer has the energy nor will to "*trick*" herself into seeking care. She notes that things are difficult but bearable and wonders if her relationship with healthcare can ever change.

Table 1. Participant backgrounds and experiences.

Participant	Ethnicity	Sexuality	Other information	Main mentioned healthcare focus(es)
AC (they/them)	Taiwanese- Canadian	Genderfluid Queer	1.5 generation immigrant Lower Mainland Neurodivergent Mid-sized body AFAB Veterinarian	Gender-affirming care (HRT)
Tea Rosa (they/them)	Indigenous (Squamish Nation) Mixed European settler heritage	Queer Non-binary Two-Spirit	Lives off reserve Moves often Sexual assault survivor AFAB White-passing	Chronic pain
Orbit (they/them)	East Asian	Queer Trans	19 years old Lower Mainland Immigrant Living in Canada for 15 years Disabled	Mental health Tourette's
Alia (she/her)	South Asian Brown Tamil	Queer Woman	Disabled Hindu Neurodivergent Upper middle class, previously lower middle class Parents were refugees 20 years old	Mental health Chronic pain

Note. Participants are listed in the order they were interviewed. The identities and experiences are listed in the order that participants shared this information.

3.2. Themes

In the following section, I share themes derived from participants' questionnaires, interviews, and member checks. To add richness and depth of knowledge, I incorporate quotes throughout. These quotes help convey the nuances, emotions, context, and details of participants' experiences. While I have categorized participants' experiences under certain themes, most themes are interconnected. As such, some experiences

grouped under one theme will touch on aspects of other themes. While I have limited repeated mentions of the same content, the same events may appear in multiple sections. In these cases, I provide analyses of the event in ways that correspond to that particular section.

3.2.1. Challenging healthcare experiences

I designed the questionnaire and interview prompts to be open-ended and neutral. It is important to note that participants reported mostly negative experiences. For ease of understanding, I will present the themes in chronological order based on Levesque et al.'s (2013) model of healthcare accessibility.

Approachability & Ability to perceive

System navigation

For Orbit, AC, and Alia, navigating the healthcare system is a challenge in itself. Orbit finds that without a family doctor, they “*do not know where to start.*” AC shared similar experiences, having transitioned from a centralized university service to the general healthcare system. Despite seeking support from practitioners, Alia also faced challenges with system navigation. When she attempted to access care at an access and assessment clinic, she was redirected to a walk-in, only to be sent back to the original access and assessment clinic. Alia reported going “*back and forth three times*” between these facilities, trying to get access to care. The lack of clear information about applicable services added to Alia’s confusion and stress. As Alia shared, “*When you’re in pain, you’re in pain. I can’t deal with the semantics of this situation... I don’t want to deal with [it].*”

Acceptability & Ability to seek

Limited options

Alia and Tea Rosa spoke of the disconnect between the services they need and those that exist. Participants shared their challenges accessing services that considered and incorporated their cultural needs and lived experiences. Alia struggled to find an acceptable publicly funded practitioner that understood her cultural background and lived experiences. Without this understanding, Alia received counselling that felt “*trivial*” and inapplicable. This discouraging pattern persisted across several practitioners, causing

Alia to question the value of pursuing public counselling. Tea Rosa encountered similar challenges due to an inability to choose their practitioners. Tea Rosa is “*not comfortable approaching male bodied people ... mostly due to [their] past, being a sexual assault survivor.*” However, Tea Rosa does not currently have access to services that allow them to choose the gender of their practitioners. Tea Rosa’s need for non-male practitioners is important for their comfort, trust, and safety. Therefore, the lack of services that openly accommodate this need threatens Tea Rosa’s options for acceptable care.

Power and Policies

Tea Rosa and AC raised concerns about certain policies and procedures. Tea Rosa shared their opposition to policies that restrict access to gender-affirming care. AC elaborated on this by pointing to medical standards that require gender-diverse people to obtain a “*diagnosis of dysphoria from a third party*” instead of “*[allowing] patients to serve as their own benchmark.*” AC’s comments shed light on how the medical system prioritizes external validation of dysphoria. The emphasis on formalizing and documenting a diagnosis allocates authority over one’s gender and experiences to professionals instead of the patient. Tea Rosa and AC’s rejection of these requirements reflect how professional values within medical practice can impact the acceptability of services. Tea Rosa and AC’s comments relate to Alia’s comments on power dynamics within the healthcare system. She shared, “A lot of the times we don't have so much of a say in the system. We just have to play within it, and I look at it, it hurts my soul.” Alia’s statement speaks to the importance of relative power, choice, and agency.

Availability and Accommodation & Ability to reach

Waitlists

The lack of available practitioners can result in long wait times. Long wait times for scheduled and walk-in appointments have led to Orbit forgoing services. Orbit was prescribed multiple medications. However, the wait times to refill or adjust their medications were so long that Orbit “*started to give up on getting the refill and at a certain point, [they] stopped taking medication.*” This negatively impacted Orbit’s mental and physical health. Further, Orbit shared that they once waited 11 months to see a psychiatrist for their Tourette’s. The long wait time sparked feelings of hopelessness and thoughts that their appointment “*would never come.*” Orbit questioned, “*The appointment*

is just the first step... if the appointment is going to take this long, how long is it going to take to actually be doing that treatment?" Orbit also found that without care or a concrete timeline, it was difficult to ask for support. Orbit's comments detail what could change if they had immediate access to healthcare:

I would have felt more hopeful, and I would have been more optimistic on getting help. I would've been able to tell other people that I was getting help. I would be able to update them, and they can probably like, support me or at the very least, drive me places... But I had no idea when the appointment would be, when they would contact me, or anything like that. I just couldn't tell anyone. I just had to deal with it myself.

Alia also commented on how wait times limited their options for care and fostered a sense of uncertainty. Alia shared the following experience after having waited months for an appointment:

When I'm like, 'If this treatment doesn't work, what do I do?' And then, they'll say 'You need to book another appointment.' And I'm like, 'What's the schedule going to look like? Like, is it a week, a month? What?' And then they're like, 'No, it's several months down the line.' And I'm like, 'Okay, but like, what am I supposed to do in that meantime?'

Age restrictions

Waitlists can create specific challenges for youth. Alia shared that when she was 16 and 17, age restrictions for public services deemed her illegible for many programs. Being *"too young for certain services and too old for others"*, practitioners could not refer Alia to services she needed. She noted that by the time she would have gotten off the waitlist, she would have aged out of the service's age requirements. Alia described this challenge as a *"really big hindrance"* for her.

Affordability & Ability to Pay

Service costs

Financial barriers prevented most participants from accessing care. Orbit and Alia are university students with limited financial means for treatment costs. Orbit does not have private insurance coverage. Even when Orbit is interested in recommended services, the financial burden *"demotivates"* Orbit from *"[receiving] any help in the first place."* Alia shared that in her case, practitioners are *"so insistent that therapy and meds are the way to go"*, however, those treatments are not consistently affordable. Even

when Alia has been able to afford medication, to make her medications last longer, she has had to “ration” them. This lowers the prescribed dosage and “*definitely [impacts her] functioning.*” Alia shares, “*I’m kind of treading water. Like, it’s hard, but I guess it’s bearable.*” Paying for treatments is further complicated by Alia’s relationship and history with finances. As the child of refugees, Alia is very aware of money and often feels pressure and guilt when spending. This prevented Alia from accessing private counselling “*for the longest time.*” While Alia eventually started private counselling, rising tuition costs meant she had to “*pick and choose*” between counselling and attending school. Alia noted that not having access to therapy when her physical symptoms flare up “*makes it so much harder to function.*”

In response to financial barriers, Orbit and Alia sought public services. Orbit accessed a free youth-focused health and wellness centre. There, Orbit received information and support about Tourette’s and connections to other health services. Orbit was surprised and happy that they could learn more about their condition. Contrastingly, Alia accessed public counselling services and faced several challenges. After a long waitlist period, Alia learned that she could not choose her practitioner. Instead, she was constantly assigned to different white heterosexual men. She shared that these practitioners did not provide culturally relevant care and did not “*make [her] feel good about [herself].*” On top of this, the health organization was “*bouncing*” Alia to different practitioners “*all the time.*” Despite not feeling connected to any of these practitioners, Alia had limited options. She noted that public counselling operates on a “*first come, first serve*” basis, where “*you can’t be picky. You should just be happy with what you’ve got.*” Frustrated, Alia questioned if she would be “*better off*” without care and if she even wanted care. These examples showcase the range of experiences participants had with financially accessible services. Orbit’s experience demonstrated how free services can be crucial to reduce financial barriers. Alia’s experience shows how financial accessibility is just one aspect of accessibility. Free services cannot guarantee accessibility in other ways.

Cancellation fees

Financial barriers are not limited to service fees. Alia shared her experiences navigating cancellation fees while disabled. Alia’s physical symptoms can unpredictably “*flare up*”, making it hard for her to attend appointments. At times, Alia cannot provide

enough notice according to cancellation policies. This leaves Alia without many options and questioning what providers “*expect*” her to do. As she puts it, “*if you don't cancel within 48 hours, then they'll charge you... but if I can't get out of bed, I can't get out of bed.*” Alia understands the reasoning behind cancellation policies. However, Alia points out the irony of such ableist practices within healthcare and speaks of her disappointment and frustration. Alia experiences this as the system prioritizing finances over the realities of disabled people.

Coverage limitations

Tea Rosa’s nation provides healthcare resources and supports for its members. This includes direct billing for some providers. Tea Rosa has accessed acupuncture through this coverage and noticed significant relief of tension and chronic pain. Tea Rosa emphasized that while the coverage is beneficial, it comes with a “*catch.*” Specifically, members who want direct billing must access the service through the nation. As someone who lives off reserve, this can create additional accessibility challenges for Tea Rosa.

I've always lived off reserve. Trying to access the services that are available through my nation gets really difficult because of travel. It can be difficult for me if I don't have money for bus passes or if I don't have the energy to take the two buses and then walk the 20-minute walk from the bus stop to the doctor's office.

While Tea Rosa can technically access services outside the nation’s network, this would require them to pay and then submit the expense for reimbursement. Tea Rosa cannot afford these up-front costs, especially with the possibility that their claim would be denied. As a result, Tea Rosa can no longer access this service.

If I tried to access that somewhere downtown, it would cost me so much out of pocket. I'm not in a space right now financially to be able to pay for something and have it potentially reimbursed later.

Appropriateness & Ability to engage

Interpersonal qualities

Hostility

Participants often felt unwelcome in healthcare spaces. Participants provided examples of interactions with other healthcare patients, non-medical staff, and

practitioners. While not mentioned in Levesque et al.'s (2013) model of accessibility, other patients contributed to the overall accessibility of services. Interactions with other patients can pose unique challenges for patients with visible identities. These interactions can contribute to a hostile and unwelcoming healthcare environment. AC shared:

There isn't currently a subspecialty that encompasses the totality of gender affirming care. Instead, it has been split to *AC uses finger quotations* 'plastic surgery', endocrinology, and psychiatry *AC laughs*. The intersection of people accessing these subspecialties for gender affirming care provides an interaction with people who are wholly unaware that this is a reason for people to access these types of care providers. It's also being like, a visibly younger person and a visibly bigger person that like, can challenge a lot of the other patients' expectations of what they were expecting to see within that waiting room and that, that creates the tension.

Awareness of judgment and the need to constantly be vigilant about others' perceptions can impact patients in various ways. AC notes that this takes *"a lot more energy and mental space, navigating through that anxiety versus having that mental energy to communicate [their] needs."* This deters AC from seeking in-person healthcare services.

Alia stated that she commonly meets practitioners and doubts if they *"really want to help people."* Alia shared that she often feels *"like [practitioners] don't like what [they're] doing"* and that this is *"so apparent in the way that they approach [her]."* Alia spoke of practitioners who do not develop relationships with her, rush treatments, and only consider the physical aspects of her condition. AC also reported a sense of animosity from healthcare staff, describing this as *"hostility."* They stated, *"[Y]our presence causes frustration from the people working within the system. Just you showing up is a problem for them."* AC acknowledged that this is in part due to the overworked healthcare system and staff. However, the hostility complicates AC's relationship with seeking care. They questioned, *"Not even touching on will I get care, it's just like, will my presence be okay in this situation?"* This may provide insight into AC's expectations. If they doubt that their presence is acceptable, it brings into question how AC can expect respectful, safe, and dignified care and how empowered AC feels to advocate for themselves as needed.

Invalidation

All four participants shared experiences of invalidation. Participants spoke about how practitioners invalidated their identities, experiences, concerns, and requests. Participants described feeling ignored, neglected, “*put down*”, and misunderstood. Participants shared stories that featured varying levels of apathy from practitioners. Orbit noted that their mental health needs “*were not taken seriously.*” This was particularly evident in Orbit’s interactions with a psychiatrist. They stated, “*One person asked to look at one of my self-harm scars. Not even asking, just demanding to see it. And they saw and they were like, ‘Oh, that’s not that bad.’ That was a big shock for me.*” This interaction shows a lack of understanding of consent and the emotional significance of self-harm scars. Instead of focusing on Orbit’s experiences and perceptions, the psychiatrist evaluates the relative severity of their scars. The interaction also suggests a power difference, where practitioners expect patients to present personal information on demand. Patients who comply may experience harm depending on the practitioner’s response.

When AC was at university, they tried to seek mental health services. Despite AC expressing their need for support, AC was denied care. The practitioner cited AC’s good academic standing as the “*main reason why a service [wouldn’t] be provided.*” This interaction implies that academic achievements erase the potential of disability. It also undermines AC’s autonomy to make decisions about their mental health. This prioritization of academic performance was also present for Alia, though in a slightly different manner. Alia’s school counsellors deemed her mental health struggles invalid and unimportant compared to her academic performance. Eventually, Alia believed her counsellors would only acknowledge her distress in extreme situations.

When I would see counsellors at my school and I would tell them kind of what I’m dealing with, they would just be like, ‘You’re not in a position to feel that way because, like, you need to uphold [your] standing in school.’ ... It was so frustrating because no one was listening to me, and no one was taking me seriously. I felt like I had to do something so dramatic for them, like, I’d have to collapse on the floor and for them to notice me.

Alia went on to share that she did have such an experience. She shared that she “*had a panic attack that was very public and people saw.*” She describes hyperventilating and not being able to “*breathe for the longest time.*” Despite this, Alia noted that “*even then, [the counsellors] didn’t take [her] seriously.*”

Tea Rosa shared how histories of invalidation can complicate situations where they are validated. After 24 years of seeking support, Tea Rosa finally had one doctor “*take [their] back pain seriously.*”¹² Tea Rosa shared that even though this was a welcome experience, it left them feeling lost. The novelty of being heard brought new uncertainties as Tea Rosa questioned, “*Where do I go from there?*” Tea Rosa described this as overwhelming, frustrating, and annoying.

“Just a kid”

Orbit and Alia both reported being invalidated because of their age. When Orbit sought healthcare as a child, their parents struggled with language barriers. When this happened, Orbit tried to communicate their own needs to practitioners. Orbit found that doctors “*wouldn't really listen to [them] because [they were] just a kid.*” In this case, Orbit’s family was already facing inequitable care due to the lack of language-accessible services. Despite being an available source of information and taking on this labor as a child, the doctor refused to listen to Orbit. This interaction suggests that some practitioners assume that younger people do not have the same level of knowledge as adults, despite Orbit being the person experiencing the symptoms.

When discussing invalidation, Orbit emphasized that “*gender identity and sexuality [play] a huge role, especially when you're youth.*” During the beginning of the COVID-19 pandemic, Orbit sought a diagnosis of Tourette’s. Orbit noted that at the same time, Tourette’s “*kind of blew up on the Internet for young people.*” Orbit found that healthcare professionals were “*skeptical of trying to help*” them. Orbit felt that practitioners assumed they were “*attention seeking.*” Alia had similar experiences when seeking support for mental health from a doctor. The practitioner dismissed Alia’s concerns and distress, attributing Alia’s experiences to her age, downplaying the severity of her situation, and trivializing her emotions. Alia shared, “*[The doctor] said to my face that I was just being a teenager and being hormonal and that what I [was] going through is every teenager's experience. But I was saying stuff about suicidal ideation and more intense stuff ... She really brushed it off.*” Whether or not Alia’s experiences are related to or common among her age group, this does not negate her distress. By

¹² Community knowledge and academic literature have documented how pain is often invalidated, underdiagnosed, and untreated among various communities (e.g., Black people, women, disabled, queer and trans people). See Mende-Siedlecki et al. (2019) for an example.

minimizing Alia's experiences, this practitioner neglected to provide access to services. Similarly to Orbit, Alia shared that practitioners often "*think you're telling a lie and that you're trying to get out of something.*"

As Alia reflected on her experiences with invalidation, she described the disappointing and frustrating experience of asking for support as a youth. She shared, "*You're supposed to trust the adults, but the adults in your life aren't taking you seriously.*" Orbit also expressed similar frustrations, stating "*We go to practitioners like them to receive help, but we aren't treated like we need it.*" These statements demonstrate how invalidation can break down trust and prevent individuals from receiving necessary support.

Adequacy

Substandard care

Participants shared numerous instances where practitioners provided superficial, rushed, and inadequate care. AC described examples of navigating this in a mid-sized body. When trying to access healthcare, doctors often focus on AC's weight. AC stated, "*I've definitely had doctors who've looked at the body I'm in and been like, 'Well, the fact that [you] don't fit the BMI or fall under certain cut offs with the BMI is the root of all of symptoms.'*" This singular focus on BMI is fatphobic¹³, framing higher BMIs as the definitive answer to AC's health concerns¹⁴. Such a narrow focus disregards other potential underlying causes and conditions, prioritizing weight over a comprehensive and holistic health assessment. This focus also creates the potential for misdiagnosis and ineffective treatment, invalidation, shame, and discomfort.

Other participants echoed similar experiences with superficial care. Orbit shared one occasion where a psychiatrist dismissed their mental health concerns "*in the first three minutes of meeting.*" Instead of conducting a thorough assessment, the psychiatrist questioned Orbit's need for healthcare based on surface-level observations.

¹³ BMI was created by Lambert Quetelet and originally intended as a population metric, not a measure of obesity or health. BMI and fatphobia have racist origins, as shown in Sabrina String's *Fearing the Black Body: The Racial Origins of Fat Phobia*. String traces fatphobia to white supremacist, classist, and misogynoiristic motives.

¹⁴ This form of medical weight bias is colloquially termed "fat broken arm syndrome". The term serves as a metaphor to highlight how fatphobic practitioners overlook legitimate medical concerns by attributing them solely to weight.

Orbit shared that they wrote a list of items to mention during their appointment. In return, Orbit stated that the psychiatrist *“looked at the list and he said, ‘Well, you seem so organized. You seem fine. You don’t look like you need any help. You’re dressing properly. Your hygiene looks fine. I don’t think you need that much help. Are you sure you’re coming to the right place?’*” Orbit shared their frustration and noted that *“just because [they] present in this certain way doesn’t mean that [their] mental health is fine or perfect.”* While external appearances can contribute to assessments (e.g., mental status exams), this approach does not gather in-depth information. Mental health issues cannot be accurately and fully understood based on initial impressions. The practitioner’s comments imply that Orbit’s concerns are invalid because they are not immediately visible. This interaction is an example of inadequate care that can hinder access to healthcare. Additionally, such comments can perpetuate misconceptions that individuals with mental health issues should exhibit specific behaviors, creating unfounded expectations regarding who should seek support¹⁵.

Orbit shared other interactions with practitioners that felt incomplete. Specifically, Orbit noted that their diagnostic experiences felt *“way too shallow and didn’t go in-depth.”* Orbit credited this to practitioners asking *“simple yes or no questions”* and *“building the diagnosis off of those”* answers. Alia shared similar experiences. Her examples related to practitioners rushing her treatment. Alia noted that doctors generally focus on getting patients *“in [and] out”* and *“whatever is the most fast and effective way to deal with [a problem] and not something that will necessarily last- kind of like a Band-Aid solution.”* Alia shared that this is particularly insulting when dealing with wait times. She expressed, *“It’s the worst feeling to wait a year on a waitlist. And then for them to rush you out of the office when you do see them... It feels like a slap in the face.”* This substandard care has had medical implications for Alia. She has been *“misdiagnosed because of being rushed”* and *“didn’t receive proper or effective treatment because [the doctor] didn’t get to know”* her. Alia noted that she was unaware of this until she happened to find another doctor who was *“appalled by what the previous doctor did.”* Only then did Alia *“realize how badly [she] was mistreated”*. Alia’s example highlights the difference that proper care can make for patients and the stark differences in the quality of care across practitioners.

¹⁵ Tobin Seibers (2004) addresses this in the context of disability, in “Disability as Masquerade”.

Medical incompetence

All participants shared experiences with medical incompetence. In these cases, practitioners did not have the skills and knowledge to provide applicable and effective treatment. For instance, AC pointed out the challenges of finding healthcare practitioners who are *“aware of healthcare challenges queer people face.”* AC spoke about the medical and interpersonal competency practitioners need to provide gender-affirming care (e.g., hormone replacement therapy and gender-affirming surgery) respectfully (e.g., using the correct name and pronouns). Alia reported similar experiences with mental health practitioners who did not share similar identities and life experiences. Alia stated, *“if [practitioners have] never experienced it, they won’t understand it. And if they have nothing to relate it to, then it’s like, it doesn’t exist [to them].”*

AC finds that they often know more about their medical concerns than their practitioners. This dynamic leads to situations where AC is expected to educate the practitioner. AC shared their frustration with this and spoke of how it impedes their access to care.

If I’m going to be here as a source of education for the healthcare provider, then why am I here? The feeling of redundancy is very frustrating. Part of the way I deal with the anxiety and worry pre-appointment is to kind of get to the edge of how much I can do on my own and then seek professional care. If the care provider doesn’t have at least that baseline of knowledge, then it becomes me regurgitating what I’ve already looked at myself and not actually getting care.

In Orbit’s case, they struggled to find practitioners who were informed about Tourette’s and could provide information. Orbit reported significant challenges getting a diagnosis, in part because *“a lot of people didn’t know what was going on.”* When Orbit engaged with services, providers *“weren’t able to offer any help or advice.”* Orbit’s delayed diagnosis suggests a lack of knowledge among several healthcare practitioners. In the end, Orbit waited two years to get a diagnosis. Despite this, the letter provided by the psychiatrist was *“too vague”* for Orbit to qualify for accommodations at their university.

Discrimination

Language access

Orbit described how language barriers and cultural bias impacted their access to care. Orbit shared that during childhood, their parents were *“not the best at English.”*

Because of this, Orbit's parents "*were not able to articulate exactly what was wrong.*" Orbit shared that "*it felt like [their family was] ignored and not taken as seriously as other patients next to [them].*" This experience highlights systemic inequalities that individuals with limited English proficiency and racialized individuals face when seeking healthcare.

Racism

Tea Rosa shared their experiences with anti-Indigenous racism within the healthcare system. When trying to access their non-insured health benefits, Tea Rosa stated that some practitioners questioned the legitimacy of the Squamish Nation itself and denied them care. As a white-passing person, Tea Rosa acknowledges that their access to care is significantly different from their family and community members. They explained when they "*access services, [they're] looked at a whole lot different than [their] sisters or [their] brother because [Tea Rosa is] white [passing].*" Tea Rosa also routinely witnesses healthcare practitioners mistreating their community members. Tea Rosa expressed anger, confusion, fear, and sorrow that their loved ones struggle to access care.

...seeing relatives that are from my community or from communities that I know and that I work in that are struggling and trying to access care, or not able to access care because of the way that they look and the way that they identify. That's really scary and overwhelming ... What's, what's the difference between that person and myself, in, in like the bigoted people's eyes, you know? It's just like, how, how can you make that distinction? You know? Like one person is better than another person, and so therefore, the lesser should not receive healthcare or whatever because... it's just a silly notion.

These experiences impact the ways that Tea Rosa supports others. While they want to encourage people to access services and support, they are "*also being mindful that those systems don't necessarily offer that.*" Tea Rosa also expressed that "*a lot of the time, that healing might come from other places, like through... ceremony or through being on the land.*"

Queerphobia

Participants shared information highlighting practitioners' limited understanding of queer and trans individuals. These experiences ranged in how directly queerphobic practitioners were. In Orbit's experience, practitioners can hold several misconceptions about queer and trans people. Orbit noted that practitioners often think gender and

sexual diversity is “a *phase*.” Orbit has also met practitioners that make assumptions and believe discriminatory stereotypes. For instance, Orbit shared:

They're like, 'Oh, you're queer. You must have some mental illness.'... I don't know how to explain it but, every time they mention the fact that I'm queer, they're like 'Oh, you're queer. You must also have anxiety. You must also have depression. You must also have ADHD.' ...one of my school counsellors, asked like, if I've been on TikTok too much. And at the time, I didn't even have the app installed and it's like, I don't watch TikTok.

Assuming mental illness based on queerness¹⁶ is stigmatizing and perpetuates harmful stereotypes. In associating the two, practitioners suggest that being queer is inherently problematic. This pathologizing of queerness also generalizes the experiences of all queer people. It neglects the uniqueness of each queer person's experience and erases the discrimination and systemic barriers contributing to higher rates of mental health challenges for queer folks. The counsellor's reference to TikTok is a misguided attempt to attribute Orbit's queerness to external influences. One's relationship to queerness can change over time and with exposure to different information. However, in this case, the counsellor seems to dismiss Orbit's identity as a mere result of social media trends and overconsumption. Orbit shared that those interactions rely on a particular stereotype about queer people:

...[it's] based off, like, the stereotype that queer people are all... [it's] a phase or like, seeking attention ... A lot of people think that a lot of queer people fake mental illness for clout or attention, or to be funny. Like, maybe there are, like, a minority that are like that, but most people aren't. It's just that we have this, like, reputation, of just adding, like collecting mental illnesses or something.

This stereotype undermines the struggles of queer people while suggesting that queer people use mental illnesses for personal gain. It reinforces the idea that queer identities and experiences are invalid and undeserving of empathy and support.

Orbit has also had the reverse experience, where practitioners who learn about Orbit's Tourette's then associate it with queerness. Orbit shared, “*They kind of said it in like, an ‘Oh, you have Tourette’s. Of course, you’re queer!’ type of deal. As if they’re a package deal and they come together.*” Such statements also contribute to the

¹⁶ Within medical fields, queerness and transness have historically been pathologized. This is evident in the previous inclusion of “homosexuality” as “sexual deviation” in the Diagnostic and Statistical Manual.

stigmatization of both queer and neurodivergent individuals. Implying there is a natural connection oversimplifies the complexities of both Tourette's and queerness, without inviting Orbit to share if and how these experiences intersect. While practitioners readily associate Orbit's queerness with mental health conditions, Orbit noticed that practitioners have challenges understanding their queerness in relation to their ethnicity. Orbit shared:

When people see that I'm Asian and queer, it definitely throws people off a bit. They don't really exactly know how to deal with that or approach that, so they would be dismissive of it and not mention it. But obviously they see me in a different way after finding that out.

This example sheds light on how intersectional identities influence how Orbit is perceived and treated within the healthcare system. As Orbit is visibly East Asian, there is implied confusion or uncertainty that Asian people can be queer. This lack of understanding may create barriers for Orbit to be respected and understood in all their complexities and intersectional experiences.

Cisheteronormativity

Orbit brought up gender-affirming care and noted that *"a lot of the times, people don't take it seriously."* When I asked them to elaborate, Orbit shared, *"I present very feminine or like, very cis-passing because I have family at home that are not supportive of queerness. So, I present very feminine or cis-passing in medical care as well."* Orbit shared that healthcare providers tend to invalidate their identity based on Orbit's presentation. Orbit stated, *"When I fill out forms and I identify that I'm non-binary, a lot of healthcare professionals double check and always confirm to ask if I made the right, like, I checked the right box and that's just invalidating."* Orbit's description shows the complexities of avoiding harm as a non-binary person. Conforming to societal expectations can be a conflict-avoiding strategy for some gender-diverse individuals. However, when healthcare professionals are not informed about the range of experiences and presentations of gender-diverse people, this can result in cissexist and invalidating interactions. Questioning Orbit's self-identification and gender reinforces expectations that gender-diverse people must present a specific way.

As a non-binary and Two-Spirit person, Tea Rosa has had similar experiences. Tea Rosa shares that accessing care has *"always been such an alienating process"*

because of how ingrained the gender binary is. They commented on how this is present in forms and through healthcare interactions. Tea Rosa is “*always misgendered*” in healthcare spaces. In addition, Tea Rosa “[*receives*] *more female-biased care because of the gender [their] body presents with.*” As an example, Tea Rosa spoke of an interaction between them and a nurse practitioner.

I’ve been off birth control for almost ten years now. When I was in high school, it caused horrible symptoms, so, took myself off of it when I realized, oh, that’s what’s causing all of these other things. And then was like, cool not going to do that again. Me and my doctor worked to be like, yeah, that’s not the play. Let’s figure out something else and we’ll come up with a care plan that’s different. And that was good. After that doctor left, the nurse care practitioner that I got *Tea Rosa pauses* the first session that I fucking had with her, she was like, ‘Oh, like I noticed you’re not on birth control at all.’ And just started, you know, giving me her whole little spiel about birth control and you know the different things for hormone stuff and I was just like, ‘Okay, that’s great. I think you need to like, decenter feminine wording.’ It just felt like an educational check in, when it was supposed to be like, I’m talking to this healthcare provider for support for myself.

The nurse practitioner assumed that everyone aligns with the traditional gender binary and that their healthcare needs can be categorized and identified accordingly. In other words, patients perceived to be male are assumed to have certain medical concerns, and vice versa for those perceived to be female. In doing so, the nurse practitioner overlooks the existence of non-binary identities and the importance of needs, preferences, and pre-existing knowledge about one’s body across all genders. In assuming that contraception is a relevant medical need, the practitioner is also making assumptions about Tea Rosa’s sexuality (e.g., sexual orientation, sexual activity, and the existence and anatomy of partners).

Tea Rosa also brings attention to the nurse practitioner’s choice of words. Tea Rosa expresses the need to “*decenter feminine wording*”, indicating that the delivery of information was also rooted in cisheteronormative perspectives. This placed Tea Rosa in a complex situation, where they were pressured to set aside their patient “*role*” and consider educating the practitioner. Tea Rosa shared how these interactions have deterred them and other Indigenous youth from seeking support.

[Practitioners’] workplaces should be providing [education] or they should be seeking that out on their own ... It’s not on the patients to be educating their healthcare providers and I find that when I’ve spoken to a lot of other

Indigenous youth that's like a big sentiment as they're like, 'I just don't want to have to go through the possibility of doing that.' I was like, 'Me neither!' That's so valid. No one should. *Tea Rosa laughs*

Continuity

All participants indicated that continuity of care is a valuable component of quality healthcare. Despite this, only AC reported consistently accessing a desired practitioner. Orbit spoke extensively about their challenges getting support with Tourette's from the same practitioners. They shared their frustrations of being repeatedly referred to different practitioners without finding support.

My biggest problem with the healthcare system [is] being tossed around from place to place as each practitioner I go to cannot help me and refer me to a different practitioner/institution. This has been happening for years and I took a break from trying to receive help for many months.

Orbit's use of the words "*tossed around... for years*" indicates a repeatedly disjointed healthcare experience. Orbit's example highlights the detrimental effects of a lack of continuous care. Orbit's hopelessness, frustration, and exhaustion with these experiences discouraged them from continuing to try and seek care.

Tea Rosa is also very familiar with being "*handed off*". Tea Rosa used to have access to health services where they could indicate their preferences for a non-male practitioner. Tea Rosa greatly appreciated this as it supported their emotional safety as a sexual assault survivor. However, since Tea Rosa turned 25, they are no longer eligible for this service. Tea Rosa was not connected to services that match their needs and now finds it a "*huge challenge*" when "*seeking healthcare services of any kind.*" They noted, "*I just prepare myself as best I can when accessing services lately because it's just been, unfortunately, back to survival mode due to all of the lapse in care.*"

Tea Rosa shared that they accessed a supportive, holistic, and trauma-informed doctor through their nation. That doctor was the "*first doctor to take [their] back pain seriously*" in 24 years. As Tea Rosa was developing the confidence to ask this doctor for accommodations and support, their doctor left. Since then, things have been "*really difficult*" for Tea Rosa as they struggle to access care.

My doctor left in October 2022, and I've just been... I haven't really been seeing anybody because the person that they connected me with is a naturopath and not authorized to do the support that I need. And then the

nurse practitioner that they had on staff also ended up leaving because cost of living in Vancouver was too high.

Tea Rosa's experience provides insight into the importance of continuity of care. Patients can have different relationships with help-seeking and healthcare professionals. For Tea Rosa, they did not have sufficient time to feel safe asking for support before their doctor left. This quote also demonstrates how external dynamics (i.e., outside of the patient-practitioner relationship) influence healthcare. Economic pressures can impact how sustainable it is for providers to practice, consequently impacting practitioner well-being and disrupting the continuity of care.

These experiences can change expectations of and relationships with healthcare. Alia noted that inconsistent care is aggravating when she finally finds a practitioner she wants to work with. She noted, "*There've just been so many bad [practitioners] that ... when you find someone [good], you want to hold on to them, but then the system doesn't allow you to do that.*" She expressed that inconsistent care fosters a sense of instability. She stated, "*I have never felt completely safe because I know that even if [they're] good, all healthcare employees can be ripped away from me.*"

3.2.2. Consequences

Participants connected their healthcare challenges to a range of emotional experiences. The most frequently expressed emotion was fear, followed by exhaustion, anger, hopelessness, and isolation. These emotions reflect the complex experiences that participants have had with healthcare providers and systems.

Negative Emotion

Fear

Fear was a prevalent emotion reported by all participants. Fear presented itself in various intensities and forms, such as hesitancy, worry, anxiety, self-doubt, suspicion, and numbness. The fear stemmed from negative healthcare experiences and was particularly relevant after experiences of discrimination and invalidation. Participants reported fear of judgment, discrimination, denial of care, and poor medical treatment at all stages of accessing healthcare. Tea Rosa provided insight by offering the following stream of consciousness: "*I have to prepare myself. What am I going to do to be ready?*"

Where am I going to be able to access this from? Am I going to be able to afford this? If this is not covered then how will I be able to afford it?" AC offered similar thoughts by questioning, *"Am I going to receive care, or will I be traumatized?"*

A lack of information about one's practitioners may amplify fear. Participants shared uncertainty about how practitioners, non-medical staff, and other patients would react to their identities. For AC, this created feelings of vulnerability. AC has been denied care before based on their ethnicity and BMI. In their questionnaire, they wrote:

I never know which [identity] they're going to react to, cause when we're interacting with the system face to face, it just can feel like a walking target board of various targets... [I'm] having to see if/when these aspects of who I am would be used to disregard my experiences or deny me respect and/or care.

When these fears are confirmed, this can create a complex reaction among patients. AC shared experiences of vindication, a sense of *"I was right!"* while also being disappointed and saddened. As AC commented, *"There's no winning."*

Fear manifested in different coping mechanisms across participants. Fear often prompted participants to engage in self-protective behaviors such as extensively searching online for information, choosing not to share information with practitioners, planning interactions, and avoiding medical care. As AC shared:

It's always treating my concerns as 'Is this a concern that is as serious as I think it to be?' It's a lot of back and forth being like, 'Okay, I actually do need professional care versus no, it's actually okay.' So, it's a lot of doubting the severity of my own concerns and also downplaying and a vicious cycle.

During appointments, some participants reported self-soothing to cope with fear (e.g., skin picking). Critically, these examples reveal an iatrogenic dynamic, wherein negative healthcare interactions induce fear and anxiety-related responses- which could themselves be perceived as medical concerns.

Exhaustion

Participants commented on how accessing healthcare and navigating harm is exhausting. For AC, the exhaustion was mostly associated with the energy and *"mental space"* it takes to prepare for appointments and anticipate harm. AC's need to be vigilant

is evident throughout the entire process of seeking healthcare. This constant state of alertness creates additional burdens.

For Orbit, Tea Rosa, and Alia, exhaustion was frequently associated with their repeated and unsuccessful attempts to seek care. In Orbit's case, exhaustion stemmed from the continuous allocation of resources needed to pursue care. The lack of support from practitioners added to Orbit's overwhelm. Tea Rosa described healthcare as "*a huge taxing process that is extremely draining and not beneficial to [their] wellbeing.*" They highlighted that "*repeatedly not being heard or repeatedly being bounced off to different points of contact and then being lost within [the healthcare system] ... really takes a toll.*" At times, Tea Rosa questions the value of seeking care if it only brings more stress. Alia shared similar perspectives, recounting numerous instances of being dismissed at emergency hospitals.

Waiting in a hospital for a few hours, maybe it's better than risking my academic career. But I don't have the energy to put myself through it. I can't. I don't want to. And I don't think I could will myself to do it. Obviously, a lot of it is mentality. But once you have those experiences, they stay in your body. Sometimes I just can't trick myself out of not feeling that.

While Alia acknowledged that care is theoretically possible, her negative experiences have decimated her willingness to seek care, even when experiencing severe physical pain.

Anger

Participants described how anger shows up in relation to their healthcare experiences. AC and Alia noted that practitioner incompetence often renders their appointments redundant. This led to frustration with services and practitioners. AC spoke about this in the context of educating their practitioners.

If I'm going to be here as a source of education for the healthcare provider then why am I here? I feel like the feeling of redundancy is very frustrating because part of the part of the way I deal with the anxiety and worry pre-appointment is to get to the edge of how much I can do on my own and then seek professional care. So, if the care provider doesn't have at least that baseline of knowledge, then it becomes me regurgitating what I've already looked at myself and not actually working towards the goal of that appointment of actually getting care.

Alia expressed similar frustration with practitioners who do not understand or empathize with her. She noted, "It's so frustrating to explain that to people who are so out of touch with our experience and it's like, talking to a brick wall." Alia described how these interactions negatively impact her relationship with healthcare. She shared, "*Obviously, some care is better than no care. But then I also find myself being frustrated, especially when I'm talking to someone who doesn't make me feel good about myself... It's... am I really better off? Like, at this point... It's like, maybe I just don't want it?*" For many participants, these experiences with anger were connected to the following theme of hopelessness.

Hopelessness

Orbit and AC expressed hopelessness when engaging with services. Orbit's sense of hopelessness related to how challenging it was to find a practitioner who knew about Tourette's. AC discussed hopelessness in the context of counseling. Despite overcoming self-doubt and reaching out to services, a practitioner denied AC care. While AC shared that they anticipated this outcome, the rejection reinforced feelings of hopelessness. AC reported feeling numb and being "*back to square one.*" AC was left questioning their worthiness of seeking help and the adequacy of available services.

Hopelessness was especially evident when I asked participants about accessible healthcare. The questionnaire asked participants to comment on what comes to mind when thinking of accessible healthcare. In response, Tea Rosa and Orbit spoke of inaccessibility. Tea Rosa shared, "*That question I struggled with, I kind of went to it and then moved on and then came back.*" Tea Rosa understands that accessible healthcare can theoretically exist. However, this is disconnected and far from their current realities. This disparity created a sense of hopelessness and longing, where even dreaming of accessibility feels unattainable. This experience was similar to Alia who described her hopes of having a practitioner with the same identities as "*unattainable*" and related it to her "*dream world.*"

Isolation

The participants' experiences revealed a sense of isolation when engaging with healthcare. Participants often felt alone when they unable to access basic respect, information, and treatments. For AC, this happened when AC knew more about certain

health conditions than their practitioners. If practitioners do not take responsibility for addressing this gap, AC is left to independently gather information, self-advocate, and ensure the comprehensiveness of care. In most cases, participants gave me the impression that they were fighting against practitioners and the healthcare system to get care. Participants also associated isolation with a lack of community support and when others actively obstructed their access to services (e.g., shaming individuals for seeking care). This isolation has practical implications for participants with limited options for care. Tea Rosa questioned, *“How do you handle that fallout when there is no support or when you've been kind of left to deal with it on your own?”*

Strategies

In response to the above challenges and emotions, participants shared a range of behaviors they use to protect themselves and access care. These behaviors are a response to harm and forms of self-protection and care. In recognition of this, I refer to these behaviors as strategies¹⁷. Participants stated that these strategies require a delicate and dynamic balancing of needs, resources, capacity, and health.

Going without care: There is agency and safety in saying no¹⁸

Abstaining from formal healthcare services was the most mentioned strategy across participants, with all participants sharing multiple instances of this behavior. Participants reported varying degrees of avoidance and diverse circumstances under which they would seek or refrain from care. AC can seek out and understand health information independently. AC will often exhaust their resources before seeking professional care. They describe this as getting *“to the edge of how much [they] can do on [their] own.”* AC learns about health conditions online, makes lifestyle changes, and may use substances. At times, these strategies enable AC to self-manage their concerns without relying on formal medical services. AC described the trade-off with the

¹⁷ My hope in terming these behaviors “strategies” is not to neglect the consequences that can come from avoiding healthcare. Rather, these strategies are a part of a larger dynamic and discussion around what it means to take care of ourselves within harmful systems and structures. I understand these actions as forms of harm reduction that are realistically available and accessible for some racialized queer and trans folks.

¹⁸ This sentence came out of discussions with Evren Salja. In discussing abstaining from healthcare, Evren offered the sentence, “There is agency in saying no.” I have expanded on this to include participants’ considerations for avoiding harm.

following: *“Do I want to go through several stages of worry [and] anxiety [seeking healthcare] or do I want to find ways to adjust my lifestyle or self-medicate?”*

Orbit shared that discrimination and invalidation have demotivated them from seeking help. Orbit explained that the potential to meet practitioners *“that would be homophobic or stigmatize queerness or mental illness”* is exhausting. As such, Orbit avoids services as a form of self-protection. Orbit’s avoidance of care demonstrates how repeated discrimination may erode trust in the overall system and impact access to care. Similarly, Tea Rosa reported withdrawing from services due to inconsistent care and constant invalidation. Currently, they only seek care in acute situations.

I’ve really withdrawn over the last year and a half and accessing services has been difficult- extremely difficult for me, so it’s only been kind of like, when I force myself to access things and it’s like, because I need it, because my body is like, giving me warning signals.

Tea Rosa’s reactionary approach has significant implications for accessing preventative care and treatments. By delaying or avoiding check-ups, screenings, and appointments, Tea Rosa may not have equal opportunities for early detection or timely treatments.

Alia describes avoiding the hospital even when she has *“more severe”* and *“debilitating”* physical pain. When this happens, Alia’s mom wants to take Alia to the hospital. However, Alia will decline and wait out her symptoms at home. She stated, *“Realistically, what are they going to do?”* Alia acknowledges that this has implications for her ability to participate in life, but doubts that practitioners will help her. She stated, *“I don’t want to be in pain in [the hospital] and then have to go to a doctor who just dismisses me.”*

Careful engagement

Preparation

All participants shared a sense of cautiousness when engaging with healthcare services. For AC, a large part of their healthcare experience is planning and preparing for appointments, such as researching treatments. AC plans their interactions with practitioners, including how much AC wants to disclose and how much they will mask their neurodivergence.

Selecting providers

Generally, Orbit is not able to choose their practitioners. In these situations, Orbit relies on a reactionary process. If they have negative experiences with a practitioner, Orbit will start again with a different practitioner. Orbit finds that youth-focused programs and organizations are more informed about and prepared to support their needs. Orbit relies on these resources to connect them to healthcare services. AC also shared their strategies for choosing practitioners. AC wanted their family doctor to understand the cultural context of their “*traditionally taboo*” concerns. As such, they selected a practitioner who was East Asian to “*understand that [and] respect the gravity of the situation.*” When accessing other services, AC relies on community recommendations. Unfortunately, these services are not always within reach. When information about practitioners is not readily available, individuals may assess safety through other methods. Orbit and AC observe how practitioners engage with other patients when possible (e.g., in waiting rooms or when supporting family accessing care).

Tea Rosa and AC indicated preferences for practitioners with shared identities. Unfortunately, due to the lack of racialized queer and trans practitioners, this limits participants’ options. Because of this, AC noted that selecting practitioners feels like “*choosing [their] poison.*” In choosing a practitioner that is visibly a member of one community, AC runs the risk of that practitioner being ill-informed or prepared to engage with their other identities.

If I go with a provider who is visibly part of the global majority and/or member of my ethnic community, I worry they might be queerphobic at worse or at best, unaware of the specific needs queer patients need & vice versa. It can feel like trying to see by what flavour of -phobia would I be denied care and/or disregarded.

Changes in presentation

Alia and AC find that changes in their behaviors tend to elicit better care from practitioners. Alia shared that she feels pressured to change her behaviors to better her chances of receiving care at emergency hospitals. She shared that she must highlight specific experiences to be taken seriously¹⁹. Alia’s mother taught her this strategy, noting

¹⁹ After careful consideration, details of this behavior change have been left out. This is for the protection of community care-seeking strategies and to avoid confirmation bias among practitioners who may read this and interpret it without the necessary cultural context.

that Alia risks denial of care without it. In AC's case, they emphasized the importance of masking, being polite, and overly empathizing with their healthcare practitioners. AC finds that this seems to "*humanize*" themselves and facilitates a "*more relaxed approach to communication.*" AC also leverages their background in veterinary medicine to "*semi-camouflage*" themselves as part of the "*in-group.*" Specifically, AC uses "*jargon to help force doctors to take [them] seriously.*" They note that the similar medical background "*forces a very clear line of communication*" and gets practitioners to "*drop walls a little bit.*" Alia and AC's behaviors show the extents to which patients may conform and adopt specific personas to access care. The need to do so implies how challenging it is for patients to be seen as credible and deserving of quality care and interactions. It also demonstrates underlying frustrations and lack of trust in the healthcare system.

Selective disclosure

Participants reported voluntary and involuntary sharing of information. In some instances, practitioners gained information through visible characteristics. In other cases, participants actively chose to disclose information. For instance, AC tentatively and strategically shares information to gauge how provider's respond. They stated, "*As someone who recent changed their name, I sometimes test the water by bringing up my name and watch for their reactions as an indicator of safety.*" AC notes that in doing so, they are "*[devoting] the energy to balance disclosing enough to find out if this person is safe versus protecting [themselves].*"

Individuals may choose not to share their identities for fear that practitioners will react poorly (e.g., discrimination or changing the focus of appointments). AC provided an example of this with the following:

I am seeking gender affirming care, so I disclose [my gender identity] relatively readily. I'm visibly part of the of the global majority, so, walking in is disclosure. *AC laughs, pauses, then looks away* I... the neurodivergent part, I don't outright disclose because I feel like that's already too much stuff on the table ... I don't want to pull attention away from the reason I'm seeking care.

AC dedicates a significant amount of time and energy to masking. Despite this, they do not have the safety indicators and positive experiences with practitioners to feel comfortable sharing their neurodivergence. This selective disclosure helps AC maintain control over the appointment's focus. However, practitioners may not be fully aware of

how they can support AC. AC experiences scarcity in their healthcare interactions, in that there seems to only be room for a certain level of disclosure. AC's statement implies that more disclosure carries greater risk of unintended consequences to the quality of their healthcare interaction. Without having a conversation about accessibility and neurodivergence, AC currently manages these concerns independently.

Research trials

The lack of successful treatment has created a deep sense of hopelessness in Alia. In her search for effective treatment, Alia participated in a largely unpaid randomized control study. This participation has come at a personal cost with time and confidentiality concerns. During her intake, Alia recognized the research assistant conducting her assessment. Alia shared:

The second I sat down and she introduced herself, I realized I've spent a summer volunteering with her, like, I spent over 100 hours volunteering with her and I don't think she recognized me. But I didn't want to say anything because I was scared, if, like, I said something they would push me out of the study because it would be a conflict of interest. So, I was just like, okay, I'm not gonna say anything, but I know. I know she's my age, and I know she lives in my neighborhood ... We have, like, a lot of mutuals ... and she went through my entire medical history.

Alia's experience highlights the importance of treatment equity and the nuances of navigating research ethics. During participation, Alia also learned that the researchers would not disclose if Alia received the treatment or placebo after the study concluded. Alia noted that this was not shared with her before beginning participation. She questioned if her discomfort during her intake distracted her from asking the "*right questions.*"

Community Support

AC and Tea Rosa sought support from community members. AC uses community recommendations to determine which practitioners to seek out. Tea Rosa finds support from a community-based program for racialized queer youth. This program offers information about decolonizing healthcare practices and healthcare rights. This program has also empowered Tea Rosa to share this information and support others.

[My partner was] like, 'I don't know if you can come with me [to the appointment].' *Tea Rosa smiles widely* And I was like, 'Yeah, I can!' I had

just had [an educational] session on decolonizing health too. So, I was like, 'Yeah. We can!' I was like, 'We literally just talked about this! This is what you can do! ... I have slides I can show you when we get home if you want to talk about it more!'

Considerations & Limitations

While these strategies can be effective, it is important to acknowledge the additional considerations and limitations. The need for participants to develop, learn, and use these strategies implies the existence of accessibility barriers. These strategies also reinforce that healthcare is not merely biology and medical treatment. Participants relied on their personal resources, such as time, relationships, and energy, to use these strategies. They shouldered the corresponding burdens while already in need of care. AC aptly described this as "*navigating a checklist that's separate from what you're actually seeking care for.*" It is crucial to recognize that individuals without access to the relevant resources may be unable to use these strategies.

Moreover, these strategies have significant limitations. They cannot safeguard participants from harm, nor guarantee better healthcare experiences. The strategies shared generally focused on a limited amount of accessibility issues, leaving other issues unaddressed. This limitation led to situations where participants had to compromise on their care. As an example, Alia relied on public services for financial accessibility, but could not choose a culturally competent practitioner. Further, some strategies may inadvertently expose participants to additional negative consequences. The most evident example is forgoing or delaying healthcare to avoid potential harm. This approach creates the potential for worsening health conditions, missed preventative care, and limited access to timely interventions.

Finally, these individual strategies cannot address systemic issues within the healthcare system and society. For instance, relying on community referrals for trans-affirmative practitioners may improve immediate access to inclusive care. However, it fails to address the underlying problems of inadequate medical training and the absence of trans-inclusive policies, guidelines, protocols, and resources. On a broader level, this challenge highlights the broader cultural context that reinforces the gender binary while marginalizing trans people. Greater systemic change is needed to interrupt these harms and facilitate safer healthcare experiences for racialized queer and trans young adults.

3.2.3. Positive Experiences

While they were few and far between, participants did report positive healthcare experiences. During these experiences, participants reported feeling heard, seen, validated, and supported. Practitioners facilitated this experience by listening, being empathetic, taking holistic approaches, and focusing on developing relationships with patients. These practitioners incorporated trauma-informed practices and pursued continuous education. Participants spoke energetically and fondly of these experiences. However, the relatively rare nature of these encounters corresponded with less questionnaire and interview content, as reflected below.

Choice

Tea Rosa and Alia described how the ability to choose practitioners benefited them. In Tea Rosa's case, they were able to indicate their preferences for a non-male practitioner at a youth-based clinic. This option helped Tea Rosa feel safer when accessing care, given their experiences as a sexual assault survivor. For Alia, having a choice in private counsellors enabled them to find someone who understood their cultural background.

Informed practitioners

Participants spoke highly of practitioners who understand and/or are aware of their cultural backgrounds and specific healthcare needs. For AC, this offers a lot of relief and "*helps maintain a doctor-patient relationship*" and "*partnership.*" Knowing that "*somebody else is and will look out for [the] health implications of [their] concerns*" is refreshing and reassuring. This collaboration fosters a sense of peace and confidence in their care, letting AC "*trust in the process.*" AC is then able to divert their attention and energy to other needs.

Even if practitioners are not entirely prepared to address the participants' health concerns, reactions to this situation can make a difference. AC shared that their doctor was not immediately able to provide gender-affirming medical care. However, their doctor was willing and enthusiastic to learn about it.

I didn't know if [gender-affirming care] was something that she was familiar with. I was prepared to have to find other doctors. But she was very enthusiastic about me being able to bring this to her and she was very

upfront about me being the only patient who she's worked with [on] gender affirming care. She just seemed very keen to look into the whole process... I got the first referral, one to two days afterwards. So, it was prompt!

This example shows how transparency with limitations can be appreciated when practitioners actively address gaps in knowledge, follow up, and provide care.

Shared backgrounds

While competency is never guaranteed, practitioners with overlapping identities can offer hope of relief and support. This was shown in AC's experience with their doctor, after finding out that their doctor is also queer.

She disclosed when I was hoping to get gender affirming care. Before her disclosure, I was prepared to have to explain what nonbinary and genderfluid means and basically convince this person that we exist. So, in that case, the overlap is greatly appreciated.

By having this shared background, AC did not have to educate their practitioner about gender and self-advocate. Instead, they were able to focus on seeking care.

Approach & Attitude

Practitioners' approaches and attitudes have the potential to enhance healthcare experiences. Orbit provided a contrasting example of interactions between their doctor and pharmacist. Despite asking questions, Orbit had difficulty getting information about a medication from their prescribing doctor. When they filled out the prescription, Orbit was surprised at how thorough and patient the pharmacist was.

When it was the pharmacist, they would actually properly talk about every detail. Like, take it step by step with what I need to do, if there's any side effects, what else I should take, or how this is going to impact me, possible side effects and things like that. I just felt like, 'Oh wow. They care about how it would turn out.'

This quote emphasizes the significance of effective communication and patient-centered care. It highlights how practitioners' behaviors can impact patients' perceptions of care and sense of support.

AC commented on the importance of practitioner attitudes given their medical needs. They spoke in the context of accessing gender-affirming care through their family physician. AC's medical needs involve life-long processes, with routine blood work and

prescriptions. As such, AC noted that it is “*just nice to have somebody who is compassionate instead of treating it like a burden.*” AC recognizes that “*the bar is on the floor*”, however, they still appreciate when practitioners are empathetic. Alia shared similar experiences, though her positive experience stemmed from holistic care and relationship development.

Some doctors are focused on the physical aspects of my condition. There are other doctors who are like, ‘Okay, obviously this is psychological experience. So, I want to have a conversation with you. I want to develop a relationship with you so I can properly have an assessment about my course of treatment.’ And it’s just such a night and day difference. It’s so much [more] obvious that they care more.

Tea Rosa also spoke fondly of a doctor who practiced holistic approaches. This practitioner emphasized trauma-informed and holistic care. Tea Rosa appreciated their practitioner’s understanding that health concerns and experiences are interconnected. Alia and Tea Rosa’s stories highlight the importance of aligning patient and provider understandings of health and treatment. These interactions enabled both participants to feel cared for and understood, a stark contrast to their general healthcare experiences. Although infrequent in nature, these positive experiences revealed an assortment of themes. These themes offer a glimpse into what participants found valuable when seeking healthcare.

3.2.4. Hopes

Given the relatively rare nature of positive experiences, it is important to identify areas of improvement. This section aims to shed light on the kinds of healthcare experiences participants would like to have and the factors that could facilitate this. Participants were asked to share their highest hopes for themselves and their communities. Participants spoke of trauma-informed and medically competent care that is patient, non-judgmental, timely, financially accessible, and collaborative. Participants also shared their hopes for gender-affirming care and body-neutral approaches to be normalized and included throughout the healthcare process. Participants shared that these changes would enable them to avoid further trauma while feeling understood, at peace, and heard. Orbit also expressed that these changes would support them in living a fulfilling life.

For this to happen, participants shared what they hoped practitioners would understand and implement. Participants asked that practitioners recognize their inherent worth as people and take their concerns seriously. Participants also wanted practitioners to be aware of medical trauma, trauma-informed care, and the health needs of different communities. AC raised the issue of transparency, noting the importance of communicating limitations in competency and taking the initiative to learn from a variety of sources, including literature reviews. Participants stressed the importance of being open to new information. This openness involves recognizing the variety of experiences within and across different communities. This also means understanding that racialized queer and trans young adults have a variety of experiences that may or may not align with practitioners' understandings and experiences of these identities.

Building on this, participants identified what systemic changes need to happen within healthcare. On a healthcare management level, this included integrating queer-inclusive practices throughout general healthcare. One example included forms with pronoun sections for all patients, not just those who share that they are queer. It also included mandating trauma-informed care and implementing training on patient-centered care, cultural competency, and the social sciences. For administrative changes, participants spoke of visible signs of allyship and enhanced confidentiality practices. On a policy level, participants commented on transphobic policies that restrict healthcare access. This change involves revising healthcare policies to recognize self-determination of gender dysphoria and the need for gender-affirming care. Tea Rosa also spoke of the importance of accessible language policy. They stated that policymakers should write policy in ways that are accessible and easy to understand.

Finally, participants mentioned structural changes. This included addressing barriers to care for both patients and healthcare providers. AC advocated for increased funding for queer-inclusive research. This was echoed across participants, as all individuals expressed gratitude for this study's existence, highlighting the scarcity of discussion and research focused on racialized queer and trans healthcare. While the study focused on patient experiences, multiple participants expressed empathy for healthcare providers. They recognized that healthcare staff are often overworked and at capacity. Participants spoke of increasing resources and support for practitioners for sustainable care practices.

Chapter 4.

Discussion & Conclusion

In this study, I sought to understand the healthcare experiences and recommendations of racialized queer and trans young adults. These findings build on existing research about healthcare inequalities for racialized, queer, and trans communities in Canada. To my knowledge, this research is the first to explicitly focus on racialized queer and trans young adults in British Columbia. I recruited four participants living in Metro Vancouver. All participants completed a questionnaire, interview, and member-check session. Using hermeneutic phenomenological analysis, I aimed to capture what it is like for participants to engage with healthcare services. I also shared participants' recommendations for improved healthcare. In the following sections, I will summarize my findings followed by considerations, implications, and applications of this research.

4.1. Summary of Results

The findings provide insight into the healthcare experiences of participants. Participants reported several interconnected accessibility barriers when seeking care. In this study, participants connected seeking healthcare with intense feelings of fear, exhaustion, anger, hopelessness, and isolation. Findings suggest that the emotional and mental tolls have downstream consequences for participants' attitudes towards healthcare providers, the healthcare system, and future healthcare interactions. These experiences also seem to influence participants' willingness to seek care when needed and the nuances of how they engage with practitioners.

This study drew participants together based on their identities as racialized queer and trans young adults. Participants also discussed their experiences in the context of other identities (e.g., disabled or neurodivergent). They described being excluded, invalidated, and lacking adequate care. The participants' experiences and perspectives suggest that the healthcare system is not designed their needs in mind. Instead, participants describe modifying their behaviors to gain access to healthcare. Unsurprisingly, participants expressed low expectations of the healthcare system.

Participants reported making difficult health choices, weighing, and sacrificing different financial, emotional, psychological, and medical needs in pursuit of their health goals. When the burden of seeking care becomes overwhelming and the hope of receiving care diminishes, participants often stop seeking care.

While rare, participants did report positive experiences with some healthcare providers. Participants spoke positively about informed and empathetic practitioners who understand their lived experiences. These practitioners were able to provide appropriate and thorough support or were willing to pursue continued education to do so. Participants often came across these practitioners by chance. Financial barriers, staffing changes, and patient reassignment meant most participants lost access to these helpful practitioners. Participants identified several changes that need to happen throughout the healthcare system for affirming, respectful, safer, and effective healthcare experiences.

4.1.1. Reflections

Conducting research within my community has been an honor and a practice in self-reflection. During the interviews, each participant expressed their gratitude that I was conducting this research. Participants noted how rare it was to have conversations about racialized queer and trans health, and rarer even in research settings. How rare it was for others to see their experiences as important. As a racialized queer and gender-diverse person, I understood this. Finding relevant healthcare services, participating in research, and reading studies often feels like fragmenting myself; I am considered a racialized or a queer person, rarely both at the same time. I also know the murkiness of wanting better care from overworked practitioners within a system that is underfunded. However, I also felt a deep discomfort with this gratitude. Using AC's words, I felt the "*bar [was] on the floor*" and that the gratitude was not mine to hold.

Among other social locations, I am a visibly racialized person, queer, and gender diverse. When seeking healthcare, I experience many of the challenges participants shared in this study. However, I am also a light-skinned, English-speaking, trans-misogyny-exempt citizen with an average-sized body. I am a graduate student, incoming counsellor, and researcher. I have access to privileges and systems of power through my identities and memberships with different institutions. I know how much harm these institutions have created for my communities. I would be mistaken to assume that my

experiences with oppression erase my access to privilege. At the time of writing this, I have not entirely figured out how to sit with this gratitude. However, I understand that this gratitude may stem from a scarcity of safety and care for racialized queer and trans people. I have since spoken to other community members about offering peer-based healthcare navigation information and support. I hope this serves as a reflection of my gratitude toward participants for all that they have offered and shared within this study.

4.2. Considerations

It is important to interpret the findings of this research with the following considerations. This study involved multiple components, including a questionnaire, interview, and member check session. As a result, individuals with limited availability (e.g., those needing to work multiple jobs) may not be adequately represented in this study. As well, I recruited participants through a community organization. For privacy reasons, I did not ask participants about the frequency, extent, and type of engagement within the partnering organization. As participants were able to find and connect with the partnering organization, they may be more socially connected or able to access related services (e.g., social, cultural, educational, and health supports). Despite this sampling consideration, participants still reported immense challenges accessing care.

The current study focuses on the experiences and perspectives of participants. The data relied on participant recall of events without verifying the accuracy or reliability of this information. However, objectivity is less significant for understanding how participants experience events and the impacts of these experiences. Regardless of the accuracy of these memories, participants' subjective experiences and interpretations cannot be overlooked. These experiences seem to have continuous impacts on their current perceptions of providers and healthcare systems.

Additionally, I conducted this study within specific geographical contexts. The participants in this study live and access services in the Lower Mainland region. Healthcare services in more northern and rural areas of British Columbia may differ significantly. Research indicates that access to healthcare services can be limited in rural locations (Kornelsen et al., 2021). This trend can be even more evident when exploring the availability of affirming healthcare for marginalized communities (Renner et

al., 2021). As such, data collected from participants in other regions of British Columbia and Canada may yield different narratives and consequently impact the findings.

Further, it is important to acknowledge that my data collection and interpretation primarily focused on racialization and sexuality. While participants provided insights into other cultural variables, such as age and disability, the questionnaire answers and interview content reflect this emphasis on racialization and sexuality. If this study had centered on other cultural variables, participants may have shared different experiences, potentially resulting in a distinct data set. Moreover, shifts in my reflections, pre-existing knowledge, and community relationships would likely have changed my interpretation of this or other data.

4.3. Implications

The following section discusses my findings in relation to existing theoretical understandings of healthcare access. In this section, I expand on Levesque et al.'s (2013) model and provide supplementary ways to understand and portray access.

4.3.1. Theoretical Understandings

Access

These findings have implications for updating current understandings of access. Levesque et al.'s (2013) model of healthcare access can systematically identify access barriers. Under the ability to engage, Levesque et al. discuss patients' abilities to participate in decision-making and treatment processes. Levesque et al. note that this depends on the appropriateness of the healthcare given. However, the model does not account for patients' adaptability in the face of poor-quality care. As demonstrated by participants, racialized queer and trans young adults may modify their behaviors in response to previous and current incompetent care. For instance, patients may engage in masking, choosing not to share information, educating practitioners, and self-advocacy. These responses represent a dynamic interplay between patients and the healthcare system. Further, they bring to light the active role that patients play in shaping their healthcare experiences. Incorporating patient responses expands current models of access and acknowledges patients' various skills and knowledge.

Although Levesque et al. (2013) do not explicitly state that their model is linear, they imply this through their use of language (e.g., “steps in the sequence” (p.4)) and graphics (i.e., an arrow with separated stages). This linearity differs from how individuals may evaluate access. For instance, affordability is the fourth accessibility criterion, following approachability, acceptability, and availability and accommodation. However, in Orbit’s case, the first three accessibility criteria were sometimes insignificant. When Orbit considered counselling, the substantial barrier of affordability overshadowed other accessibility features, rendering them irrelevant. In other words, in Orbit’s eyes, counselling was too expensive to care about or consider other aspects of accessibility. An updated model of access to healthcare should indicate that patients may prioritize specific accessibility features, depending on the context. This update is shown below, with an “Equal significance” template (Figure 3) and a “Weighted significance” example that uses Orbit’s experiences (Figure 4).

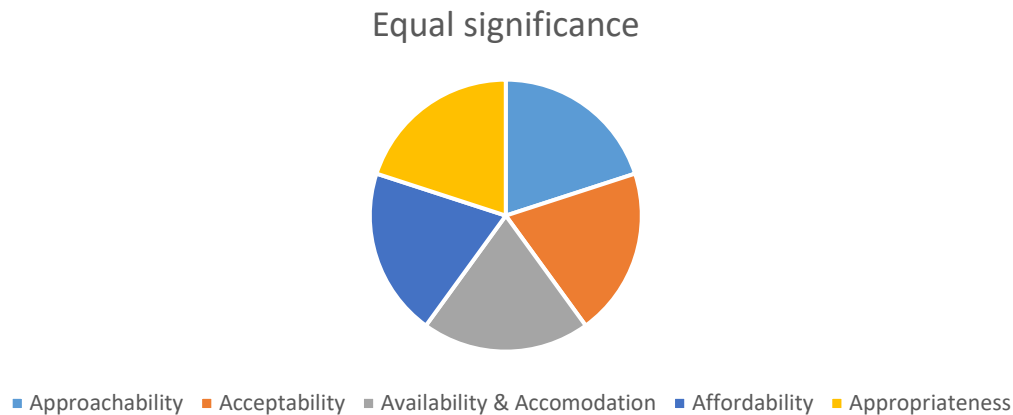


Figure 3. Representation of equally significant accessibility importance.

The “Equal significance” template represents an equal valuing of all accessibility features. This would align with Levesque et al.’s (2013) discussion of accessibility. In this case, all accessibility features are equally important. This template can be adjusted to reflect a patient’s perspective. The “Weighted significance” version below represents a prioritization of affordability relative to all other dimensions. This chart reflects Orbit’s main concerns around cost. This is one example of how the significance of accessibility dimensions can shift across patients and contexts. Adjusting the template to reflect a patient’s prioritization of different dimensions can guide efforts to address access issues.

Weighted significance

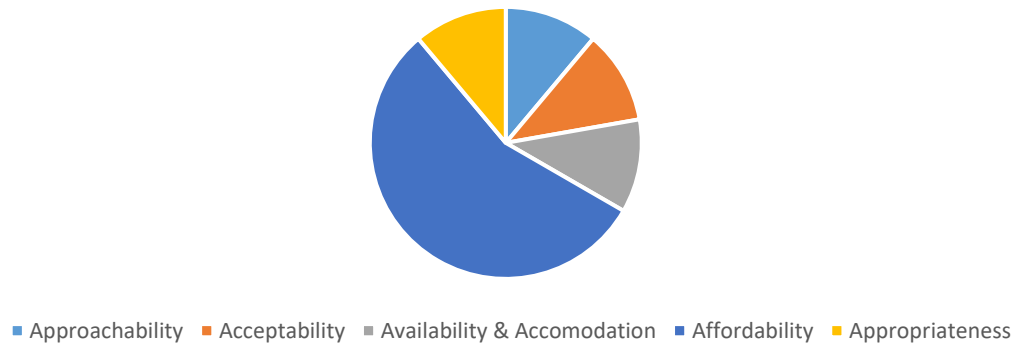


Figure 4. Example of differentially significant accessibility importance.

Behavior Change Models

The findings from this thesis support current models of behavior change, particularly the Health Belief Model (HBM). The HBM is a framework that explains individuals' healthcare-related behaviors (Becker, 1974). The HBM focuses on an individual's perceived susceptibility and severity of a condition in relation to the perceived benefits and costs of specific health behaviors. To illustrate the application of the HBM, we can consider decisions about flu vaccinations. According to the HBM, if someone believes they are susceptible to the flu and acknowledges the potentially significant consequences, they are more likely to be motivated to receive the vaccine. This person may also be interested if they believe the vaccine is effective and easily accessible. In the current study, participants demonstrated an awareness of relevant health concerns, indicating perceived susceptibility. They were also able to identify the impacts of these health concerns. However, participants struggled with perceived benefits and barriers associated with seeking healthcare. Many participants believed that practitioners could not provide the necessary services, reducing the perceived benefit of healthcare. Participants shared how this belief contributed to their decision to stop seeking services. Additionally, participants identified various accessibility barriers that further demotivated them from seeking healthcare.

The HBM also details the importance of the patient-practitioner relationship and continuity of care. Becker (1974) emphasizes the impact of interpersonal skills, noting that patients who feel misunderstood and rejected may be less likely to adhere to medical care. This aspect of the model aligns with my findings about invalidation,

discrimination, and disrespect. Participants connected these negative experiences to their perceptions of practitioners and subsequent reluctance to seek future healthcare. Further, Becker's insight on continuity of care is particularly relevant. He suggests that patients who consistently have the same practitioner may be more likely to engage in health-promoting behaviors. While most participants in this study do not have access to such continuity, they expressed their frustrations with disjointed care. As such, the HBM offers valuable insight into why participants in this study commonly reported abstaining from healthcare services. Ultimately, the findings from this research suggest the relevance of the HBM in understanding healthcare-related decisions. Such models can inform service improvement and future research.

4.3.2. Future Research

This study highlighted the need for further intersectional research on healthcare barriers and experiences. By incorporating an understanding of intersectionality, researchers can better understand the complexities and unique power dynamics that shape participants' encounters with the healthcare system. Moreover, my findings emphasize the importance of centering community voices and narratives in healthcare research and initiatives. Participants' narratives suggest a lack of interpersonal and medical competency within the healthcare system. Despite this, multiple individuals spoke of the advantages of community-based and youth-centered programs for direct and referral services. Future research can delve into the experiences of these services and programs, exploring the factors contributing to their effectiveness. I suggest that such research involve qualitative components. As participants suggested, healthcare is a dynamic and multi-staged process. Qualitative research offers opportunities to develop an in-depth understanding of these complexities. Further, qualitative methodology offers participants platforms to share their perspectives. While qualitative research generally relies on transcribed text, audio clips can be incorporated when reporting findings (Chandler et al., 2015). This offers a direct way for participants' voices, tones, and emotions to be heard. This may be particularly meaningful as participants in this study often reported being disregarded, invalidated, and misunderstood.

Participants called for significant systemic changes that would require sufficient time to advocate for and implement. As we work toward this change, there is still an immediate need for improved services. Research can explore strategies for current

practitioners to repair and rebuild relationships with patients following instances of harm. Future endeavors can also explore patient and practitioner experiences of the same interaction, noting how individuals' perspectives, priorities, and needs converge and differ. My research suggestions include exploring the relationship and dynamic between a practitioner and a patient. To better understand the perspectives, thoughts, and feelings of both parties, I recommend the use of interpersonal process recall, IPR. IPR involves audio and video recording of interactions (Kettley et al., 2015). Participants then review the recordings and elaborate on their emotions, thoughts, and experiences. IPR is often used to reflect on the dynamics between practitioners and clients. As such, IPR may be especially helpful in understanding healthcare interactions between racialized queer and trans patients and their practitioners. I also recommend that further research address the structural barriers to quality healthcare embedded in current models of healthcare provision (e.g., exploring how duration of appointment time impacts communication and quality of care).

4.3.3. Applications

As I was recruiting and conducting interviews, I noticed how each participant spoke of isolation while navigating healthcare. I would love for participants to see the commonality in their experiences and the strength in their collective wisdom and strategies. Inspired by other educational comic book guides²⁰, I recommend that the findings from this research and others be graphically represented with accessible language (with participants' consent). Such formats are often more accessible and challenge traditional academic knowledge sharing.

Another recommendation is creating a community-run platform that centralizes safety information. In this study, participants struggled to find background information on practitioners when choosing services. Clinic websites and individual practitioners may not provide relevant information. At times, professional standards of practice reinforce this lack of information. In the counselling field, the Canadian Counselling and Psychotherapy Association (2013) prohibits the use of testimonials from current or former clients when advertising. However, community reports on interactions with

²⁰ For examples, please see Syan Rose and Leah Lakshmi Piepzna-Samarasinha's *Our Work is Everywhere* and A. Andrew's *A Quick & Easy Guide to Sex & Disability*.

counsellors can be incredibly valuable. While counsellors can label and market themselves as anti-oppressive, anti-racist, and 2SLGBTQ+ friendly, their counselling practices may not reflect this. Therefore, restrictions on community testimonies do not account for how some marginalized communities navigate safety²¹. Further, safety information and healthcare recommendations are often exchanged through word of mouth. However, individuals who are less socially connected may not have access to this information. Community members may also rely on social media platforms, such as Facebook groups, to ask for and provide information. To my knowledge, there are no current dedicated platforms that focus on healthcare for racialized queer and trans people in British Columbia. This can make it challenging for individuals to find relevant information as they sift through other content, such as job postings, marketplace listings, and support requests. Moreover, instances of racism and ableism within these groups are not uncommon, creating further barriers for racialized and disabled individuals seeking inclusive and supportive healthcare guidance. Such a platform can draw insights from existing services such as Healing in Colour (a directory of racialized service providers), MindMapBC (a database of 2SLGBTQ+ affirming mental health services), and RateMDs (a review site for doctors), while also providing ways for community members to share their experiences. I am currently in conversations to explore the creation of such a platform.

Counselling

Participants shared challenges accessing affordable, informed, and affirming counselling. These challenges highlight the need for a range of improvements across the counselling field. Based on participants' experiences and suggestions, cost is a significant barrier to counselling. Affordable services may lessen this burden, supporting individuals in accessing support without jeopardizing their finances. Private and publicly funded practitioners, clinics, and organizations can improve affordability through free and sliding-scale services that reflect the financial realities of clients. These financially accessible services call for innovative, systemic, and political solutions. However, until

²¹ Evren Salja's (2018) *Queer considerations for overlapping relationships* critically examines dominant narratives about overlapping relationships for queer and trans counsellors. Among other concepts, this manuscript discusses the role of community connection, representation, and visibility for queer and trans clients.

more sustainable and stable public funding is available, providers may be able to subsidize costs through grants, donations, and crowdfunding.

Tea Rosa highlighted an important limitation of current services. They spoke of the need for cultural forms of healing such as ceremony and access to homelands. This insight emphasizes the need for counsellors and other practitioners to broaden their understanding and definitions of support beyond traditional talk therapy. Incorporating these forms of healing could be done through interdisciplinary services. I note here that certain healing practices, such as sweat-lodge ceremonies, have significant cultural, historical, and spiritual importance. Such practices may require conductors to receive specific training and teachings. Cultural forms of healing should not be misused or appropriated by individuals outside of these communities and roles. As such, practitioners who are unable and unqualified to provide this support should be prepared to refer clients to appropriate community resources.

Participants also emphasized the importance of optimal fit with their practitioners. One recommendation is for clinics to prioritize clients' needs and preferences when matching clients with counsellors. Clinics can ask clients what they expect and need from their counsellors. Clinics can then use this information to assign clients to counsellors who have the necessary experiences, knowledge, and expertise to provide support. This supports treatment optimization and centers on agency and client-centered care. There is the possibility that clinics do not have practitioners who can meet clients' needs. As Alia shared, some may assume that some care is better than no care. However, as suggested by participants' stories, this is not universally true. Counsellors may need to refer clients to other practitioners. These referrals should reflect the holistic needs of clients (e.g., skills, expertise, affordability, availability, and cultural background). Critically, this relies on the assumption that such a suitable practitioner exists. This then brings into question the availability of culturally diverse counsellors.

Past research and findings from this study suggest that finding a culturally competent counsellor can be particularly challenging for racialized queer and trans young adults (Patel, 2018). To address this issue, I recommend that counselling programs reconsider and expand their recruitment policies and practices to reflect the barriers that marginalized communities face. Many programs require a bachelor's degree, minimum grade requirements, the completion of specific courses, and

application and tuition fees. Given the financial and scheduling components associated with these requirements, applications can create significant barriers for racialized queer and trans young adults. While work and volunteer experiences are often considered, the emphasis on formalized education and support roles can disregard the value of lived experience. It can also create uncertainty for individuals whose experiences may not align with traditional understandings of “helping related” roles, such as sex workers, Facebook group moderators, members of pods²², and social media content creators²³. Here I warn against the assumption that all racialized queer and trans clients want a racialized queer and trans counsellor. I also warn against assuming all racialized queer and trans counsellors have the necessary training, skills, and knowledge to provide culturally competent care. Instead, I am advocating for cohorts of students who can bring a range of perspectives, backgrounds, community relationships, and experiences to their work. Theoretically and practically, these cohorts could increase the options available to all clients.

Critically, I believe more changes are needed within academia and workplaces to support racialized queer and trans counselling students and practitioners. Without actively addressing discriminatory practices, teachings, and structures, we risk subjecting people to additional harm in the name of inclusivity. Some academic literature has explored the educational experiences of racialized students with a subset of queer participants. Racialized students in counselling and psychology graduate programs have reported a range of discriminatory experiences (Haskins et al., 2013; Winley et al., 2020; Woolston, 2022). These experiences include isolation, tokenization, and a lack of a culturally representative curriculum (Haskins et al., 2013; Winley et al., 2020). Racialized students may also experience explicit or implicit expectations to educate their non-racialized counterparts without compensation or consent (Winley et al., 2020). In addition to the emotional and psychological harm, such discrimination can also impact the quality of training. Multiple students have expressed concerns about teaching practices that predominately center on the needs of non-racialized students with limited

²² Pods and pod mapping involve a particular relationship centered on transformative justice practices and principles. For those of us wanting to learn more, I recommend reading Mia Mingus’ “Pod and Pod Mapping Worksheet” available from the Bay Area Transformative Justice Collective.

²³ A particularly fitting example is [@gendersauce](#), an account that creates and shares memes and poetry about a range of topics and human experiences (e.g., queerness, abundance, kink, gender-affirming care, shame, and rest).

cultural competency (Winley et al., 2020). Racialized students reported feeling held back in their training as professors prioritized non-racialized students' needs and comprehension levels. Community literature has also documented similar experiences. Zena Sharman (2021) comments on how queer and trans healthcare providers and students "face discrimination at work and school, experiences exacerbated by the racism, ableism, and sexual violence so pervasive in these spaces" (p. 18-19). Sharman comments on how individuals learn to sacrifice aspects of themselves to access these institutions:

I invite you to think about how you've learned to leave parts of yourself or your community behind to access health care because you know it's unsafe or impossible to get care when you show up in the fullness and complexity of who you are. We learn to leave behind parts of ourselves and our communities as the price of gaining access to institutions and systems designed according to norms and assumptions we'll never fit into, whether we're accessing those spaces as patient, provider, student, educator, advocate, or activist. As we do the work of systemic change, it's imperative we remember these systems weren't mad for us or by us and in some cases were created to discipline, control, or eradicate us and our queer and trans kin. (p. 46-47)

Therefore, I recommend that academic institutions and workplaces hire external community-based consulting companies to understand and address such issues. These organizations can offer workshops, policy analyses, and audits guided by values such as anti-oppression, intersectionality, feminism, and community. I also recommend that these consultations become an ongoing practice, both as a proactive measure and in response to instances of harm. These recommendations have the potential to enhance the emotional safety of individuals pursuing counselling careers, thus promoting the sustainable increase and retention of practitioners with diverse backgrounds and skills. This change would then address the challenges that participants identified in finding culturally competent practitioners.

4.4. Conclusion

This study has offered insight into what it can be like to navigate healthcare as racialized queer and trans young adults. The readily available range of negative

healthcare experiences within this and other studies suggest the presence of systemic issues within British Columbia's healthcare system and society. As Zena Sharman (2021) stated, "every system is perfectly designed to get the results it gets" (p. 109). Addressing these challenges requires more than reducing costs or inclusive education. I believe it calls for a significant change to the social, economic, and political factors perpetuating inequalities and upholding the unjust treatment of marginalized communities within and beyond healthcare.

As I conclude this thesis, I am left questioning "What next?" The gravity of the situation often tempts me to try and fix everything all at once. Instead, I think of participants' stories, specifically the interactions and practitioners that made a difference. I am reminded of the importance of the small and the slow. The impacts that only intentional actions, relationship building, consent, and time can offer. I firmly believe in the power of collective action and community-driven solutions. This research has only been possible because of the care, teachings, and vulnerability of community members. It is only fitting that I offer these findings back to my communities to decide our next steps, if and when we choose to use them. It is my hope that these findings will facilitate further dialogue and serve as a call to action for all of us to move toward equitable healthcare that truly embodies care.

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