

Beyond Disclosure: A Human Rights Approach to Understanding Queer Women's Interactions with Healthcare Providers when Seeking Sexual Healthcare

by

Sarah Nicole Blackmore

B.A., University of Guelph, 2011

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts

in the

Counselling Psychology Program
Faculty of Education

© **Sarah Nicole Blackmore 2015**

SIMON FRASER UNIVERSITY

Fall 2015

All rights reserved.

However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for "Fair Dealing." Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

Approval

Name: Sarah Blackmore
Degree: Master of Arts
Title: *Beyond Disclosure: A Human Rights Approach to Understanding Queer Women's Interactions with Healthcare Providers When Seeking Sexual Healthcare*
Examining Committee: **Chair:** Dr. Ann Chinnery
Associate Professor

Dr. Sharalyn Jordan
Senior Supervisor
Assistant Professor
Faculty of Education

Dr. Marina Morrow
Supervisor
Professor
Faculty of Health Science

Dr. Jennifer Marchbank
External Examiner
Associate Professor
Gender, Sexuality, & Women's Studies
Simon Fraser University

Date Defended/Approved: December 15, 2015

Ethics Statement



The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

- a. human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

- b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

- c. as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

- d. as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

update Spring 2010

Abstract

This study explores interactions between queer women and healthcare providers within the context of sexual health and identifies barriers to and facilitators of equitable healthcare delivery. Constructivist grounded theory supplemented with situational mapping guided secondary analysis of nine participant interview transcripts from an original study on queer women's health. The current study situates queer women's sexual healthcare seeking within the broader social processes of heteronormativity and heterosexism. Through data analysis and interpretation, a three-tiered contextual framework for queer women's sexual healthcare seeking was identified. The healthcare space is the broadest level of the framework and the first material context queer women encounter when seeking sexual healthcare. The context of relational healthcare dynamics is the second tier of the framework and includes interactions between queer women as patients seeking healthcare from healthcare providers. The sexual healthcare interactions context is the third tier and specifically focuses on interactions related sexual healthcare. Different issues enabling or constraining queer women's health equity permeate these three contexts. Implications of the study findings are discussed at both the systemic and interactional levels of healthcare delivery.

Keywords: queer women; sexual health; interactions; healthcare; human rights

Acknowledgements

I would like to acknowledge the contributions of the people who made this project possible through their support and assistance.

Firstly, I would like to acknowledge Dr. Mary Bryson's kind offer to allow me to conduct a secondary data analysis of the data she collected for the national multi-site research project titled, "Health Care Practices and Relationships: The Experiences of Queer Women and Primary Care Providers". This study would not have been possible without Dr. Bryson's permission to reuse this rich source of data.

I am forever grateful for the educational, professional, and personal support from my primary supervisor Dr. Sharalyn Jordan. Thank you Dr. Jordan for your unwavering encouragement and the constant reminder of the importance of this research. I am very appreciative of your patience with my writing process and thoroughness, you have taught me a great deal about qualitative research.

Thank you to Dr. Marina Morrow. I am thankful for your willingness to hit the ground running with my study. Your feedback and guidance were invaluable throughout the editing process.

I am grateful for my family and partner who have provided me with reassurance and support throughout this long journey. I would like to thank all three of my parents for their unconditional support for my pursuit of my educational and professional goals. Mom, Dad, and Al, I would not have been able to do this without you, thank you. To my siblings Anna and Andrew, thank you for your encouragement, comedic relief and the never ending question – "When are you going to be finished?". Finally, I would like to thank my partner Blaise, who has been a pillar of strength throughout the toughest part of this process. Your continual optimism that I would in fact get through this helped me see the light at the end of the tunnel.

Table of Contents

Approval	ii
Ethics Statement	iii
Abstract	iv
Acknowledgements	v
Table of Contents	vi
List of Tables	ix
List of Acronyms	x
Chapter 1. Introduction	1
1.1. Personal Connection to the Research	2
1.2. Research Purpose and Rationale	5
1.3. Summary of Chapters	6
Chapter 2. Literature Review	8
2.1. Introduction	8
2.2. Queer Women’s Sexual Health	13
2.2.1. Epidemiology of STI’s Amongst Queer Women	14
2.2.2. Sexual Histories and Practices	18
2.2.3. Uptake of Preventative Measures Use	20
2.3. Disclosure	22
2.4. Beyond Disclosure: Queer Women’s Sexual Health Care Interactions	29
2.5. Approaches and Models to Conceptualizing Health	32
2.5.1. The Health as a Human Rights Approach	34
2.5.2. Critiques of the Human Rights Approach to Health	38
2.6. Queer Women in Research: Sexual Orientation & Terminology	39
2.7. Chapter Summary	47
Chapter 3. Method	48
3.1. Research Design	49
3.2. Qualitative Approach	49
3.2.1. Constructivist Grounded Theory	50
3.3. Secondary Data Analysis	53
3.4. Procedure	56
3.4.1. The Interview	57
3.4.2. Participants	58
3.5. Data Analysis	62
3.5.1. Coding	64
3.5.2. Theoretical Sampling, Saturation, and Sorting	66
3.5.3. Situational Mapping	67
3.6. Quality of Research	70
3.6.1. Trustworthiness	70
3.6.2. Evaluation of Grounded Theory Studies	72
3.7. Subjectivity of the Researcher	73

3.8. Chapter Conclusion	75
Chapter 4. Findings and Discussion	76
4.1. The Process of Women’s Interactions with Healthcare Provides When Seeking Sexual Healthcare	77
4.1.1. Healthcare Space	78
Accessing and Encountering Barriers to Accessing Clinics	79
Gauging Queer Inclusivity of Clinic Based on Location	81
Assessing LGBTQ Visibility	81
4.1.2. Relational Healthcare Dynamics	83
Assessing Gender and Sexual Orientation of Healthcare Provider	83
Disclosure	84
Fearing Disclosure	85
Contemplating Disclosure	86
Enacting Disclosure Tactics	86
Lying to Healthcare Provider	87
Feeling Awkward	89
Feeling Cared For	89
Being Dismissed by Healthcare Provider	90
Experiencing Healthcare Provider as Accepting and Inclusive	90
4.1.3. Sexual Healthcare Interactions	91
Receiving Inadequate Sexual Healthcare	91
Heterosexist Sequencing of Sexual Health Questions	93
Educating Healthcare Provider	94
Experiencing Exclusive and Sex Negative Sexual Healthcare	95
Experiencing Inclusive and Sex Positive Sexual Healthcare	95
Perceiving Healthcare Provider as Unaware and Judgmental of Diverse Sexual Practices	96
Getting Tested?	97
Asking Sexual Health Questions	98
4.1.4. Navigating Human Rights	99
Experiencing Heterosexism Systemically	100
Experiencing Heterosexism Interactionally	101
Being Stereotyped	102
Experiencing Weight-Related Stigma	103
Intersecting Privilege and Oppression	104
Going Back Into the Closet	105
4.1.5. Recommendations for Healthcare Providers	108
Being Open	108
Not Making Assumptions	109
Becoming Knowledgeable About Queer Issues	109
Recognizing Patient Self-Agency	110
Respecting Patients’ Partner	110
Considering Cultural Identities	111
Enacting Inclusive Health	111
Taking a Holistic Approach	112
4.1.6. Recommendations for Queer Women	112
Feeling Confident and Expecting to be Treated Well	113
Assessing Clinical Experience	113
Bringing an Advocate to Appointments	114
Building a Community Movement Around Health	114
4.2. Chapter Summary	115

Chapter 5. Conclusion	117
5.1. Study Summary	117
5.2. Limitations and Strengths	118
5.2.1. Limitations	118
5.2.2. Strengths	119
5.3. Recommendations for Future Research	121
5.4. Implications of the Research	122
5.4.1. Implications Directly From Study Participants	122
Recommendations for Healthcare Providers	122
Recommendations for Queer Women	124
5.4.2. Implications From Study Analyses	125
Systemic Level Healthcare Implications	126
Interactional Level Healthcare Implications	127
5.5. Conclusion	128
References	130
Appendix A. Primary Study: Recruitment Posters.....	136
Appendix B. Primary Study: Interview Consent Form.....	137
Appendix C. Primary Study: Interview Guide	141

List of Tables

Table 3.1.	Participants' Demographic Information	62
Table 3.2.	Situational Map Ordered/Working Version	68

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BDSM	Bondage and Discipline domination and Submission and Sadomasochism
CDC	Centre for Disease Control
DNA	Deoxyribonucleic Acid
GP	General Practitioner
HCP	Healthcare Provider
HIV	Human Immunodeficiency Virus/
HPV	Human Papilloma Virus
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MOA	Medical Office Assistant
MSM	Men who have Sex with Men
PAP	Papanicolaou
PCR	Polymerase Chain Reaction
SDOH	Social Determinants of Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
WSW	Women who have Sex with Women

Chapter 1.

Introduction

Canadian research shows that lesbians have lower rates of consulting family doctors and are less likely to have Pap tests, compared to heterosexual women (Tjepkema, 2008). Problematically, lesbian and bisexual women are often considered to be at lower risk of sexually transmitted infections (STIs) and less likely to engage in risky behaviours, which translates into the perception that this socially marginalized sexuality group has no distinct health concerns (Fish & Bewley, 2010). However, as McNair (2003) argues, lesbian and bisexual women have specific healthcare needs in areas of sexual and cervical health amongst other areas. Health inequalities exist for queer women as a result of prevailing heteronormativity as well as discrimination through homophobia and heterosexism. Negative experiences with healthcare providers can lead to avoidance of routine healthcare and preventative screening (McNair, 2003), which contribute to inequitable treatment in healthcare. As such, queer women are rendered invisible as patients and unrecognized as users of healthcare (Fish & Bewley, 2010).

A review of the existing literature on queer women's interactions with healthcare providers within the context of sexual healthcare, revealed that very few studies have explored this complex interactional process. Researchers initially identified the issue of disclosure and non-disclosure, which involves either revealing or withholding one's sexual identity usually outside of heterosexuality, as a focus for understanding queer women's interactions with healthcare providers. In order to gain a better understanding of the complex relational process between queer women and healthcare providers beyond the issue of disclosure, I chose to conduct a grounded theory study analyzing nine transcribed interviews with a focus on queer women's interactions with healthcare providers when seeking sexual healthcare.

1.1. Personal Connection to the Research

In my application for the Master of Arts Counselling Psychology Program at Simon Fraser University, I identified my research interest in the area of lesbians' sexual health. At the time, both personal experience seeking sexual health care as a sexually fluid woman and a preliminary literature review sensitized me to the barriers queer women face when seeking sexual health care. Pursuing my own academic research, in partial fulfillment of my graduate degree requirements, in the area of queer women's efforts to seek sexual healthcare has provided me with the opportunity to further explore this topic.

My interest in exploring queer women's interactions with healthcare providers within the context of sexual health was instigated by two defining developments – being involved in a same sex relationship and becoming passionate about social justice. At 19 years old, I became involved in my first same-sex relationship. At the beginning of this relationship, I went through a period of confusion and fear about my sexuality. In high school I was involved in a long-term relationship with my then boyfriend and although I had experienced curiosity in relation to same-sex attraction, I had never thought about acting on this curiosity. Coming to terms with my same-sex attraction and taking the risk to pursue a relationship with a woman was one of the most difficult and rewarding experiences of my life. For almost one year I kept this relationship a secret from my family and close friends and I was able to live somewhat of a double life, separating my relationship with my then partner at our university in Ontario without jeopardizing my relationships at home in Vancouver by “coming out”. As I gained acceptance for my fluid sexual orientation and myself and endured the stress associated with having different identities, it came time to tell my family and friends about my same-sex relationship. I experienced debilitating fear when I thought of coming out to my family and friends and as I spoke with my personal counsellor in preparation for this arduous conversation, I expressed my despair of being perceived differently by my loved ones. Luckily for me, this fear was not warranted. I am extremely fortunate to have encountered open-mindedness, acceptance, love, and support from both family and friends. Coming out lifted an enormous weight off of my shoulders and allowed me to experience the joys associated with being in a loving relationship.

My involvement in a same-sex relationship was the first time that I became aware of experiencing stigma, discrimination, and marginalization. I am a Canadian woman who has the privilege of being white, coming from an upper-middle class family, being able-bodied, having access to education, and identifying as cis-gender. Experiencing oppression was a startling new experience for me. I continue to be grateful for the acceptance of and the rights afforded to LGBTQ people within the Canadian context and I am very much aware that coming out elsewhere in the world would be more dangerous and could have a much larger negative impact on my life. Becoming aware of my personal experience of limitations and barriers associated with belonging to a marginalized group, as well as learning about the human rights violations committed against LGBTQ people world wide sparked the second development that instigated my interest in this research topic – social justice.

My passion for social justice and human rights developed throughout the course of my Masters degree in Counselling Psychology at Simon Fraser University. Personal reflection of my own areas of privilege and experiences of oppression and the intersectionality between the two, along with the counselling philosophy of expressing empathy to those who are suffering, prompted my desire to develop awareness and enact positive change for marginalized groups. Social justice and human rights principles quickly became part of my personal and professional values. My commitment to social justice and human rights translated to my clinical counselling practice, attending workshops through Vancouver Coastal Health's PRSIM Education Series, which is an education an information service for the LGBTQ community, and volunteering at QMUNITY, BC's queer resource centre, as a Queer Competency Trainer. As I began to delve into the literature on the adversities experienced by LGBTQ people seeking healthcare, I recognized an opportunity to pursue a research topic that was aligned with my social justice leanings.

Focusing on queer women's sexual health was especially relevant for me and my LGBTQ female friends. As a feminine cis-gender woman, that is, someone who conforms with societies' match between biological sex identified at birth and gender identity, I repeatedly encountered interactions with my healthcare providers in which I was assumed to be heterosexual. This was most common during discussions of my

sexual health in which an affirmative answer to being sexually active was immediately followed by questions pertaining to contraception. Research shows that healthcare providers ask their female patients heterosexually biased questions within the context of sexual health (Fish & Bewley, 2010). These interactions frustrated and angered me, and reminded me of my marginalization; in the first couple of years after coming out, these types of interactions rendered me silent by not revealing my same-sex relationship due to the fear of going against the “norm”. The pinnacle of my frustration and anger was reached when my then partner came back from a doctor’s appointment saying that she was informed by her doctor that she did not require a Pap smear because she was not having heterosexual sex. This goes directly against research that supports the recommendation that queer women be routinely offered cervical cytology screening at the same rate as heterosexual women (Marrazzo et al., 1998; Bailey, Kavanagh, Owen, McLean & Skinner, 2000). Based on these experiences and similar experiences of my LGBTQ female friends, I began to wonder about how other queer women experienced interactions with their healthcare providers within the context of sexual health.

The thesis component of my Masters of Arts in Counselling Psychology at Simon Fraser University afforded me the opportunity to explore this topic further. With the support of my primary supervisor Dr. Sharalyn Jordan, I was able to identify a research aim that authentically connected an area of research necessitating further understanding with my passion for social justice and human rights. Dr. Jordan proposed a secondary data analysis of data collected for Dr. Mary Bryson’s (University of British Columbia) national multi-site research project titled, “Health Care Practices and Relationships: The Experiences of Queer Women and Primary Care Providers”. As an interviewer for this primary study, Dr. Jordan was familiar with the content of the interviews, which included in-depth discussions of queer women’s interactions with healthcare providers within the context of sexual health. As such, I chose to conduct grounded theory analysis, supplemented with situational mapping, of nine transcribed interviews from the primary study focusing on the process of queer women’s interactions with healthcare providers within the context of sexual health.

1.2. Research Purpose and Rationale

The purpose of the current research is to understand the process of queer women's interactions with healthcare providers when seeking sexual health care. This exploratory research aimed to examine this process so that the knowledge produced by this study could contribute to identifying how healthcare systems and healthcare providers can more inclusively and equitably interact with queer women. Queer women have negative experiences interacting with healthcare providers, which serve as barriers to equitable healthcare and contribute to avoidance of healthcare seeking, especially preventative sexual healthcare (Diamant, Wold, Spritzer, & Gelberg, 2000; Kerker, Motashari, & Thorpe, 2006). Put simply, lesbians have specific but poorly met health needs (Hunt & Fish, 2008).

This research rests on social justice values of healthcare as a human right. Previous research has addressed a human rights approach to health, the health inequities experienced by queer women, and the sexual health needs of this marginalized sexuality group. Hunt and Backman (2008) advocate for a human rights approach to health claiming that it, "is the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations" (Hunt & Backman, 2008). McNair (2003) contends that the health inequalities that exist for lesbian and bisexual women are largely related to experiences of homophobia and heterosexism. And research shows that lesbian and bisexual women have varied sexual histories with both male and female partners, which means that healthcare providers must engage in careful sexual history taking without assumptions (Bailey, Farquhar, Owen, & Wittaker, 2003).

Discrimination and inequality enacted through homophobia and heterosexism are pervasive in the interactional process between queer women and healthcare providers (McNair, 2003). One component of the relational dynamics between queer women and their healthcare providers is the aspect of disclosure, which refers to the act of revealing one's sexual orientation. A vast amount of previous research has focused on disclosure when considering queer women's interactions with healthcare providers. Disclosure is a complicated and at many times, an ongoing struggle for queer women. However, it is

only one aspect of the interactional process between queer women and healthcare providers.

This research contributes to existing academic knowledge by extending beyond the paradigm of disclosure. Instead, the focus of this research is on the processual interactions between queer women and their healthcare providers within the context of sexual health. Applying a human rights lens recognizes that these interactions are situated in social contexts of prevailing heterosexism and homophobia with important implications for queer women's health equity. Importantly, the current study integrates a processual focus within the framework of a human rights approach to health in an effort to more holistically understand queer women's interactions with healthcare providers within the context of sexual health.

1.3. Summary of Chapters

The five chapters of this thesis outline the analytical process, present the study findings, and provide a discussion of the research implications. This introductory chapter, Chapter One, lays the foundation for the current study by establishing my personal connection to the topic as well as providing contextual information for the rationale and purpose of this study.

In Chapter Two, I present a thorough overview of relevant literature to queer women's interactions with healthcare providers within the context of sexual healthcare. The chapter begins by highlighting queer women's sexual health through the presentation of relevant research addressing the epidemiology of STI's, sexual behaviour and practices, and healthcare access and utilization of preventative measures. This section is followed by outlining research that has been conducted on the predominant disclosure framework for studying queer women's interactions with healthcare providers. Then the limited research focusing on the relational dynamics between queer women and healthcare providers beyond the issues of disclosure is discussed. An explanation of the current study's chosen framework, a human-rights framework is provided, which centralizes the disparities for queer women as a minority group. Finally, the conceptualization of sexual orientation as a construct is outlined and

background information for sexual identity terminology, detailing how past research has navigated the inclusion of non-heterosexual women in research is provided.

In Chapter Three I provide a comprehensive description of the research method. The first section outlines the epistemological and theoretical foundations for the current study, which is followed by support for the use of secondary data analysis. Then the procedural and analytical methods of grounded theory (Charmaz, 2006) supplemented with situational mapping (Clarke, 2003) are described. The next section addresses the quality of the research in terms of trustworthiness and constructivist grounded theory criteria. The final section of this chapter provides a description of the subjectivity of myself as the primary researcher.

Chapter Four presents the findings from the current study and discusses these findings in relation to previous research in this area. The six main categories, as well as the subcategories identified within each main category are explored along with supporting participant quotes. The chapter begins with an explanation of the three-tiered contextual framework that was developed as a means to understand the process of interactions with healthcare providers concerning sexual health. The chapter concludes with a discussion of the recommendations for both healthcare providers and queer women in an effort to reduce discriminatory barriers and enhance inclusive and equitable healthcare interactions.

Chapter Five, the concluding chapter of this thesis, outlines the strengths and limitations of the study and provides recommendations for future research. The implications of this research are also addressed through the explicit recommendations for healthcare providers and queer women seeking healthcare provided directly by the study participants. Moreover, research implications for both the systemic and interactional levels of healthcare delivery are presented based on the data analysis.

Chapter 2.

Literature Review

2.1. Introduction

This chapter presents a review of the literature relevant to the current study. In order to provide context and rationale for the exploration of queer women's interactions with healthcare providers when seeking sexual healthcare, this chapter has been organized into five main sections: queer women's sexual health, issues pertaining to disclosing or withhold one's sexual identity from healthcare providers, lesbian and bisexual women's experiences interacting with healthcare providers beyond disclosure and non-disclosure, approaches, models, and frameworks for conceptualizing health, including the current study's health as a human right approach, and queer women in research. Given the interdisciplinary nature of this research, the literature search involved multiple databases such as Web of Science, Women's Studies International, PubMed, Google Scholar, JSTOR, PsycINFO, and PsycARTICLES. Furthermore, reference mining, in which articles are identified in the reference lists of previously read studies, was used as a tool to source relevant studies.

The first section of this chapter, queer women's sexual health, provides firm evidence of systemic erasure of queer women from sexual health research and practice, which has created disparities and confusion that queer women must navigate. The disclosure section presents the plethora of research that has been conducted from this paradigm; the following section, beyond disclosure, presents the limited research focusing on the interactions between queer women and healthcare providers extending beyond disclosure concerns. These two sections discuss the limitations of the disclosure paradigm and provide rational for the current study's interactional focus. The fourth section, approaches and models to conceptualizing health, reviews historical health

frameworks and discusses the literature relevant to the current study's human rights approach to health. This approach espouses the value that health is a right and is grounded in the meaningful and everyday ways that inequalities are produced in healthcare systems and interactions. Finally, given the varying methodologies for studying socially marginalized sexualities, the fifth section - queer women in research, references literature that addresses the difficulties and complexities associated with conceptualizing the constructs of sexual orientation and sexual identity. This chapter begins with a brief introduction highlighting interrelatedness of these sections and is followed by more in depth discussions of these sections separately.

Lesbians have specific but poorly met health needs (Hunt & Fish, 2008). As a socially marginalized sexuality group, LGBTQ (lesbian, gay, bisexual, trans, and queer) women encounter various health disparities that are compounded by experiences of discrimination, stigma, and negative stereotypes (Mollen, 2012). These negative experiences occur at both the systemic and interactional levels of healthcare. Despite having more health risks than other women, lesbians access preventative medical care less frequently (Steele, Tinmouth, & Lu, 2006). Research shows that lesbians, bisexual women and women who have sex with women are less likely to access preventative sexual health care such as Pap smears and mammograms (Diamant, Wold, Spritzer, & Gelberg, 2000; Kerker, Motashari, & Thorpe, 2006).

It is important to situate lesbians' avoidance of preventative healthcare within the context of heterosexist structuring of healthcare (Stevens, 1995), which favours heterosexual individuals and systematically erases women of marginalized sexualities. Systemic marginalization is further enacted through the relative silence that exists for sexual health issues for women of marginalized sexualities within mainstream medical literature, textbooks, research, and policy (McNair, 2005). The systematic erasure of queer women's sexuality from research agendas translates into less research being conducted on the associated health inequities and thus contributes to the invisibility experienced by this socially marginalized sexuality group.

Within the context of systemic erasure of queer women from health care, experiences of discrimination as a result of homophobia and heterosexism further

contribute to the health inequalities that exist for queer women (McNair, 2003). Discrimination and inequality are enacted through the negative attitudes healthcare providers have towards lesbian patients (McNair, 2003). Homophobia and heterosexism permeate the interactions queer women have with their healthcare providers and influence their patterns of health seeking in such a way that they may delay or avoid medical treatment (McNair, 2003). Homophobia is a discriminatory prejudice and practice rooted in fear and/or loathing of lesbians and gay men (Platzer & James, 2000). Homophobia comprises a range of negative attitudes and can manifest as hatred, ignorance, and exclusion (Platzer & James, 2000). At the interactional level, healthcare providers with homophobic attitudes may intentionally or unintentionally discriminate against their queer patients. The negative attitudes held by healthcare providers do not necessarily have to be overt to serve as barriers to quality health care for queer women; the heterosexist assumption (also called heterosexism) in which lesbian women are assumed to be heterosexual further marginalizes this sexual minority group (McNair, 2003). Research shows that at an interactional level, health care providers endorse the heterosexist assumption subtly through their use of language (Fish & Bewley, 2010). The questions that healthcare providers ask their female patients may be heterosexually biased and thus marginalize their queer patients. For example, a question inquiring about a women's level of sexual activity followed by a question pertaining to contraception suggests that what is meant by the initial question is heterosexual sexual activity (Fish & Bewley, 2010). At the systemic level, assumptions of heterosexuality are enacted through heteronormativity, in which heterosexuality is deemed to be the norm, with any sexual variation considered to be deviant and subordinate (Platzer & James, 2000). In this way heterosexuality is afforded value over other types of sexuality (Gay and Lesbian Medical Association, as cited in McNair, 2003); individuals who participate in non-heterosexual relationships are marginalized by the power of the heterosexual norm (Platzer & James, 2000). In their 2010 study, in which qualitative data was collected through online surveys, Fish and Bewley concluded that heterosexism and heteronormativity contributed to lesbian and bisexual women feeling invisible and uncomfortable and was perceived to be a barrier to effective health care.

Stevens' (1995) feminist narrative analysis provides further support for the negative impacts of heterosexism at the interactional level and heteronormativity at the

systemic level of health care. At the systemic level, the heterosexist structure of health care delivery obstructed health care seeking, knowledge about health, and behaviours for lesbians (Stevens, 1995). At the systemic level, the heterosexual bias was reported by participants to be present in written forms, health brochures and posters, advertisements, and reading materials in the waiting room (Stevens, 1995). These experience of the heterosexual assumption at the systemic level may result in sexual minority women feeling further marginalized. At the interactional level, health care providers' heterosexual assumptions mitigated potentially supportive interactions with lesbian clients (Stevens, 1995). In some cases, health care providers' heterosexual assumptions impeded their ability to thoroughly assess and intervene. This is evident in the following participant quote from Stevens 1995 study:

I had blood in my urine and was really scared. I tried to answer the doctor's questions about sex but they were all phrased around having intercourse with a man. I had to correct him several times. And he kind of choked, you know, and looked startled. Then there was a reaction time before he could go on. It was hard on me. (p. 28).

This quote illustrates the adverse impact of the heterosexual assumption at the interactional level. Furthermore, additional support is provided for the enactment of heterosexism within the context of sexual health. As such, this quote is particularly relevant in providing a rationale for the current study's focus on further understanding the interactional process queer women engage in with healthcare providers with regards to their sexual health.

Problematically, many healthcare professionals maintain a position that lesbian health is synonymous with women's health, despite evidence that marginalized sexuality groups experience different patterns of health and illness (McNair, 2003). One of the areas of primary health that is substantially misunderstood for queer women is the area of sexual health. The risks associated with sexually transmitted infections (STI's) for women who have sex with women have been underestimated (Hunt & Fish, 2008). Research shows that 17% of self-identified lesbians in the United States report having a diagnosis at some stage in their lifetime of an STI, the same percentage as that reported for population-based representative samples of women (Diamant, Wold, Sptizer, & Gelberg, 2000). However, non-heterosexual women access screening less frequently,

delay treatment, and are less likely to have a regular healthcare practitioner than heterosexual women (McNair, 2003).

Based on their findings from a large cross-sectional survey conducted with lesbian and bisexual women from both clinical and community settings, Bailey, Farquhar, Owen, and Whittaker (2003) conclude that health care providers should practice careful and thorough sexual history taking without making assumptions in order to provide sexual health advice to women of marginalized sexualities. The findings from their study show that health care providers rarely take the time to ask questions related to sexual history for self-identified lesbian and bisexual women (Bailey, Farquhar, Owen, & Whittaker, 2003). Healthcare professionals may be surprised to find out that between 80 and 90% of lesbians have a recent history of sex with men (Bailey et al., 2003; Fethers, Marks, Mindel, & Estcourt, 2000). Another misunderstood area is the rate of transmission of sexual infections for women who exclusively have sex with women. For example, HPV has been reported to occur in 21% of lesbians with no prior sexual contact with men (Marrazzo et al., 1998). These data contradict the common assumption of low STI risk with female sexual partners and highlight the need for healthcare practitioners to have a better understanding of queer women's sexual health. Health care professionals need to increase their competency with this population in order to best meet the sexual health care needs of queer women in an equitable and non-discriminatory manner. However, as the previously cited literature supports, the misconceptions and discriminatory practices that healthcare providers operate under serve as barriers for appropriate and equitable sexual health care for queer women.

In order to provide relevant context for the current study's research problem, the literature examined in this section will explore the following topics: queer women's sexual health; the concept of disclosing sexual identity in healthcare interactions; interactions between queer women and healthcare providers beyond the issue of disclosure; approaches, models, and frameworks for conceptualizing health, including the current study's human rights approach to health; and queer women in research, which outlines research attending to the methodology challenges for studying sexually marginalized women. These topics will provide a foundation for the current study's

constructivist grounded theory approach to the exploration of queer women's interactions with healthcare providers within the context of sexual health.

2.2. Queer Women's Sexual Health

Sexual health is a specified area in which health care providers poorly understand the sexual health risks and sexual behaviours of queer women. Traditionally, women who have sex with women (WSW) have been inaccurately perceived to be a low-risk group for sexually transmitted infections (STIs) and cervical cytology screening initiatives (Fethers, Marks, Mindle, & Estcourt, 2000). However as Gorgos and Marrazzo (2011) argue, WSW should not be presumed to be at low or no risk for STIs based on their sexual orientation; reporting of same-sex behaviour from women should not deter health care providers from considering and performing screening for STIs. This is supported by the findings that transmission of STIs between women includes trichomoniasis, genital herpes, genital warts, and human papillomavirus (Bailey, Farquhar, Owen, & Mangtani, 2004; Marrazzo et al., 1998). Furthermore, bacterial vaginosis (BV), which can increase the likelihood of contracting an STI, has been found to be significantly more common in WSW (Fethers et al., 2000). The discrepancy between the sexual health needs of queer women and the sexual healthcare they are receiving may result in unequal healthcare. The misconception by some lesbians that they have less need for cervical smears (Bailey, Kavanagh, Owen, McLean, & Skinner, 2000) coupled with their perception that they are at low risk for STI's may contribute to their decreased likelihood to obtain STI testing (Bauer & Welles, 2001). When lesbians do access health care, their negative healthcare experiences, including assumptions of heterosexuality which results in inappropriate advice (Hunt & Fish, 2008) may perpetuate their decreased likelihood to obtain sexual health care. Healthcare providers may be surprised to know that a lesbian sexual orientation does not preclude sexual activity with men, in fact, the majority of self-identified lesbians have engaged in heterosexual sexual activities with men (Bailey, Farquhar, Owen, Whittaker, 2003; Evans, Scally, Wellard, & Wilson, 2007; Fethers et al., 2000). Queer women engage in various sexual practices with both men and women and these differing sexual behaviours have particular implications for healthcare providers offering appropriate

sexual health advice. Healthcare practitioners often do not account for queer women's variable sexual history and sexual behaviour, which may lead to interactions with this marginalized group based either on heterosexist presumptions or inaccurate stereotypes.

In clinical practice confusion still exists about whether lesbians should be offered routine cervical smears (Bailey, Kavanagh, Owen, McLean, & Skinner, 2000). A large systematic study of cervical cytology showed that cytological abnormalities were significantly more common in lesbian women who had previously been sexually active with men than women who were 'exclusively lesbian' (defined as women who had never been sexually active with men) (Bailey et al., 2000). The authors from this study suggest that lesbians should be routinely offered cervical cytology because cervical smear abnormalities were found in both groups of lesbian women (i.e. the exclusively lesbian group and the group with heterosexual histories) (Bailey et al., 2000). In terms of transmission, data suggests that HPV is sexually transmitted between women who engage in sexual practices by means of digital-vaginal sex, digital-anal sex, oral sex and the use of insertive toys (Marrazzo et al., 1998). Based on these findings, it is recommended that healthcare providers offer routine Pap smear screening for all sexually active women and do not distinguish between women who identify as lesbian, women who engage in sexual practices with women, and women who have heterosexual sexual histories (Bailey et al., 2000; Marrazzo, et al., 1998).

In accordance with past research, the following section will address the issues concerning queer women's sexual health by addressing STI prevalence and transmission, sexual behaviour and practices, and health care access and utilization of preventative measures (i.e. Pap smears). Despite the organization of these concepts into these three defining sections, it should be noted that all are interrelated and the majority of research has treated them as such.

2.2.1. Epidemiology of STI's Amongst Queer Women

Compared with the extensive data that are available regarding STIs among men who have sex with men (MSM), relatively little has been published about STI prevalence

and risks among other sexual and gender minorities, including women who have sex with women (WSW) (Gorgos & Marrazzo, 2011). As a result, the misconception that WSW are at low risk of STIs may be reinforced because of the under-representation of sexual health research for this marginalized group (Ripley, 2011). This lack of research for queer women's sexual health may be a result of systemic bias in which women are devalued more generally or it may be related to the historical pathological understanding of homosexuality within the medical model. The following will account for the research that has been published on the STI prevalence and transmission amongst WSW and self-identified lesbians in order to provide relevant information for queer women's sexual health needs.

Research shows varying results in terms of diagnosis and transmission of STIs for queer women. Bailey, Farquhar, Owen, and Mangtani (2004) found a low prevalence of STIs in their sample of WSW. In their study, trichomoniasis, genital warts, and genital herpes were infrequently diagnosed, and pelvic inflammatory disease (PID), chlamydia, and gonorrhea infections were rare (Bailey et al., 2004). The main findings of this study included the detection that both candida, a type of fungal infection, and bacterial vaginosis (BV) were commonly found in their sample of self-identified lesbians (Bailey et al., 2004). As a result, despite the low prevalence of STIs found in their sample, the authors caution healthcare providers against making assumptions based on sexual identity (Bailey et al., 2004). Instead, the authors advocate for the importance of taking a thorough sexual history and offering health advice based on sexual behaviour, rather than sexual identity alone (Bailey et al., 2004). Bailey et al.'s study draws attention to how healthcare providers interact with lesbian patients and thus provides support for the current study's interactional focus, which includes identifying the barriers of and facilitators to equitable sexual healthcare delivery.

In their 2000 study, Fethers, Marks, Mindel, and Estcourt sought to understand the sexual health risks and needs of women who have sex with women (WSW) through a retrospective cross-sectional study. The authors identified three different groups from their large sample size of 1432 women: a control group, consisting of women who had reported never having sex with another woman, a WSW group, consisting of women who had reported sexual activity with another woman, and an exclusive WSW group,

which consisted of women who reported female sexual activity and no sexual contact with a male in the past 12 months (Fethers et al., 2000). Based on these groups, two sets of comparisons were made: the WSW group was compared to the control group and the exclusive WSW group was compared to the control group (Fethers et al., 2000). In line with Bailey et al.'s (2004) findings, Fethers et al., (2000) found that bacterial vaginosis (BV) was significantly more common for WSW than controls and gonorrhea and chlamydia were uncommon in the WSW group. This study contributed to the literature by including the prevalence of hepatitis diagnoses; WSW were more likely to be Hepatitis C antibody positive and Hepatitis B was significantly more common amongst WSW than controls (Fethers et al., 2000). Interestingly, 44% of the WSW group reported a previous diagnosis of one or more STIs, compared with 32% of the control group (women who had reported never having sex with women) (Fethers et al., 2000). In terms of sexual risk behaviour, both the WSW and exclusive WSW groups were found to have similar risk profiles: they were significantly more likely to report past sexual contact with a homosexual or bisexual man and sexual contact with an injecting drug user (Fethers et al., 2000). These findings demonstrate that WSW are engaging in what the authors refer to as "riskier behaviours", which may make them more susceptible to contracting STIs (Fethers et al., 2000). Overall, this large-scale cross-sectional study demonstrated significant differences in certain STIs and blood borne viruses and risk of contraction and spread of STI's in WSW and exclusive WSW compared to women who do not report sex with women (Fethers et al., 2000). One of the limitations of this study is the lack of comparison between the WSW group and the exclusive WSW group in terms of STI prevalence, STI transmission, and sexual and non-sexual risk behaviours.

There is one notable study that contributed to the understanding of the type-specific prevalence and transmission of genital human papillomavirus (HPV) infection in WSW. In their 1998 study, Marrazzo et al. used polymerase chain reaction (PCR) detection of HPV DNA and specifically investigated the prevalence of HPV-6 and HPV-16 serum antibodies in 149 women who were sexually active with women. The authors also examined frequency of routine pap smears (Marrazzo et al., 1998). The presence of HPV DNA by PRC was strongly associated with more recent sex with men and a higher lifetime number of male partners (Marrazzo et al., 1998). However, HPV DNA was also detected among women who reported no prior sex with men or sex with men many

years earlier (up to 18 years). The authors note that these data suggest that HPV is sexually transmitted between women and also confirms that most WSW have sexual histories that include sex with men (Marrazzo et al., 1998). WSW who had never had sex with men received less frequent Pap smears screenings, suggesting that this preventative measure may be influenced by reported sexual history with men (Marrazzo et al., 1998). Based on their findings, these authors recommend routine Pap smear screening for WSW at the same rate as heterosexual women (Marrazzo et al., 1998). More recently, Henderson (2009) conducted a literature review searching PubMed, Web of Science and the Internet for articles on lesbians, cervical cancer and cervical cancer risk factors focusing on HPV screening behaviours. Henderson (2009) found that HPV can be transmitted sexually between women and concludes, just as Marrazzo et al. (1998) did, that regular cervical screening is as important for lesbian women as it is for heterosexual women.

Gorgos and Marrazzo, in their (2011) systematic literature search on STIs in women who have sex with women (WSW), summarized the key findings across approximately seventy articles on the epidemiology of STIs, the risk and protective factors related to STIs, and recommendations for STI testing among WSW. Their results support both Bailey et al.'s (2004) and Fethers et al.'s (2000) findings that chlamydia and gonorrhoea infections among WSW are uncommon. The authors also found that genital HPV infection is common among WSW, with certain strains associated with cervical cancer, and sexual transmission of HPV likely occurs between women. Bacterial vaginosis (BV) was found to be common among women in general and even more so among women with female partners and lesbian partnerships can share strain-specific genital bacteria (Gorgos & Marrazzo, 2011). The authors caution against comparing studies examining STIs among WSW and lesbians because of the different methods used to reflect female-to-female sexual contact (Gorgos & Marrazzo, 2011). Evans, Scally, Wellard, and Wilson (2007) included a caveat of this nature in their study, stating that differences between sexual identity and sexual behaviour must be appreciated. As can be seen from the previously cited studies, some researchers identify women based on self-identified sexual orientation (e.g. lesbian) whereas others utilize self-reported sexual behaviours and partner choice (eg. WSW).

An overview of the complexities and variance found in the research addressing STI prevalence and transmission amongst queer women provides relevant context for the current study's focus on sexual health. The conflicting findings regarding STI prevalence amongst women who have sex with women (WSW) illustrates the variability and complexity of sexual health issues for this population. It is important for healthcare providers to understand the complexities related to STI prevalence and transmission for this marginalized sexual minority group in order to provide appropriate and equitable sexual healthcare. In conjunction with healthcare providers having a sufficient level of sexual health knowledge for queer women, they must also be able to effectively communicate with their patients. The current study aims to address this objective by exploring the interactions between queer women and healthcare providers within the context of sexual health.

2.2.2. Sexual Histories and Practices

Directly related to STI prevalence and transmission are the sexual behaviours and practices queer women engage in. Healthcare providers may be uninformed about the specific sexual behaviours queer women participate in and may make inaccurate assumptions about sexual history based on sexual identity (Bailey, Farquhar, Owen, Whittaker, 2003). Research shows that queer women report various sexual practices with both women and men.

In Bailey, Farquhar, Owen, and Whittaker's 2003 study, over 1000 lesbians and bisexual women, from both clinical and community settings, were asked about their sexual histories and sexual behaviours. In their sample, 97% of the women reported past sexual activity with women and 85% reported past or present sexual activity with men (Bailey et al., 2003). The high percentage of women who reported past sexual activity with men illustrates the incongruence between sexual identity, sexual attraction, and sexual behaviour; 98% of the participants self-identified with terms under the queer umbrella and 2% identified as "other" in terms of sexual orientation (Bailey et al., 2003). This finding supports the notion that the majority of self-identified lesbians have sexual histories that include sexual activity with men. Furthermore, this study found that first sexual experience for lesbians and bisexual women tended to be with a man (Bailey et

al., 2003). Based on this data, the authors concluded that lesbians and bisexual women have varied sexual histories with both male and female partners (Bailey et al., 2003). This data supports previous study findings, such as Marrizzo et al. (1998), that lesbian sexual orientation does not preclude sexual activity with men.

A subset of 328 women from this study were asked questions about safer sex with both women and men in the past 10 years (Bailey, Farquhar, Owen, & Whittaker 2003). When it comes to safer sex practices, it appears as though lesbian and bisexual women are at risk for STI transmission as result of low rates of condom use and sterilization of shared sex toys (Bailey et al., 2003). In order for lesbians and bisexual women to receive appropriate sexual health advice, the authors recommend that healthcare providers remain nonjudgmental when taking a careful sexual history and avoid making assumptions based on sexual identity (Bailey et al., 2003). The current study will further explore how healthcare providers ask questions about sexual activity in both inclusive and non-inclusive ways.

In an effort to have a well-informed safer-sex intervention for WSW, Marrazzo, Coffey, and Bingham (2005) conducted focus groups with 23 lesbian and bisexual women aged 18-29. One of the main topics of the focus group discussions was sexual practices between females (Marrazzo, Coffey, & Bingham, 2005). All participants agreed that toys are rarely cleaned during sex despite the fact that toys are frequently shared between partners and the use of barrier methods for oral-vaginal and oral-anal sex was not a common approach to reduce transmission risk of STIs (Marrazzo et al., 2005). When considering penetrative sex with fingers or hands, which is common practice both vaginally and anally, participants concurred that hand washing is common (Marrazzo et al., 2005). Especially relevant to the current study, was the finding that WSW perceive healthcare providers to have limited information and knowledge about lesbian's sexual health and that lesbians are unlikely to discuss sexual health topics with each other (Marrazzo et al., 2005). As such, participants identified that healthcare providers need to be better educated about lesbian sexual health, particularly with regards to symptoms, transmission, preventative measures, and treatment of bacterial vaginosis (BV) (Marrazzo et al., 2005). Given the perception of the participants that STI risk reduction behaviours are primarily a concern for heterosexual women, it is clear that healthcare

providers play a vital role in the sexual healthcare of WSW. In terms of implications for interventions, Marrazzo et al. highlighted the importance of sensitive health care that includes knowledge specific to lesbian health concerns and transmission of STIs and BV between female sex partners. It is clear that queer women need inclusive care and advice from healthcare providers. The current study's focus on exploring the interactions between queer women and healthcare providers will serve to help explain what other factors may be important for appropriate service to this marginalized group.

2.2.3. Uptake of Preventative Measures Use

It appears as though both queer women and healthcare providers are unclear about the requirement of cervical screenings (Pap smears) as an appropriate preventative measure. Research shows that lesbians have poor uptake of cervical screening (Bailey, Kavanagh, Owen, McLean, & Skinner, 2000; Kerker, Mostashari, & Thorpe, 2006). However, based on their findings that genital HPV and squamous intraepithelial lesions are common among WSW, including those who have not had sex with men, Marrazzo et al. (1998) recommend that routine Pap smear screening should occur at the same rate as those for heterosexual women. The articles cited in the following section contribute to the literature in the arena of utilization of preventative measures for sexual healthcare for queer women.

In their 2000 study, Bailey, Kavanagh, Owen, McLean, and Skinner sought to address the confusion existing in clinical practice about whether or not lesbians should be offered routine cervical smears. In their study, 803 women completed questionnaires and 624 participated in a cervical cytology test (Bailey, Kavanagh, Owen, McLean, & Skinner, 2000). Although cytological abnormalities were significantly more common in women who had been sexually active with men than in the 'exclusively lesbian' group, 80% of participants had heterosexual histories (Bailey et al., 2000). In terms of rates of cervical smear uptake, 42% of the 'exclusively lesbian' group had never had a Pap test compared to 12% of the women who reported being heterosexually active (Bailey et al., 2000). The perception that WSW have less of a need for cervical smear testing was significantly more prevalent in the 'exclusively lesbian' group (Bailey et al., 2000). However, because cervical smear abnormalities were found in women with no history of

sexual activity with men, the authors recommend that lesbians be routinely offered cervical cytology screening (Bailey et al., 2000). The authors conclude the poor uptake of cervical screening by a significant proportion of lesbians, coupled with their perception that they have less need for cervical smears, highlights the need for education of lesbians and healthcare providers (Bailey et al., 2000). Although it is important for queer women to take responsibility for their sexual health, it must be acknowledged that mainstream sexual health information is directed towards heterosexual sexual activity. Therefore, it is imperative that healthcare providers have accurate information to communicate to queer women regarding preventative measures.

As previously mentioned, there are multiple associations of sexual orientation that include attraction, behaviour, and identity. Kerker, Mostashari, and Thorpe (2006) argue that the majority of “previous research identifies [women who have sex with women] WSW by sexual identity and rarely examines stratifications of sexual behaviour and identity simultaneously” (p. 971). Therefore, the authors sought to understand the differences between women who identify as lesbian and WSW but do not identify as lesbian, in terms of health behaviours. One of their unique contributions to the literature in this area was the implementation of a multi-lingual population-based study in which interviews were conducted in over 25 languages through two cross-sectional surveys (Kerker et al., 2006). The importance of Kerker et al.’s study lies in their examination of the stratifications of sexual behaviour and sexual identity simultaneously (Kerker et al., 2006). This study also inspected the relationship between sexual behaviour and both health care access, including health care coverage and contact with a primary care provider, and health care utilization (Pap test and mammogram use) (Kerker et al., 2006). The findings from this study indicated that WSW, regardless of sexual identity, had less access to health care coverage and utilized preventative measures less than non-WSW (Kerker et al., 2006). WSW having less access to health care coverage demonstrates inequalities experienced by this marginalized group and thus supports the use of the current study’s health as a human right framework. Kerker et al. found that women with congruent behaviour and identity (i.e. women who identified as lesbian or bisexual and reported sexual activity with women) had higher utilization of health care services than women who had incongruent behaviour and identity (i.e. identified as heterosexual and reported sexual activity with women). This study demonstrate the

complexity of sexual behaviour and sexual identity with the finding that 5% of the sexually active women between 18-64 years of age reported having had sex with women in the past year, however, only 1.5% identified as lesbian (Kerker et al., 2006).

In sum, research shows that queer women have specific sexual health concerns related to their variable sexual activity with both women and men. The assumption that queer women are at a low risk for STI's is inaccurate and serves to perpetuate inadequate and unequal access to sexual health care for this marginalized population, especially in terms of utilization of preventative measures such as cervical cytology screening. This section has provided firm evidence of systemic erasure of queer women from sexual healthcare delivery, which has contributed to the barriers to equitable care that queer women are burdened with. The following section presents research that has been conducted with queer women from the dominant disclosure paradigm, in order to highlight the limitations of this framework and provide rationale for the current study's interactional focus.

2.3. Disclosure

The prevalence of heteronormativity in our culture means that heterosexual women do not have to worry that disclosure of their sexuality will result in poor care, discrimination, rejection or even violence (Eliason & Schope, 2001). Heterosexism features mainstream cultural and societal attitudes that inherently values heterosexuality more highly than other marginalized sexuality groups (McNair, 2003). The heterosexual presumption sanctions queer women to "pass" as heterosexual in health care encounters and imposes heterosexuality on queer women (Fish, 2006). The pervasiveness and perpetuation of heterosexism creates erasure and stigma for queer women who are seeking sexual health care and treatment. As a direct result of these concerns, one of the primary areas of research for queer women's health is the issue of disclosure.

Disclosure refers to the act of informing people about one's sexual orientation. A lesbian woman must choose whether or not to disclose her sexual orientation in every new encounter, including when consulting a health care practitioner (Bjorkman &

Malterud, 2007). Fish (2006) argues that the heterosexual presumption imposed on lesbian and bisexual women by healthcare providers prevents disclosure. Moreover, the discrimination lesbians experience upon disclosing a non-heterosexual sexual orientation negatively influences their patterns of health seeking by preventing access to healthcare and reducing openness and trust within the healthcare setting (McNair, 2003). The following literature reviewed will explore the positive and negative effects of disclosure, the strategies queer women engage in during the disclosure process, and the relevance of disclosure within the context of sexual healthcare. Finally, an article considering disclosure from the healthcare provider's perspective, including the barriers to facilitating disclosure, will be presented. The purpose of this section is to provide a review of literature relevant to the aspect of disclosure as part of the interactional process queer women engage in with their healthcare providers when seeking sexual health care. Research shows that for sexually marginalized women, disclosure and nondisclosure of non-heterosexual sexual orientation impacts their interactions with healthcare providers. Although disclosure is an important aspect of the interactional process between queer women and their healthcare providers, it is limited in its ability to provide an in-depth understanding of this complex process. The literature presented here will provide a backdrop for the argument that although disclosure is an appropriate starting point to consider in terms of queer women's interactions with healthcare providers, there is much more involved in this complex interactional process.

Research shows that there can be benefits and consequences that result from disclosure of non-heterosexual sexual orientation to healthcare providers (Eliason and Schope, 2001; Bjorkman & Malterud, 2007; Boehmer & Case, 2004). The benefits of disclosure for lesbians have been found to include: increased satisfaction and comfort with the health care received, greater ease in communicating with doctors, and inclusion of same-sex partner in treatment decisions (Bjorkman & Malterud, 2007). Furthermore, disclosure can generate a feeling of being seen as a whole person and can help to simplify the explanation of circumstances for lesbian women (Bjorkman & Malterud, 2007). These findings highlight the positive impacts of disclosure as related to relaying information of medical relevance, explaining relationship circumstances, and feeling comfortable to be one's authentic self. However, despite the positive relational and health benefits that may result from disclosure, with the caveat that these benefits only

arise if the healthcare provider receives this information openly and nonjudgmentally, there are risks for women who disclose sexually marginalized status. The risks of disclosure include, but are not limited to, embarrassment, silence, and/or the refusal of care (Fish & Bewley, 2010). The negative impacts of disclosure can be seen in the results of Eliason and Schope's (2001) study, which included lesbians, gay men, and bisexual people. In their exploration of the factors related to disclosure, 16% of participants reported negative reactions from health care providers upon disclosure. These negative reactions included anger or hostility, discomfort, disgust, fear, shock and embarrassment (Eliason & Schope, 2001). Furthermore, over one-third of the female participants from this study reported feeling relieved and/or safer by not disclosing their sexual orientation to health care providers (Eliason & Schope, 2001). Despite the finding that women were more likely to disclose their non-heterosexual sexual orientation, they also reported engaging in more protective strategies (e.g. monitoring healthcare provider for clues about acceptance) and overall being more uncomfortable than men in healthcare settings (Eliason & Schope, 2001). These findings demonstrate the dilemma queer women face each and every time they find themselves in a new healthcare interaction whereby the pros and cons of disclosure must be weighed, often without knowing how the healthcare provider will react. According to Eliason and Schope (2001), the changes in societal attitudes, which include a movement towards acceptance of sexually marginalized status, have not extended to healthcare settings. The finding that only 68% of women had disclosed their non-heterosexual sexual orientation to their regular family physicians supports their argument (Eliason & Schope, 2001). Interestingly, only 51% of men disclosed their non-heterosexual sexual orientation to their regular family physicians (Eliason & Schope, 2001). As such, Eliason and Schope attribute female gender as a predictor of disclosure and attribute this to the reasons women seek healthcare services. According to the authors, most women have become accustomed to the question, "Are you sexually active?" answering affirmatively to this questions usually leads to a question about birth control, which forces a lesbian or bisexual woman to make the decision of whether or not to disclose their sexual orientation (Eliason & Schope, 2001). This finding is particularly relevant in supporting the current study's focus specifically on the interactions between healthcare providers and queer women with respect to sexual healthcare. The following section will explore the tactics sexually marginalized women employ when disclosing their sexual identity.

In their 1992 qualitative study, Hitchcock and Wilson sought to understand disclosure as a concept and the behaviours it explains in order to help clarify the obstacles lesbians encounter when interacting with health care providers. Their study examined the following: the conditions under which lesbians decide to disclose or not disclose sexual orientation to health care providers; the strategies lesbians use to manage relationships with health care providers; the consequences lesbians have experienced or expect to experience when they self-disclose; and how these expectations affect health-seeking and compliance behavior (Hitchcock & Wilson, 1992). Hitchcock and Wilson (1992) found that lesbians use a process of personal risking in managing and sustaining a health environment that provides safe health care and psychological comfort. The four interactional stances that were identified in this study, and have since been used as a theoretical framework in subsequent studies, were: passive disclosure (giving clues about sexual identity), passive nondisclosure (hiding or avoiding questions about sexual identity), active disclosure (directly telling a health care professional about one's sexual identity) and active nondisclosure (claiming an assumed identity) (Hitchcock & Wilson, 1992). Importantly, these researchers found that for lesbians, it is essential that healthcare is physically safe and psychologically comfortable, particularly with regards to sexual orientation.

Many researchers have gone on to implement and adapt Hitchcock and Wilson's interactional stances for disclosure. More recently, Eliason and Schope (2001) adapted Hitchcock and Wilson's (1992) original disclosure model and found that LGB people use a number of protective strategies, many of which were similar to those found in the original study, when considering their disclosure. These protective strategies included: closely monitoring the healthcare providers' behavior for clues about acceptance (36%), asking someone about the health care provider before making an appointment (30%), scanning the environment for clues about the healthcare providers' knowledge and acceptance (18%), and bringing someone along for support (6%). These findings illustrate the anticipatory and reactionary tactics that LGB people use when considering disclosure. Hitchcock and Wilson (1992) identified a similar two-phase social process that lesbians engage in to secure their safety within the health care system: in the anticipatory phase, the risk of disclosure is calculated, and in the interactional phase, lesbians scan and monitor their environment and re-evaluate their risk of disclosure.

Overall, Hitchcock and Wilson's (1992) findings on disclosure confirmed that lesbians are uncomfortable in many healthcare situations and Eliason and Schope (2001) concluded that the low rates of disclosure for LGB people are a result of their perception that healthcare settings and healthcare providers are unsafe and threatening. This literature supports the salience of disclosure for non-heterosexual women when interacting with healthcare providers. Next, is a brief review of the literature regarding the relationship between disclosure and the types of health issues in which queer women seek healthcare.

When considering the focus of the current study on queer women's interactions with health care providers within the context of sexual healthcare, disclosure of sexual orientation is especially relevant. Particular health problems, such as those relating to sexual behavior are considered more relevant to one's sexual identity than other health problems (Fish, 2006). In other words, sexual health is considered to be more closely related to one's sexual identity than, for example, cold symptoms or a heart condition. Fish (1996) maintains that the relevance of one's sexual identity to the health problem is said to be more likely to prompt disclosure. Sexual identity is considered most relevant when heterosexuality is routinely assumed in discussions around: sexual history taking, sexually transmitted diseases and contraception (Fish, 2006). In these circumstances, disclosure is said to be important information for health care providers because it facilitates accurate diagnoses and appropriate treatment (Eliason & Schope, 2001). The relevance of disclosure to queer women's sexual health and the finding that the heterosexual presumptions is most salient in discussions of sexual health, provides support for the current study's focus on queer women's interactions with healthcare providers when seeking sexual healthcare. However, Fish (2006) contests the concept of relevance when considering disclosure to health care professionals because it perpetuates a biomedical approach to lesbians' and gay men's health. The assumption that health care providers only need to know about sexual identity in order to provide an accurate diagnosis continues a dependence on a biomedical approach to health (Fish, 2006). Instead, it is suggested that healthcare providers need to know about sexual identity in order to provide holistic health care, not just a quick diagnosis (Fish, 2006). Fish (2006) argues, "By using relevance as a marker for disclosure... we may be perpetuating some of the heterosexist views about lesbians and gay men that we are

seeking to challenge” (p. 145). A relevance approach to disclosure, which reinforces the notion that sexual identity is only related to some aspects of health, is synonymous with the biomedical approach to health, which separates bodies into distinct units (Fish, 2006). Moreover, selectivity compartmentalizing sexual identity, through a relevance approach to disclosure, extends the problematic belief that sexually marginalized identities can be disconnected from health. Heterosexual identity, on the other hand, is consistently assumed and thus inherently connected to an individual’s health (Fish, 2006). This creates an inherently unequal approach to health in which heterosexuality is accorded privilege and non-heterosexuality is disadvantaged.

In sum, although the relevance approach to disclosure emphasizes the relationship between sexual identity and sexual behaviour, striving for a more holistic approach to health demands the acknowledgment of marginalized sexual identity for all aspects of health, not just sexual health. Up until this point, disclosure has been considered from the perspective of queer women who must make decisions about outing themselves to healthcare providers, and if so which tactics they will invoke in order to do so (e.g. active or passive). The next section reviews a study that includes the concept of disclosure from the healthcare providers’ perspective.

McNair, Hegarty, and Taft’s (2012) study sought to address the gap in the literature concerning both the diversity of disclosure needs amongst same-sex attracted women, as well as the barriers and facilitators of disclosure from the perspective of general practitioners. This latter aim of the study is particularly important because according to these authors, there is very little literature on the provider perspective regarding disclosure of sexual orientation (McNair, Hegarty, & Taft, 2012). Importantly, this study addresses how disclosure for same-sex attracted women is negotiated with GP’s in healthcare interactions and questions where the responsibility for disclosure lies. A strength of this study was its multifaceted approach through inclusion of three research paradigms: phenomenology, which addressed the lived experience of participants; critical theory, used to explore experiences of social injustice; and liberal feminism, to both address concepts of power within the relationships between same-sex attracted women and their GP’s and encourage reflexivity (McNair et al., 2012). The researchers conducted interviews with 24 patient-GP pairs (McNair et al., 2012). The

findings from this study show that disclosure of sexual orientation was regarded as difficult by both women and GP's, with a majority of people in both groups believing it to be 'easier' for the other to initiate the process (McNair et al., 2012). Women preferred GP's to ask about their sexual orientation, while GP's preferred their patients to disclose their sexual orientation. The barriers to disclosure for non-heterosexual women have been previously addressed and as such, the following will focus on the barriers to initiating conversations about sexual orientation for GP's. The risks for not initiating a discussion about sexual orientation for the GP's included: irrevocable damage to the patient-doctor relationship and the potential for doctors to compromise their own professional standing in patients' eyes by revealing their inadequacies in this area (McNair et al., 2012). One of the contributing factors to the fear of irreversibly damaging the patient-doctor relationship was the GP's assumption that heterosexual patients would be offended if they were asked about their sexual orientation (McNair et al., 2012). This assumption led GP's to only ask about sexual orientation to those patients "who they were fairly sure were lesbian" (McNair et al., 2012, p. 213). In this way, GP's were not giving their patients equal opportunities for appropriate healthcare because they were operating under stereotypes of what a lesbian may look like. Despite the majority of GP's identifying as patient-centered, with a holistic approach to patient care, most stated that sexual orientation was generally not relevant (McNair et al., 2012). This short-sightedness included an absence of sexual history questions from three GP's (McNair et al., 2012). These findings demonstrate a contradiction for GP's who claim to offer patient-centered and holistic care and yet willfully ignore the construct of sexual orientation and sexual identity. This is particularly concerning because sexually marginalized groups experience different patterns of health and illness (McNair, 2003). Arguably, a holistic and patient-centered approach to health and healthcare would include sexual history taking and the consideration of marginalized sexual orientation for patients.

Based on the findings from this study, the authors argue for a relationship-centered framework, rather than a patient-centered framework, which requires both parties (i.e. patient and GP) to participate (McNair et al., 2012). Thus within a relational model, the burden of disclosure is not solely placed on non-heterosexual women. The recommendation to attend to relational aspects begins to extend the concept of

disclosure as the only element of importance for queer women interacting with their healthcare providers. However, almost no literature exists on the interactional process between queer women and their healthcare providers beyond the issue of disclosure. Disclosure continues to be the dominant research lens yet this concept is limited in its ability to explain the fuller picture of how queer women engage in meaning-making based on their interactions with healthcare providers.

2.4. Beyond Disclosure: Queer Women's Sexual Health Care Interactions

There appears to be a sizeable gap in the existing literature with regards to queer women's interactions with healthcare providers beyond the issues concerning disclosure. The current study seeks to fill this gap by looking holistically at queer women's experiences interacting with healthcare professionals when seeking sexual healthcare and/or sexual health information. Stevens (1994) conducted one of the few studies that went beyond the issue of disclosure in her feminist narrative research with a racially and economically diverse sample of lesbians in San Francisco. In this study, participants were asked to relate positive and negative encounters in healthcare, with a focus on critical events that defined whether or not they felt cared for by healthcare providers (Stevens, 1994). Interviews and focus groups were utilized to elicit narrative accounts from lesbians about their interactions with health care providers (Stevens, 1994). The narrative design of this study sought to address the shortcomings of previous research that constricted data collection to issues of disclosure and sexual orientation (Stevens, 1994). Data from this study included audiotapes of individual interviews, focus groups, and field notes, which were analyzed in a multistaged narrative analysis (Stevens, 1994). Participant narratives were analyzed in terms content and context and story similarities and differences were analyzed among ethnic/racial, socioeconomic, and health status subgroups in the sample (Stevens, 1994). In the final stage of data analysis, participant health care narratives were analyzed in their entirety. Across a wide range of health care facilities, health care providers, and health conditions, 23% of participants evaluated their interactions with health care providers as positive and, overwhelmingly, 77% of lesbians evaluated their interactions as negative (Stevens,

1994). Common dimensions of caring and non-caring components emerged as fundamental to lesbians' experiences in healthcare interactions across ethnic/racial, socioeconomic, and health status (Stevens, 1994). The caring component included women's recollection of encounters with health care providers who: treated them as human beings, approached them confidently yet with warmth and sensitivity, believed them, recognized the multidimensionality of women's lives, understood the specific circumstances particular individuals faced, and had a desire to unite with clients in their struggle (Stevens, 1994). The non-caring component comprised of: rough handling and outright sexual abuse by male health care providers (reported by 16% of participants), rejection from health care providers, and instantaneous assumptions made in relation to stereotypes about gender, skin colour, poverty, body size and illness (Stevens, 1994). In relation to the current study's focus on sexual health, it is important to note that the rough handling and sexual abuse experienced by women in this study most commonly occurred during invasive pelvic exams. These negative experiences were defined by the term intrusion, which was characterized by, "the act of wrongfully entering upon what belongs to another, of advancing beyond limits without permission or welcome" (Stevens, 1994, p. 646). Experiences of intrusion were contrasted with women who recounted stories coded as "intimate care", in which health care providers approached women with respectful warmth and thoughtfulness (Stevens, 1994). Stevens concluded that suffering severe bodily intrusions contributed to negative healthcare encounters for the women in this study. In fact, nearly half of the participants in this study (44%) had virtually stopped seeking health care because of their negatively evaluated interactions with health care providers (Stevens, 1994). More concerning was the finding that half of the women who discontinued accessing healthcare services suffered from chronic health conditions such as cancer and diabetes (Stevens, 1994).

Stevens (1994) study extended the understanding of lesbians' experiences with healthcare providers beyond the notion of disclosure. Based on her findings, the author argues that disclosure of lesbian identity is not the only meaningful factor in lesbian's health care interactions, but rather a component of a complex interactional experience (Stevens, 1994). By focusing on lesbian's interactions with healthcare providers, this qualitative study established a greater understanding of the negative and positive dimensions of caring and non-caring. The current study seeks to extend this

understanding by using constructivist grounded theory to explore the interactional process between queer women and healthcare providers within the context of sexual healthcare.

More recently, Bjorkman and Malterud (2009) conducted a qualitative study that explored lesbians' healthcare experiences and identified two interactional aspects beyond disclosure. Participants answered two open-ended questions designed to elicit qualitative data about healthcare experiences through a web-based questionnaire. After analysis, Bjorkman and Malterud (2009) identified three different aspects of health care professionals' abilities, regarded as essential by lesbian participants that would contribute to positive interactions. In order for lesbians to receive quality care, healthcare professionals need to have (1) awareness that not all patients are heterosexual, (2) an open attitude towards homosexuality, and (3) specific knowledge of lesbian health issues (Bjorkman & Malterud, 2009). These three dimensions appear to be interconnected and healthcare professionals must exhibit awareness, openness, and specific health knowledge simultaneously in order for positive health experiences to result for lesbians (Bjorkman & Malterud, 2009). The important contribution of this study to understanding lesbians' interactions with healthcare providers lies in the third finding, namely the critical importance of healthcare providers maintaining appropriate and sufficient medical knowledge. Participants in this study shared stories, both positive and negative, about interactions with healthcare providers on the topic of sexual health. A number of women shared negative histories revealing that healthcare professionals had problems informing lesbian patients about sexually transmittable diseases, including being told that screening for cervical cancer (Pap smear) was not needed (Bjorkman & Malterud, 2009). These women described how they were left with uncertainty and unanswered questions (Bjorkman & Malterud, 2009). This finding further illustrates the complex nature of the interactions queer women experience with health care providers when seeking sexual health care. Not only are lesbians being physically intruded upon, as shown by Stevens' (1994) study, but they are also simultaneously navigating interactions with healthcare providers who are ignorant and unaware of the specific sexual health practices and needs of lesbian women. Bjorkman and Malterud (2009) found that when healthcare professionals were knowledgeable of specific health concerns, including helpful information about safer sex, participants evaluated their

experiences as positive. Thus, it appears as though appropriate healthcare knowledge and communication of this knowledge impacts the interactional process between lesbian women and health care providers.

In conclusion, research supports the notion that understanding queer women's interactions with health care providers extend beyond the issues concerning disclosure. According to Stevens (1994), interactional dimensions between lesbians and health care providers include fundamental experiences that can be contrasted in terms of care and noncare. However, the conclusions drawn from Stevens (1994) study are limited due to the temporal context in which this study is situated. Bjorkman and Malterud's (2009) more recent study also extends beyond the disclosure paradigm by recognizing contributing factors to positive and negative experiences, including the influence of health care providers medical knowledge, on the interactions with lesbian women seeking health care. However, this study does not specifically focus on the interactional process in which queer women and health care providers are involved. The current study applies constructivist grounded theory method to address this gap in the literature in an effort to further understand the interactional process between queer women and health care providers within the context of sexual health. The following section outlines another approach, aside from the disclosure paradigm, to understanding queer women's interactions with healthcare providers. Approaches and models to conceptualizing health will be reviewed and relevant literature to the current study's human rights approach to health will be presented.

2.5. Approaches and Models to Conceptualizing Health

For lesbian, gay, bisexual, trans, and queer (LGBTQ) people, human rights are at the heart of global political struggles for social equality (Kollman & Waites, 2009). A human rights approach to health advocates that every human being deserves the right to the highest attainable standard of health. Within the human rights health framework, the *right to health* includes non-discrimination, equality, equity, participation, and access to health information (Hunt & Backman, 2008). In this way, the health as a human right framework takes a more holistic approach to health that extends beyond physical impairments and biological disease and incorporates the impact of social

marginalization. Fish (2010) argues, “the distinctiveness of a human rights approach lies in the recognition that social inequalities have an impact on health and health-care” (p. 356). This is an especially important consideration given the discrimination queer women encounter through homophobia and heterosexism. As previously mentioned, queer women experience health inequalities at the interactional level that result from homophobia and heterosexism and at the systemic level through the prevalence of heteronormativity. The health as a human right framework is arguably the most appropriate health model for queer women because of its focus on the detrimental impact of the disparities this marginalized group faces and the importance of striving for equality in order to provide competent and respectful sexual healthcare.

Approaching health as a human right is an emergent perspective that is influencing reforms in health and social care (Fish & Bewley, 2010). Despite the numerous existing health frameworks, including biomedical, health promotion, and social determinants, a human rights-based approach is the only perspective that is supported by moral values and is legally enforced internationally (Hunt & Backman, 2008).

A health as a human rights framework addresses key limitations of historical and dominant health research and policy frameworks. The biomedical model assumes disease to be fully accounted for by biological abnormalities and disregards the social, psychological, and behavioural dimensions of illness (Engel, 1977). The main limitation of the biomedical model is its reductionist and exclusionist foundations and its lack of inclusion of the psychosocial factors that undoubtedly contribute to disease, illness, and overall health. A health promotion model extends beyond a purely biological basis and has been defined as a positive concept emphasizing social and personal resources and physical capabilities including: peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity (World Health Organization, 1986, as cited in Brewslow, 1999). However, despite recognizing the principle of equity, the health promotion model has been criticized for failing to account for economic inequalities, social discrimination (Laverack & Labonte, 2000) and its inherent individual focus. Thus, although this model proposes to acknowledge social inequalities, it would not be a suitable framework when considering queer women because of the lack of

appreciation for how deeply rooted in inequality this marginalized group's health issues are.

The social determinants of health (SDOH) model acknowledges the influence of social context and recognizes that population health is influenced by nonmedical and nonbehavioural characteristics (Raphael, 2006). The recognition of psychosocial factors that impact and influence health addresses the fundamental limitation of the biomedical model's restricted understanding of the strictly physiological nature of health and illness. However, the appropriateness of this model for socially marginalized sexualities is called in to question when considering which determinants of health are recognized. Raphael's (2006) synthesis of the SDOH outlined by the Canadian Institute of Advanced Research, a British working group, and the U.S Centres for Disease Control, identified the following key determinants of health: aboriginal status, early life, education, employment/unemployment and working conditions, food security, health care services, housing, income distribution, social safety net, and social exclusion (Raphael, 2006). When considering the sample for the current study, the social exclusion determinant of health may include queer women but it is unclear whether or not this determinant addresses socially marginalized sexualities. As such, in order for the SDOH model to be an appropriate approach to framing queer women's sexual health, there would have to be a specific recognition of sexual orientation/sexual identity. The SDOH model, despite recognizing inequities as influencing health, is not rooted in social justice principles of addressing unequal access to health care. Moreover, although the SDOH model may acknowledge sexual orientation/sexual identity as a determinant of health, this model does not adequately explain the process by which marginalized individuals are impacted by their minority sexual orientation in healthcare interactions.

2.5.1. The Health as a Human Rights Approach

Unlike in the biomedical, health promotion, and SDOH models, issues of health equity and non-discrimination are the foundational elements of the health as a human right framework. Over the last several years, the discourse of human rights-based approaches to health has garnered particular attention when considering marginalized groups. A human rights approach to health allows for the recognition that social

inequalities impact health and health-care (Fish & Bewley, 2010). Unlike the biomedical, health promotion, and SDOH models, the health as a human right model sufficiently addresses the impact of social inequality for marginalized groups, including queer women in the healthcare setting. In fact, the health as a human rights model places inequality and discrimination experienced by marginalized groups at the very heart of their health issues. A human rights perspective argues for the right to the highest attainable standard of health (Hunt & Backman, 2008). Unequal rights are central to the oppression that marginalized sexuality groups face on a daily basis (Kollman & Waites, 2009).

A review of the literature reveals that the intersection of a human rights approach to health and queer women's health was not developed until the mid-nineties in an essay by Miller, Rosga, and Satterthwaite (1995). In their article, the authors initiate this conversation noting that health has often been a site of oppression for lesbians due to the conceptualization of homosexuality as an illness in need of treatment (Miller, Rosga, & Satterthwaite, 1995). This article highlighted that lesbian well-being must take into consideration social and individual factors, including basic human needs. The authors concluded that the human rights paradigm offers lesbians an opportunity to articulate rights claims and therefore is conducive to protecting lesbian health (Miller, Rosga, & Satterthwaite, 1995).

In 2006, at the International Conference on LGBT Human Rights, a set of international legal principals, called the Yogyakarta Principles, were developed to address human rights violations based on sexual orientation and gender identity ("The Yogyakarta Principles", 2007). The Yogyakarta Principles seek to address the ongoing human rights violations targeted towards persons because of their actual or perceived sexual orientation or gender identity ("The Yogyakarta Principles", 2007). These principles "address a broad range of human rights standards and their application of issues of sexual orientation and gender identity" (p. 7) including Principle 17 – the right to the highest attainable standard of health. Principle 17 declares, "everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation and gender identity" ("The Yogyakarta Principles", 2006, p. 22). Particularly relevant to the current study, sexual and

reproductive health are specifically identified as fundamental aspects to the highest attainable standard of health (“The Yogyakarta Principles”, 2006). As will be discussed later, injustices and violations commonly occur within the context of sexual health for queer women.

Over time, the juncture of a human rights-based approach to health and queer women’s health has begun to attract the attention of researchers internationally including Australia, the United Kingdom, Canada, and the United States. According to McNair (2003), health inequalities exist for lesbian and bisexual women, and are largely related to experiences of homophobia and heterosexism. McNair does not specifically advocate for a human rights-based approach to conceptualizing queer women’s sexual health. However, McNair does argue that inequality, discrimination, and cultural incompetence are issues that plague lesbian and bisexual women’s healthcare.

More recently, Fish and Bewley (2010) focused on how lesbian and bisexual identified women’s health can be considered as a health inequality. Drawing on qualitative data collected as part of a larger online survey, participants completed three open-ended questions eliciting information about the nature of their healthcare experiences, their recommendations for improving services, and any other healthcare experiences (Fish & Bewley). Data analysis revealed four broad themes: heteronormativity in healthcare, improving attitudes among healthcare providers, equality in access, and raising awareness and informed communities (Fish & Bewley, 2010). According to the authors, the presumption of heterosexuality by healthcare providers contributed to the heteronormativity of healthcare environments. Importantly for the current study, women reported that heterosexual presumptions were most routinely made in relation to sexual history taking, contraception discussions, and cervical screening (Fish & Bewley, 2010). This finding highlights the importance of further exploring the interactions between queer women and healthcare providers within the context of sexual health so as to better understand this interactional process. Within the second theme – improving knowledge and attitudes among healthcare providers - participants reported that healthcare providers were frequently unable to provide them with relevant health advice and at times they were refused healthcare (Fish & Bewley, 2010). In terms of equality in access to healthcare, participants emphasized the need

for: appropriate language and terminology, for the inclusion of lesbian and bisexual women in assessment and demographic forms, and for various measures to be taken in order to signal acceptance of women of marginalized sexualities (Fish & Bewley, 2010). The fourth theme – raising awareness and informed communities – encompassed the need to raise awareness about specific health needs; participants highlighted sexual health as an important area for healthcare providers to have relevant knowledge (Fish & Bewley, 2010). Again, non-heterosexual women's sexual health is identified as an important area of consideration, thus providing further support for the current study's focus on queer women's sexual health.

According to Fish and Bewley (2010), the accounts of participants underscore the centrality of the human rights principles of fairness, respect, equality, dignity and autonomy. The expectation of fairness was demonstrated by participants' desire for a transparent process for investigating complaints; in terms of respect, participants called for respect for diverse families (Fish & Bewley, 2010). Within the principle of equality, participants expected appropriate confidentiality policies and a commitment to improving services for sexual minorities; in order to feel dignified, participants requested healthcare providers avoid thoughtless or degrading treatment such as questions about contraception during cervical cytology screening (Fish & Bewley, 2010). The human rights principle of autonomy was exemplified by participants' requests for relevant information about healthcare (Fish & Bewley, 2010). The centrality of these human rights principles in conceptualizing queer women's health inequalities directly addresses the complex ways that sexual orientation discrimination affects health. This approach to healthcare focuses on improving the quality of patients' experiences, developing an inclusive approach to the design and delivery of health services and engaging meaningfully with marginalized groups (Fish & Bewley, 2010). Health care practitioners committed to human rights principles contribute to patient-practitioner equality by developing their skills in communicating appropriately with queer women (Fish & Bewley, 2010).

2.5.2. Critiques of the Human Rights Approach to Health

Although Fish and Bewley (2010) provide clear support for the implementation of a human rights-based framework for approaching health for women of marginalized sexualities, there is contention about the strength of this approach. Both Dean Spade (2011) and Matthew Waites (2009) dispute the appropriateness and effectiveness of the application of a human rights-based framework as a means of attending to the inequities experienced by socially marginalized sexuality groups. In his argument for critical trans politics, which addresses the legal rights of trans people, Spade (2011) argues that the discrimination principle as a method of identifying and addressing oppression has been ineffective in movements towards equality. Spade (2011) contends that the legal focus on anti-discrimination has been well supported by prominently funded lesbian and gay reform organizations and yet fails to address the legal issues that create the greatest vulnerabilities for trans people. For Spade (2011), equality and inclusiveness are not enough create a level-playing field for socially marginalized sexualities. Spade (2011) writes that, “transformative change can only arise through mass mobilization led by populations most directly impacted by the harmful systems that distribute vulnerability and security” (p. 28). The current study capitalizes on this notion of transformative change by providing contemporary research on queer women’s sexual health, an area that continues to be invisibility both in academic research and clinical practice. Furthermore, the current study seeks to address “systems that distribute vulnerability” by attending to the systemic barriers and facilitators to equitable and competent sexual healthcare for queer women.

Another debate occurring in this area of the literature is Waites’ (2009) argument that the categorical variables ‘sexual orientation’ and ‘gender identity’ are in direct conflict with a human rights-based approach to LGBTQ rights. This argument echoes queer theory’s poststructuralist critique of the unified and autonomous self, which suggests homosexuality should not be studied in terms of marginalization, but rather a study of the sexualizing organizational structures in society (Seidman, 1996, as cited in Gamson, 2003). According to Waites, the central use of these categories serve to perpetuate a binary model of gender, and sexual behaviour, sexual identity and sexual desire, that are defined exclusively in relation to a single gender. His argument calls for

the use of social theory and queer theory in focusing on concepts such as justice, liberation, and self-determination instead of human rights (Waites, 2009). Waites refutes the claim that sexual orientation and gender identity are integral to every person's dignity and humanity; arguing that a human rights-based framework presumes western views of gender and identity categories that do not extend cross-culturally. His argument extends to the problems associated with emphasizing these underlying categories in LGBTQ human rights-based models due to the marginalization of asexual individuals and gender diverse individuals. Although Waites presents a valid argument with important considerations, he does not provide practical instruction for conducting research with women of marginalized sexualities. Gamson (2003) counters Waites' argument stating that the notion of homosexual identities as unstable, performative, conditional, and discursively produced as creating "epistemological difficulties that translate into methodological ones" (p. 556) when studying sexually identified populations. In other words, by consistently critiquing conceptualizations of 'sexual orientation' and 'gender identity' without offering alternatives, it poses great difficulties in opportunities to understand these groups through research. The concept of 'sexual orientation' and the methodological difficulties associated with defining and researching sexually marginalized populations will be discussed in the following section. The current research addresses the tension between acknowledging sexual identity as unstable and socially constructed while maintaining an identifiable research population by using the inclusive term "queer". Furthermore, participants in the primary study were able to self-identify with their own terms when describing their sexual orientation and sexual identity, which allowed for identification with multiple identity terms, as well as recognition of identity fluidity. The next section provides a review of the literature relevant to conducting research with socially marginalized sexuality groups.

2.6. Queer Women in Research: Sexual Orientation & Terminology

In general, queer women are underrepresented in health research. Brogan, Frank, Elon, and O'Hanlan (2001) argue that the lack of inclusion of sexually marginalized women in research stems from social stigmatization, which in turn leads to

sexual identity misclassification errors that likely favour heterosexual assignment of lesbians. Thus, even when queer women do participate in research studies, the assumption of heterosexuality (i.e. heterosexism) results in the misidentification of these women as heterosexual. Moreover, if the process of sexual orientation data collection does not include appropriate confidentiality measures and adequate safety protocols for queer women, then this marginalized group may not feel comfortable disclosing a non-heterosexual sexual orientation (Brogan, Frank, Elon, & O'Hanlan, 2001). Again, this may lead to a misclassification of sexual orientation for queer women. Social stigmatization and insufficient privacy and security measures are only a couple of the barriers that contribute to the methodology issues of appropriately identifying queer women as such in research. The following section seeks to provide a context for the methodology challenges that exist for researchers when studying sexually marginalized women and ultimately provides a rationale for the use of the term queer women for the current study. The subsequent referenced literature draws attention to the difficulties and complexities researchers face when conceptualizing the constructs of sexual orientation and sexual identity.

Health research has used varied and sometimes unclear definitions of the construct sexual orientation. The varied terminology that has been used to conceptualize sexual orientation in this literature review accurately reflects the broad array of vocabulary used in research. The terms lesbian, bisexual, queer, non-heterosexual, gay, women who have sex with women (WSW), and sexually marginalized women, have all been used to describe this population. Understandably, the usage of these various terms by researchers has been problematic for a variety of reasons including limiting comparability and generalizability of findings. The crux of the difficulty in identifying sexually marginalized women lies in the three-dimensional nature of sexual orientation. The three dimensions of sexual orientation that have been widely acknowledged through population-based studies are: identity, attraction, and behaviour (Laumann, Gagnon, Michael, & Michaels, 1994). Further complicating this matter is the notion that discordance exists between these dimensions. The results from Diamond's (2000) study illustrate that sexual identity, sexual attraction, and sexual behaviour are not always congruent for women. Furthermore, these dimensions are unstable and change over time. This notion is supported by Diamond's (2000) finding that half of the 80 self-

identified lesbian, bisexual and “unlabeled” women who participated in the two-year longitudinal study changed sexual identities more than once and one third changed identities in between the initial and follow-up interviews. The changes found in sexual attractions were generally small, but larger changes did occur in bisexual and unlabeled women (Diamond, 2000). In terms of sexual behaviours, most women pursued sexual behaviour consistent with their attractions, however one quarter of lesbians reported sexual contact with men (Diamond, 2000). These findings are consistent with the findings previously noted by Marrazzo et al. (1998) and Bailey et al. (2003), in which women’s non-heterosexual sexual identity classification did not preclude sexual activity with men. Diamond concludes that the sexual dimensions of identity, attraction, and behaviour are unstable and fluid for non-heterosexual women. Due to the inconsistencies between the sexual orientation dimensions of identity, attraction, and behaviour, it is inadvisable to classify women’s sexual identity based on any of these dimensions in isolation. Instead, a more holistic and inclusive approach to classifying sexual orientation allows for the consideration of all three dimensions of sexual identity for women.

In accordance with the primary study, the current study’s use of the term “queer” reflects an inclusive and anti-oppressive approach to investigating sexually marginalized women’s interactions with healthcare providers when seeking sexual health care. Although the term queer was historically used as an expression of homophobic slang, in recent years this word is being reclaimed and used as an umbrella term for a diverse group of socially marginalized sexual identifications. Queer is an identity marker that is defined by a deviation from sex and gender norms and recognizes fluidity (Gamson, 2003). This recognition of fluidity is vital given the research support for the unstable and fluid sexual orientation dimensions previously outlined. The term queer is an overarching umbrella category that is more inclusive than terms such as lesbian, bisexual, and women who have sex with women (WSW). These terms tend to only reflect certain aspects of sexual orientation; for example, the term WSW only refers to women’s sexual behaviour and does not take into consideration the dimensions of sexual attraction and sexual identity. The term queer captures commonalities of experience shared by diverse communities such as Aboriginal LGB persons who identify as two spirit, and those who identify as transgender, transsexual, and intersex. The use of the term queer recognizes

the shared experiences of social exclusion and marginalization of LGBTQ individuals and is intended to be vague and complex as a reflection of the many diverse sexual orientation and sexual identity categories LGBTQ.

Support for the use of a sexual orientation and sexual identity term that is more inclusive, such as the term queer, can be found in Bauer and Jairam's (2008) methodological recommendations for research with sexually marginalized women. The authors highlight the difficulties associated with the various terminology and the different constructs (i.e. identity, behaviour, and attraction) used to measure sexual orientation in health research (Bauer & Jairam, 2008). In their review of health research papers published between 2000 and 2006, a total of 201 papers were analyzed in which the authors found more than 100 different ways of measuring sexual orientation (Bauer & Jairam, 2008). Of women aged 20-44 years, 92.4% reported heterosexual sexual orientation, 2.5% reported bisexuality, 1.4% reported homosexuality, and 3.7% of women chose "something else" (Bauer & Jairam, 2008). This latter group was comparable in size to the combined total of women who identified as homosexual or bisexual (Bauer & Jairam, 2008). Bauer and Jairam (2008) state that the "something else" group probably consists of a diverse group of women who did not identify with the limited sexual identities (i.e. heterosexual, bisexual, homosexual) offered. The "something else" group likely included women with other sexually marginalized identities, such as queer, two-spirit, dyke, or pan sexual and it is also possible that some lesbian-identified women chose this category because few women personally identify with the term "homosexual" (Bowen et al., 2004, as cited in Bauer & Jairam, 2008). Based on these findings, the authors recommend an inclusion of more identity groups or the option for an open-ended identity question that would allow researchers an opportunity to know if a participant self-identified with a sexually marginalized identity (Bauer & Jairam, 2008). This latter recommendation is particularly relevant to the current study because the umbrella term queer encompasses women who identify as lesbian, gay, bisexual, trans, and other. In the current study women were empowered to self-identify using their own words, which falls under the recommendation from Bauer and Jairam (2008) for researchers to allow for an open-ended identity question. The final recommendation the authors advocate for is that the manner in which sexually marginalized status is measured in research studies should closely relate to the theoretical framework that is

being used for the study (Bauer & Jairam, 2008). The use of a human rights-based framework for the current study, with its basis in non-discrimination and equality, supports the use of the more inclusive term queer women as an overarching term that encompasses the multiple self-identification terms chosen by participants. The current study extends the recommendation for self-determination of identity by encouraging participants to use multiple identifying words so as to acknowledge the complexity of identity. This approach to conceptualizing sexual identity and sexual orientation addresses the limitations of research that has espoused a focus on women's sexual behaviour.

Problematically, health-related research for sexually marginalized women has heavily utilized the behaviourally based term women who have sex with women (WSW). The term WSW inherently disregards the sexual orientation dimensions of identity and attraction and narrowly focuses on sexual behaviour as a means of categorization. In the previous sexual health section, the term WSW was used in accordance with its usage in the referenced studies. However, this term is both limiting and discriminatory. The following draws attention to the limitations and discriminatory implications of the usage of the term WSW in research with sexually marginalized populations. In their 2005 article, Young and Meyer vehemently criticize the use of the terms MSM (men who have sex with men) and WSW in public health discourse. Young and Meyer argue against the supposedly neutrality of the terms MSM and WSW and highlight the implications for the social dimensions of sexuality, the significance of self-labeling, and the insufficiency in accounting for variability in sexual behaviour. The authors contend that the behavioural focus of the terms MSM and WSW inhibits an understanding of same-sex relationships that go beyond sexual activity (Young & Meyer, 2005).

Young and Meyer (2005) identify three concerns regarding the use of the terms WSW and MSM related to the current study: the social dimension of sexuality is lost, the preconceived and limited behaviour categories undermine self-labeling, and important facets of sexual behaviour are misunderstood, which has implications for public health research and intervention (Young & Meyer, 2005). The first identified concern, which highlights the obstruction of the social meaning of sexuality by focusing solely on behaviour, disregards the social aspects of sexual identity that are imperative to

understanding sexual health. Reducing sexual orientation and sexual identity to sexual behaviour ignores the communities, norms, values, and culture associated with marginalized sexuality groups that can have important implications for health (Young & Meyer, 2005). Furthermore, the author's note how the terms MSM and WSW have been racialized to implicitly refer to people of colour, economically disadvantaged people, or diverse groups on the periphery of mainstream "white" gay and lesbian communities (Young & Meyer, 2005). The second concern - self-labeling - highlights the importance of allowing participants to self-identify with sexual identity categories of their choice. The authors write that individuals in sexually marginalized groups prefer to use their own identity terms, but that public health writers ignore sexual identity by confining individuals to MSM or WSW categories (Young & Meyer, 2005). This argument supports the current study's approach to utilizing the term queer women as an umbrella term, in order to sustain a definable research population, along with the encouragement for women to self-identify with their own words and/or terms commonly used (e.g. lesbian, dyke, butch, femme etc.). The third concern identified by Young and Meyer (2005) targets the supposedly greatest advantage of the terms MSM and WSW – their basis in sexual behaviour. Unlike identity terms such as lesbian, gay, and bisexual, the benefit of using the behaviourally grounded terms MSM and WSW, is that they are rooted in the sexual behaviour individuals engage in (Young & Meyer, 2005). However, as the authors contend, despite the behavioural focus of these terms, researchers rarely engage in the important task of describing the sexual behaviours engaged in (Young & Meyer, 2005). Without this vital information, healthcare providers are unable to provide sexually marginalized women with adequate sexual health care, including preventative measures. Thus, the behavioural focus of the term WSW, which does not provide sufficient information regarding women's sexual practices, consequently renders this term as inadequate to describe sexually marginalized women. Young and Meyer (2005) summarize their argument by stating that the use of "reductive labels is unethical because it denies the right of identity to members of sexually marginalized groups whose marginalization and mistreatment in medical settings have been amply documented" (p. 1148). Instead, researchers should attend to the variations and complexities in the conceptualization of sexual identity and sexual orientation. However, there are numerous methodological challenges associated with the dismantling of the constructs of sexual orientation and sexual identity. Queer theory's social constructivist approach to

sexual identity and sexual orientation results in unclear definitions of these terms and thus renders the sexually marginalized population as unidentifiable. The following section offers a critical discussion of queer theory and the implications for conducting research.

Queer theory challenges notions of essential self and identity and emphasizes the socially constructed nature of gender sexual behaviours and sexual identities. Joshua Gamson, a sociology professor at the University of San Francisco, has addressed the limitations of queer theory, both generally and in terms of the methodological constraints for qualitative research. Gamson (1995) argues that queer theory's effort to deconstruct identity categories potentially undermines the desire for sexually marginalized groups to build a collective identity with certain group boundaries. Queer theory seeks to dismantle the concept of sexual minorities and of "gay" and "lesbian" identities and even "male" and "female" descriptors (Gamson, 1995). Queer theory deconstructs identity categories by exposing the power relations that create and sustain them. Gamson (2003) on the other hand, maintains that identity categories are the basis for political power and activism. Gamson's (2003) notion of recognizing sexually marginalized status as foundational for equality is consistent with the current study's approach to acknowledging the oppression queer women, as an identifiable group, encounter in their interactions with healthcare providers as a starting point for human-rights claims.

In terms of the methodological challenges queer theory raises, Gamson (2003) argues that queer theory calls into question the existence of gay and lesbians as distinct recognizable populations, making them difficult to research. This difficulty lies in queer theory's view of identities as the product of discourse, which destabilizes identity categories. The history of researching sexually marginalized populations began with difficulty locating these individuals, followed by gay and lesbian studies serving as a catalyst to the dramatic increase in the amount of sexually marginalized individuals speaking out, which has led to the post-modern destabilization of identity categories and a hesitation to identify gay and lesbian identities (Gamson, 2003). Bryson (2002) poses an important question with regards to the destabilization of lesbian identity; she asks, "What are the ethical implications of conducting research that aims to destabilize lesbian

identity?” (p. 376). Conducting research that aims or includes deconstructive ontological views of identity may undermine individuals who have taken various risks to lay claim to their sexual identities (Bryson, 2002).

The current study seeks to steer a middle path between queer theory’s understanding of sexual identities as entirely socially and discursively constructed and essentialist identity theories that contend sexualities are concrete, unitary, stable traits. Both the primary study and the current secondary data analysis seek to acknowledge the socially constituted nature of sexual identities and pay attention to how they are meaningful and matter in everyday interactions. This is accomplished through the application of qualitative research, which aims to be less objectifying and more attuned to cultural and political meaning creation (Gamson, 2003). Furthermore, qualitative research provides space for repressed voices and personal experiences, which means that researching sexually marginalized groups is possible while attaining sexual identity description (Gamson, 2003). Queer theory and queer studies is more apt to focus on sexual categorization processes and their deconstruction than focusing on studying specific populations (Gamson, 2003). In this way, complete alignment with queer theory is not suitable for the current study because the emphasis is on the meaning-making queer women engage in following interactions with healthcare providers rather than gaining an understanding of the sexual identity processes. Bryson (2002) identifies this tension as the complexity of working within the postmodern destabilization of identity categories while simultaneously struggling to identify people based on identity membership in order to conduct research. The current research works within this tension by recognizing the socially constructed nature of sexual identity categories while concurrently acknowledging the importance of participants’ self-agency in claiming their sexual orientation identity. Self sexual-identification may be important for queer women’s meaning-making and self understanding, which may contribute to their experiences on a daily basis and may specifically impact their access to healthcare.

This section has outlined some of the methodological difficulties associated with researching a sexually marginalized population. Heteronormative bias and the erasure of queer sexualities have lead to the problem of underrepresentation of queer women in research. Part of this problem is due to the complex nature of sexual identity and sexual

orientation and the various terminologies that have been used to define these constructs. As the literature suggests, one of the major issues in researching sexually marginalized women is having criteria for a definable collective population without perpetuating reductionistic labels that deny the right of self-labelling and thus result in marginalization. The current study seeks to find an appropriate balance between these two issues by employing the use of the term queer women, as an overarching and encompassing term, while encouraging women to engage in self-determination by choosing descriptive words and terms that are congruent with their self-identity.

2.7. Chapter Summary

In sum, the literature reviewed in this section provides firm evidence of systemic erasure of queer women from sexual healthcare delivery, which has led to constraints of equitable care. The predominant disclosure paradigm, and the limited research extending beyond disclosure have been presented in order to provide rationale for the current study's interactional focus. Various health models and frameworks, such as the biomedical model, the health promotions model, and the social determinants of health model have been discussed in order to provide justification for the current study's human rights approach to health. Importantly, the health as a human rights model addresses the impact of social inequality for marginalized groups, including queer women, in the healthcare setting. The methodological challenges that exist when researching sexually marginalized women have been discussed in order to preface the same difficulties faced in the current study. The recommendations for including open sexual-identity questions have been incorporated into this research by means of the open-ended identity questions that were asked to participants in the primary study and the incorporation of the inclusive umbrella term queer.

Chapter 3.

Method

Numerous studies exploring queer women's sexual health, including STI prevalence and transmission and sexual behaviours and practices demonstrates that this socially marginalized population encounters specific and unique sexual health concerns. Extant social science research clearly locates the problem with prevailing discrimination through homophobia and heterosexism. However, the issue of whether or not women disclose their sexual orientation to healthcare providers has become the focus of health research. Disclosure, viewed in isolation from social contexts, provides a limited understanding of queer women's efforts to seek equitable, inclusive, and knowledge-based sexual health care. A sizeable gap exists in research focusing on queer women's interactions with health care providers beyond the disclosure framework. The current constructivist grounded theory study, supplemented by situational analysis, seeks to help fill this gap in the research by providing a complex and context situated understanding of the process of queer women's interactions with healthcare providers when seeking sexual healthcare.

This chapter outlines the methods, procedures, and analysis used in the current study. The first section outlines the epistemological and theoretical foundations for selecting the qualitative approach and specifically, the constructivist grounded theory method. The second section delineates the supporting arguments for the current study's use of secondary data analysis. The third and fourth sections outline the procedural details including the interviewing instrument used in the primary study and a description of the participants, both from the primary study and for the current secondary data analysis. Then the analytical procedures that were employed for the current study are described. Following this section, the quality of the research in terms of trustworthiness and constructivist grounded theory criteria are articulated. Finally, the last section of this

chapter provides a description that situates the researcher within the context of the current study.

3.1. Research Design

3.2. Qualitative Approach

Qualitative research is best utilized when a problem or issue needs to be explored, especially when a complex understanding of a phenomenon is needed (Creswell, 2013). When current theoretical explanations insufficiently capture the complexity of a problem or issue, qualitative research allows for a complex and holistic exploration. The aim of the current research is to go beyond the limited disclosure framework, which focuses on the aspect of revealing one's sexual orientation, used to understand queer women's interactions with health care providers and offer a more comprehensive understanding of this complex process.

Qualitative research approaches may be particularly appropriate when researching marginalized groups. Creswell (2013) argues that qualitative methodology allows the silenced voices of minority individuals to be heard. In this way, qualitative methodology is compatible with the current study's human-rights framework that focuses on issues of discrimination and inequality for queer women in terms of their experiences seeking sexual healthcare. Support for the use of qualitative research for the LGBTQ population is further garnered by Gamson (2003) who argues that the focus on meaning-making and lived experience allows for these socially marginalized individuals to be understood. In this way, qualitative methodology is compatible with the current study's focus on exploring and understanding the experiences of queer women interacting with health care providers when seeking sexual health care.

The following characteristics of qualitative research highlight three particularly important features of the current study: a focus on participants' meaning, researcher reflexivity, and providing a holistic account (Creswell, 2013). Firstly, in order to accommodate multiple perspectives and diverse views, the current study sought to

explore queer women's experiences seeking sexual health care from health care providers. Through analyzing the accounts of a diverse group of women who self identified under the queer umbrella, participants' meanings were captured by focusing on the relational and human rights aspects of their interactions with healthcare providers. Secondly, researcher reflexivity is a particularly salient issue because I have my own personal experience with the research phenomenon. Denzin and Lincoln (2011) define qualitative research as a "situated activity" in which the observer, located within the context of the research study, attempts to make sense of a phenomena based on the meaning-making participants engage in. This recognition of the researcher as located within the world of the participants is an important feature of qualitative research. As a researcher, I do not attempt to be removed from the research context, but rather, to recognize and attend to my own biases and subjectivity as I make continued efforts to focus on the accounts of the participants. And thirdly, the qualitative approach allows for a more holistic understanding of queer women's experiences seeking sexual health care because of the inclusion of multiple perspectives and a focus on relational and interactional elements, as well as the situated context within which healthcare provider interactions occur.

3.2.1. Constructivist Grounded Theory

The qualitative approach chosen for the current study is grounded theory. Grounded theory is most appropriate when a theory or understanding of a phenomenon is not available or, if existing theories fail to account for the complexities of the process under investigation (Creswell, 2013). In this way, grounded theory is exploratory in nature and allows for an understanding of a phenomenon to be generated. For the current study, grounded theory is used to help explain the interactions queer women have with healthcare providers when seeking sexual health care. Grounded theory moves beyond mere description of a process and encourages critical inquiry in an effort to generate a theoretical explanation (Creswell, 2013). One of the key tenets of grounded theory is that the development of an explanation is bottom-up rather than top-down (Creswell, 2013). Within this inductive approach, the researcher does not aim to prove or disprove a preconceived hypothesis (Whiteside et al., 2012). Apriori theories are not used as lenses to view the data; rather, the theory is grounded in the data from

the participants who have experienced the phenomena (Corbin & Strauss, 1998 as cited in Creswell, 2013). One of the defining features of a grounded theory study is that it focuses on an action that requires explanation (Creswell, 2013). Furthermore, this action has phases or steps that occur over a period of time. For the current study, this translates to focusing on the active interactions between queer women and health care providers in which both parties verbally and non-verbally communicate with one another over a period of time.

Within the grounded theory tradition, Charmaz's constructivist grounded theory was selected. Glaser and Strauss developed the original grounded theory methodology in order to facilitate "the discovery of theory from data systematically obtained from social research" (Glaser & Strauss, 1999, p. 2). A theory is defined as an explanation of a process, action or phenomena developed by the researcher based on underlying categories present in the data (Creswell, 2013). Since their original conceptualization of grounded theory, Glaser and Strauss have diverged and developed their own versions of the theory with different emphasis (Creswell, 2013). More recently, Cathy Charmaz has applied a social constructivist lens to the grounded theory method. According to Charmaz (2006), the constructivist lens addresses how and why participants construct meanings and actions while situating the studied phenomenon within embedded larger contexts, which recognizes various positions and relationships. Charmaz (2006) has taken an approach that draws attention to the role of the researcher and to the multiple realities and complexities that exist for participants. Unlike Glaser and Strauss' assertion that theory emerges from the data separate from the researcher, Charmaz (2006) argues that the researcher constructs grounded theory through interactions, past and present, with the world. Constructivist grounded theory assumes the ontological philosophy of multiple realities, including the realities of both the researcher and the participants (Charmaz, 2006). Constructivist grounded theory also differs in its definition of theory. Unlike the positivist definition of theory, Charmaz's (2006) constructivist grounded theory adopts an interpretive definition emphasizing understanding over explanation. Therefore, the resulting explanation from a constructivist grounded theory study is in and of itself an interpretation (Charmaz, 2000, 2002, as cited in Charmaz, 2006). The constructivist approach emphasizes that data and analysis are generated from researcher and participant experiences while prioritizing the phenomena of study

(Charmaz, 2006). This reflexive stance fits well within the qualitative approach and highlights the active nature of the researcher throughout the research process.

Particularly relevant for the human-rights framework of the current study, Charmaz's constructivist grounded theory allows for the study phenomena to be situated within the larger social context. This is an important consideration because it allows for the recognition of the hierarchies of power queer women encounter when experiencing discrimination and inequality at both the systemic and interactional levels. Grounded theory allows for the analysis of processes, such as the enacted processes of justices and injustices that occur over time through interactions (Charmaz, 2008). The processual emphasis in grounded theory allows for the exploration of power and oppression within the context of relationships between individuals and relationships with larger social structures (Charmaz, 2008). For the current study, this relates to exploring the relationships between queer women and healthcare providers and the relationships between queer women and the health institutions where they seek care. Sensitivity at the outset of the research process to human rights issues assisted in identifying underlying processes and explicit actions that may contribute to equality and inequality (Charmaz, 2008). In complying with the inductive nature of grounded theory methodology, I did not project human-rights issues onto the data, but rather I was primed and had a heightened sensitivity to issues of equality, power, and discrimination. A strength of Charmaz's constructivist grounded theory within the lens of a human-rights framework is situating individuals within structures and organizations (Charmaz, 2008). In this way, the studied phenomenon is not isolated from its situated context, thereby avoiding the danger of qualitative studies that treat the study phenomenon as detached from its conditions and environment (Charmaz, 2008). For the current study this translated into recognizing the various locations within Vancouver, BC, the participants sought healthcare, as well as the type of healthcare institutions participants attended. For example, participants noted when they would intentionally seek healthcare in queer identified neighborhoods in Vancouver and the types of healthcare institutions, such as walk-in clinics and the Centre for Disease Control, where healthcare was sought.

3.3. Secondary Data Analysis

The current study involves secondary data analysis from data originally collected for Dr. Mary Bryson's multi-site Canadian Institute of Health Research (CIHR) funded research project titled "Health Care Practices and Relationships: The Experiences of Queer Women and Primary Care Providers". The purpose of the original study was to explore how queer women experience health and health care. In the primary study, the definition of health was broad and included physical health, mental health, sexual health etc. The current study specifically focused on the participants' discussions of their interactions with health care providers regarding their sexual health. The following section provides support for the implementation of secondary data analysis for the current study.

Heaton (1998) defines secondary analysis as the re-use of pre-existing qualitative data, which may include a variety of data sources such as interviews and questionnaires derived from the primary study. Secondary data analysis differs from meta-analysis and systemic reviews because it involves reexamining the data rather than reviewing published findings from previous research (Heaton, 1998). Secondary data analysis allows for the exploration of new or additional research questions (Heaton, 1998). For the current study, the secondary data analysis specifically focuses on one of the many aspects of health explored in the primary study - sexual health. The mode of data sharing for the current study is what Heaton (1998) has termed "formal data sharing", which means that data that was previously collected for the primary study has been re-used for the current study. As Heaton (1998) highlights, these datasets are usually well documented for archiving and have met ethical requirements for being shared. The UBC Ethical Review Board approved Dr. Bryson's primary study and the Simon Fraser University Office of Research Ethics approved the current secondary data analysis. Moreover, participant consent obtained in the primary study included granting permission for researchers to use their data in further research aligned with the original study purpose – understanding queer women's experiences with health and healthcare.

The implementation of secondary data analysis is supported for qualitative research more generally, and for grounded theory methodology more specifically. In

their (2010) paper titled, *Secondary Analysis of Qualitative Data: A Valuable Method for Exploring Sensitive Issues with and Elusive Population*, Long-Sutehall, Sque, and Addington-Hall provide two valid arguments for the use of secondary data analysis. These authors contend that applying secondary data analysis fulfills two aims: (1) accessing an elusive research population (Fielding, 2004, as cited by Long-Sutehall et al.), and (2) addressing a sensitive area of research, particularly, sensitive topics related to health (Long-Sutehall et al.). These aims are directly relevant for the current study and thus provide a strong rationale for the implementation of secondary data analysis. Queer women are a sexually marginalized group that has historically been pathologized in the fields of medicine and research (Gamson, 2003). As a result of this history of discrimination, it may be difficult to locate queer women as research participants willing to disclose their sexual orientation. I argue that this lack of willingness to participate in present-day research, potentially grounded in fear of unequal and discriminatory treatment, meets the conditions for queer women to be considered an “elusive” population. As evident from the research presented in the literature review, queer women’s experiences seeking sexual health care is a sensitive health issue. The sensitivity of this issue lies in the health inequalities experienced by this population as a direct result of discrimination through homophobia and heterosexism. In this way, the use of secondary data analysis reduces research intrusiveness and decreases the burden placed on respondents, who have already shared their experiences in the primary study (Szabo & Strang, 1997; Rubin & Babbie, 2008, as cited in Whiteside, Mills, & McCalman, 2012). In other words, because of the richness of the data collected from the primary study, the participants do not have to unnecessarily undergo yet another interview process whereby they are asked to recall and describe potentially painful memories.

Secondary data analysis is rarely employed by grounded theorists despite Glaser and Strauss’ assertion that secondary datasets are appropriate sources of data (Glaser & Strauss, 1967, as cited in Whiteside et al. 2012). The concern specifically related to grounded theory is whether the use of secondary data limits the possibility for theory construction (Whiteside et al.). Furthermore, the grounded theory method of theoretical sampling, which requires the researcher to undertake simultaneous targeted data collection and analysis, is difficult because it must occur within the confines of the

primary dataset (Szabo & Strang, 1997, as cited by Whiteside et al., 2012). One of the limitations of the current study is that the application of secondary data analysis constrained theoretical sampling. A more in-depth discussion of the current study's application of theoretical sampling is offered in the Data Analysis section of this chapter. For now, I would like to highlight that the nineteen interview transcripts available from the Vancouver sample was abundant enough to allow for the current study's inclusion criterion – participant discussions of interactions with healthcare providers within the context of sexual health care - to be met.

Whiteside et al. (2012) identify data quality, data fit, and researcher closeness as potential challenges within the context of conducting secondary data analysis for grounded theory methodology. The open communication between Dr. Mary Bryson, the principal investigator for the primary study, and myself allowed for questions about the data to be answered and addressed. I was confident in the nature and quality of the data because my senior supervisor, Dr. Sharalyn Jordan, was involved in the primary study as an interviewer for a portion of the interviews conducted in Vancouver. Furthermore, the methods and data-collection procedures from the primary study were well documented and allowed for a clear understanding of the primary study's research process. According to Heaton (1998), appropriate documentation, required for archiving purposes, contributes to the suitability of secondary data analysis. The data was determined to be a good fit for the current study because the secondary data analysis focused on one of the aspects of health, sexual health, from the primary study's broad definition of health. Discussions of sexual health and participant's descriptions of interactions with healthcare providers within the context of sexual health was documented in approximately half of the interview transcripts from the primary study. Moreover, the data provided rich descriptions of the participants' experiences seeking sexual health care from health care providers. Finally, in addressing the concern of the researcher's relationship to the data, caution exists for both closeness and distance to the primary data (Hinds et al., 1997, as cited in Whiteside et al., 2012). When the researcher is more distant from the data, there is the risk of lacking sensitivity to the study context and the relationship between researcher and participant (Heaton, 1998, as cited in Whiteside et al., 2012). The distance from the primary research was mitigated by my senior supervisor's role as an interviewer in the primary study. Furthermore, I had

contact with the primary researcher, Dr. Bryson, and had several opportunities to discuss the data. The contact with both Dr. Jordan and Dr. Bryson served to lessen the distance between the secondary researcher and the primary data.

It is important to acknowledge that the focus of the two studies were different. The original study sought to gain an understanding of how queer women experience health and health care, while the secondary study involved a specific focus on exploring how queer women experience health care interactions related to their sexual health. This means that the current study was not a mere replication of the primary study, but rather an extension of the purpose of the initial study with an intensified focus on one aspect of healthcare, namely sexual healthcare.

3.4. Procedure

My senior supervisor, Dr. Sharalyn Jordan, connected me with Dr. Mary Bryson, the principle investigator of the primary study. Upon explaining my proposal, Dr. Bryson agreed that the primary study would be a good fit for the current study's secondary data analysis. The current study received ethics approval and was delegated "minimal risk" from the Simon Fraser University Office of Research Ethics. Procedures for ethical research practice were obtained for the primary study from the University of British Columbia's Behavioural Research Ethics Board (BREB). The data I received from the primary study included transcripts and participant demographic information, both of which had personally identifiable information redacted. No digital versions of the primary study data were obtained for the current study and I did not have access to the identifying information for the primary study participants.

Recruitment for the primary study included 20-25 queer women, 15-20 nurses, and 15-20 general practitioners from the two sites – Vancouver, British Columbia and Halifax, Nova Scotia. The scope of the current study did not include analyzing the interviews of the nurses and general practitioners and in order to maintain contextual sensitivity, only the interview transcripts from queer women from the Vancouver sample were included in the analysis. More detailed information will be provided in the Participants section pertaining to the Vancouver sample of queer women; the other

collected data is outside the scope of the current study. Posters (see Appendix A) were distributed through community collaborators, teen health centres, LGBTQ media and venues; ads were distributed through university websites, queer listserves, local newspapers, hospital and clinics. A research team member from the primary study contacted the individuals who responded to the various forms of recruitment and advertising by phone or email. During this initial discussion, the study was explained and demographic data was collected for those who agreed to participate. Purposeful sampling techniques were deliberately employed at this time in order to gain a diverse sample in terms of gender, sexual orientation, race, ethnicity, and class.

Informed consent for the primary study was obtained prior to the start of the interview. The interviews ranged in length from 1-2 hours and followed a flexible interview guideline. Upon completion of the interviews, participants were provided with a movie gift card as a honorarium. The following two sections provide a more detailed description of the interview structure and process and the participant inclusion and exclusion criteria.

3.4.1. The Interview

A total of 21 individual interviews were conducted with queer women in Vancouver, BC for the primary study. Two of these interviews were archived and not accessible for the current secondary data analysis because they were insufficient. Thus, nineteen interviews were available for the current study. The interviews occurred in a variety of locations including the participants' homes, local coffee shops, and in an office space at the University of British Columbia. For the location of the interview, emphasis was placed on ensuring that the participant felt comfortable to speak freely and uninterrupted. Before beginning the interviews, the interviewers provided participants with hard copies of the informed consent document (see Appendix B) that outlined the purpose and nature of the study as well as the limits of confidentiality. After consent was obtained, the interviewer turned on the digital recording device and began the interview.

The interviews were semi-structured and consisted of questions that were mostly open-ended. The interview questions for the primary study aimed to explore two main

aspects: (1) life experiences as queer women, such as identity issues, experiences of discrimination and of inclusion, strategies for accessing information, knowledge, health practitioners, and for participating in the community, and (2) various aspects of queer women and health that included both experiences of health and experiences of healthcare. The interviews included questions pertaining to seven specified areas: demographic information, identity and complexity, general health, reflecting on experiences, health care providers, experiences of health care, and advice. An Interview Guide (see Appendix C) provided flexible structure for each of the interviews conducted. The structure and format of these interviews is consistent with Charmaz's (2006) argument for devising a few broad, open-ended and nonjudgmental questions in order to facilitate unforeseen dialogue, including stories. The interviews varied in length from one to two hours and they were conducted by either the Principle Investigator, Dr. Mary Bryson, or one of two Graduate Research Assistants at the time of the study Dr. Sharalyn Jordan or Dr. Linda Dame. Upon completion of the interviews, the participants were thanked and provided with a \$20 gift card.

3.4.2. Participants

The participant inclusion criteria from the primary study was: lesbian, gay, bisexual, trans, and/or queer (LGBTQ) identified women who have accessed any health services in Vancouver or Halifax and are at least 18 years-of-age. The primary study specified that all past, present and future women who self identify as LGBTQ were welcome to participate. The term "queer women" was selected as the most inclusive of all possible phrases. Queer can be used both as an adjective, one that has been reclaimed from its pejorative meaning, and a verb (to challenge and interfere with the conventional understanding of the term "women"). Participants were excluded from the primary study if they were younger than 18 years of age and did not identify (past, present, or future) as women. Furthermore, anyone who was unable to participate in an interview conducted in English was excluded because of the lack of bilingual interviews and/or interpreters. For the current secondary data analysis, sampling occurred within the Vancouver, BC sample of nineteen queer women.

For Charmaz (2006) sample size relates to the overall quality and credibility of the study. Charmaz (2006) does not quantify an adequate sample size, but rather she emphasizes “rich, substantial, and relevant data” (p. 18). Charmaz’s (2006) conceptualization of credibility refers to the depth and scope of the data and the quality of the data analysis by means of systematic comparison between coding categories. The grounded theory principles of theoretical sampling and theoretical saturation guided the sampling process. Theoretical sampling is a purposive type of sampling in which the researcher aims to cultivate the properties of developing categories and does not aim for random sampling nor a representative distribution of a population (Charmaz, 2006). The primary study involved purposive sampling in terms of seeking diverse queer women in terms of gender identity, sexual orientation, socioeconomic status, and ethnicity. Moreover, the current study followed the theoretical sampling method of seeking information to help illuminate the relevance of the identified categories. For example, for the subcategory *going back into the closet*, theoretical sampling was employed through researching the relevant provincial and federal laws pertaining to fertility treatment for same-sex couples; healthcare policy on this issue was also researched and critically considered. This type of information gathering helped to define the boundaries and relevance of this subcategory, which is congruent with the purpose of theoretical sampling - “to sample to develop the theoretical categories” (Charmaz, 2006, p.189). In terms of theoretical sampling through seeking participants beyond the initial sample size, the current study was limited by the constraints of secondary data analysis. Theoretical saturation, the point at which gathering more data about a category reveals no new properties (Charmaz, 2006) was limited to the constraints of secondary data analysis.

Upon receiving the data from the primary study, I carried out in-depth readings of the Vancouver, BC sample of the participants’ interviews. In total nineteen interview transcripts were thoroughly read and considered for inclusion in the current study. Nine interview transcripts met the inclusion criterion for the current study. In order to be considered an appropriate fit for the current study, the interview transcripts must have included participant discussions of interactions with healthcare providers with regards to their sexual health. The primary study explored queer women’s health and healthcare more broadly; discussions of sexual health did not always arise during the interviews. For this reason, the transcripts were vetted for participant discussions of interactions

with healthcare providers specifically related to sexual health. This decision-making process, with regards to determining the transcript inclusion criterion, is aligned with the purpose the current study to provide an in-depth and complex understanding of queer women's interactions with healthcare providers with regards to their sexual health.

The following paragraph describes the demographics of the selected participants. The ages of the queer women ranged from 22 to 64. Eight participants identified as White, Caucasian and/or Canadian, with reported mixed Euro-Canadian heritages such as Polish, Ukrainian, and Scottish with French Canadian; one participant identified as Japanese Canadian. In terms of gender identity and sexual orientation, the participants were encouraged to choose terms that they self-identified with so that they were not limited to choosing predetermined labels and categories. Gender identity refers to one's internal and psychological sense of oneself as male, female, both, in between, or neither ("Queer Terminology", 2013). Three participants identified their gender identity as CisF, meaning that they identify with the female gender they were identified with at birth. Cisgender refers to a gender identity that society considers to match the biological sex assigned at birth ("Queer Terminology", 2013). One participant identified her gender identity as female without the cis prefix. Three participants classified their gender identity as *butch*, which is a word that some queer people use to describe gender expression that is perceived by many as being masculine ("Queer Terminology", 2013). With regards to sexual orientation, a couple of participants chose multiple descriptors which may speak to the three dimensions of sexual orientation – identity, attraction, and behaviour – previously discussed in the literature review chapter. The varying terms queer women chose to describe their sexual orientation highlights the complex nature of this construct. Two women identified with the term queer. Two participants identified their sexual orientation with the term lesbian, which can be defined as a woman who is primarily romantically and sexually attracted to women ("Queer Terminology", 2013). Two participants used the term *dyke*, a word that can be used as an insult or an identity term that has been reclaimed by some lesbians as a positive term, to describe their sexual orientation. One participant identified as bisexual, which is understood to be an individual who is attracted to, and may form sexual relationships with women and men ("Queer Terminology", 2013). One participant identified as *poly*, which is a common short-hand for polyamorous – a term that denotes being sexually, and/or emotionally,

and/or spiritually involved with any number of individuals (more than one) (Lewis, 2011). Three participants identified their sexual orientation as *kinky*, which is a general BDSM (bondage, and discipline, domination and submission, and sadomasochism) term that may involve fetish sexual behaviour (Barker, Iantaffi, Gupta, 2007). Finally, one participant identified with the word *gay* for her sexual orientation. The word *gay* can be defined as a person who is mostly attracted to individuals of the same gender and it is often used to refer to men only (“Queer Terminology”, 2013). For Stephanie, the participant who identified with the term *gay*, she noted that the word *lesbian* “triggers such painful memories” (Stephanie, p.4) for her because she was brutally beaten a couple of times in high school and during one of those times she was called a “fucking lesbo”. In terms of socioeconomic status, there was participant variability in both educational level and employment. Two participants completed some high school, one participant obtained a diploma, three participants completed undergraduate degrees and three participants completed graduated degrees. Two participants were unemployed (one on income assistance), two participants were employed in clerical occupations, two participants worked in social services, two participants were in management roles, and one participant was a university professor. Six out of the nine participants did not have children, two participants had children and one participant was pregnant at the time of the interview.

General demographic information including the participant information discussed, as well as education level, employment, and number of children is outline in Table 3.1.

Table 3.1. Participants' Demographic Information

Pseudonym	Age	Ethnicity	Gender Identity	Sexual Orientation	Education	Employment	Children
Amy	38	Japanese Canadian	Gender Fluid	Queer; Kinky	Graduate Degree (in progress)	Admin Assistant	0
Marilyn	64	English	CisF	Lesbian	Grade 10; 1 year Community College	N/A	2
Jordan	48	Polish American	Butch	Lesbian; Kinky	Graduate Degree	University Professor	1
Brenda	24	Ukrainian & Scottish w. French Canadian	Butch	Dyke	Some High School	Social Services	0
Rhonda	24	Canadian	CisF	Bisexual	Undergrad Degree	Admin Assistant	0
Shelia	37	Canadian	CisF	Lesbian	Graduate Degree	Executive Director	5 months pregnant
Beth	22	White	"Predominantly Female"	Queer	Undergrad Degree	Child Care	0
Alice	27	White	Futch (Queer; Butch)	Kinky; Poly; Dyke	Diploma	Manager	0
Stephanie	24	White	Female	Gay	Undergrad Degree	Income Assistance	0

The re-use of the data for the current study does not breach the confidentiality agreement from the primary study because participants were informed of and consented to the use of data collected from their interviews for further research.

3.5. Data Analysis

Analysis procedures described in Charmaz's constructivist grounded theory was used to guide and inform the multiple phases of the data analysis process. The following

section provides a detailed outline for the current study's data analysis process as informed by Charmaz's (2006) procedures for conducting constructivist grounded theory. The following will be addressed: the two phases of coding, the application of the constant comparative method, the use of memoing to support data analysis, and the parameters under which theoretical sampling, saturation, and sorting occurred.

Once the relevant interview transcripts were selected for the current secondary data analysis, I ascribed codes to the interview data. Coding is the first step in moving beyond the concrete participant statements in the data to making analytic interpretations; coding is the crucial link between data collection and development of an emergent understanding of the research question (Charmaz, 2006). Grounded theory codes are defined by what is interpreted from the data through an interactive process (Charmaz, 2006). Within constructivist grounded theory it is recognized that codes are constructed by the researcher based on interactions with the participants through studying their statements (Charmaz, 2006). In this way, codes are defined and later refined in an effort to understand participants' views and actions from their perspectives (Charmaz, 2006). Constructivist grounded theory acknowledges the crucial role of language in how and what codes are created. According to Charmaz (2006), the personal views and values to which language reflects are translated into the codes created. As a result, codes arise from the languages, meanings, and perspectives of both the researcher and the participants (Charmaz, 2006). Throughout the coding process, I remained open and close to the data while simultaneously being primed to interpret ways in which the participants' rights to healthcare were being undermined, such as through discrimination, or protected through inclusive practices and acceptance. With regards to the human-rights priming, I followed Charmaz's (2006) guidelines to recognize priming as representing one truth among many and not as the "truth". In this way, more awareness was gained of the human-rights priming concepts and when; when human rights issues were identified, it was after considering how the participants understood their situations and interactions. Therefore, enlisting human-rights codes was done so conscientiously rather than automatically. For example, the code *experiencing discrimination interactionally* was identified when participants recalled their experiences interacting with healthcare providers in which they felt they were treated unequally or less than as a result of their sexual orientation.

3.5.1. Coding

Grounded theory coding consists of two main phases: an initial coding phase and a focused coding phase. For the current study, the initial coding phase involved staying close to the data and remaining open to all possible theoretical directions. This was accomplished through the application of line-by-line coding, in which each line of the participant transcript was named. This approach prompts the researcher to remain open and initiate new ideas (Charmaz, 2006). A strength of the grounded theory method is that it contains this type of corrective that reduces the likelihood that the researcher will impose their preconceived notions on the data (Charmaz, 2006). Another grounded theory approach to stay close to the data in the initial phase is to code with words that reflect action. According to Charmaz (2006), this method reduces the tendency to make conceptual leaps in adopting theories before the necessary analytic work has been done. With this principle in mind, I identified codes based in actions where possible; for example, *receiving inadequate sexual healthcare, enacting disclosure tactics, and experiencing heterosexism*. Throughout the initial coding phase the constant comparative method (Glaser & Strauss, 1967, as cited by Charmaz, 2006) was used to establish analytic distinctions. Data was compared with data to identify both similarities and differences; at times incidents within the same interview were compared with one another and at other times incidents and statements were compared across interview transcripts. It was through this process that the codes *experiencing inclusive & sex positive sexual healthcare* and *experiencing exclusive & sex negative sexual healthcare* were identified. During the initial coding phase, some in vivo codes - codes based on participants' words were applied. According to Charmaz (2006) in vivo codes help the researcher to preserve participants' meanings of their views and actions in the coding itself. An example of an in vivo code that was created in the initial coding phase is the *engaging in higher risk sexual activities* subcategory. Recognizing that this code uses the language of the participants is important because as a researcher, I did not impose my beliefs on what constitutes "risky" sexual activities but rather the participants themselves determined their sexual practices to be risky. Initial coding aims to be provisional, comparative, and grounded in the data in order to fulfill two criteria for grounded theory analysis: fit and relevance (Charmaz, 2006). Fit pertains to constructing codes and developing categories that crystallize participants' experiences (Charmaz,

2006). Relevance is achieved when a perceptive analytic framework is offered that interprets what is happening and makes relationships between implicit processes (Charmaz, 2006). Careful coding through the initial coding phase helps the researcher refrain from attributing personal motives, fears, or unresolved personal issues on to the data. This is important because I have personal experience with the research phenomenon. In terms of the initial coding phase, one of the limitations of the current study is that early data coding did not allow for pursuit of further data collection because of the constraints of this secondary data analysis study.

Following the initial coding phase, I engaged in the second phase of the grounded theory data analysis process – the focused coding phase. Following Charmaz’s (2006) constructivist grounded theory guidelines, the most significant and frequent initial codes were selected to sort, synthesize and integrate that data (Charmaz, 2006). Through the process of determining the adequacy of the initial codes, the following higher order categories were identified: healthcare space, relational healthcare dynamics, sexual healthcare interactions, and navigating human rights. Based on the explicit recommendations queer women provided, the recommendations for healthcare providers category and the recommendations for queer women category were also identified. Engaging in the constant comparative method and memo-writing lead to the identification of numerous subcategories within each of the higher order categories. In this second phase of coding, I used the comparative method to move across interviews and compared participant’s experiences, actions, and interpretations. The process of comparing data to data and data to the initial codes contributed to the development of the focused codes. For example, through the constant comparison method the salient code *experiencing heterosexism* illuminated another code – *going back into the closet*. *Experiencing Heterosexism* was a frequent code that applies to participants who were incorrectly assumed to be heterosexual and therefore experienced marginalization. However, the *going back into the closet* code represents a situation in which a participant presented as heterosexual in order to gain access to fertility treatment. Through using the constant comparative method, this paradox of privilege and oppression within the context of heterosexism could be identified. The grounded theory process of “memoing” involves creating notes capturing the researcher’s thoughts, recognizing comparisons and connections within the data, and crystallizing questions

and directions to pursue analytically (Charmaz, 2006). According to Charmaz (2006), memo-writing constitutes an essential method in grounded theory because it prompts the researcher to analyze the data and codes early in the research process. Credibility is therefore enhanced by the use of ongoing observation through memo-writing. In constructing memos, I followed Charmaz's (2006) guidelines including but not limited to: identifying what is going on in the situation, recognizing the impact of how structure and context serve to support, maintain, impede, or change the participant's actions and statements, and describe how the categories and subcategories emerged and changed. Through enacting the comparative method and memo-writing the subcategories within each of the six higher order categories were finalized. Within the context of the current study's secondary data analysis, one of the limitations of memo-writing was that subsequent data collection was limited to the interview transcripts provided from the primary study. Throughout the focused coding phase, continue efforts were made to remain close to the data and keep codes active.

3.5.2. Theoretical Sampling, Saturation, and Sorting

The grounded theory principles of theoretical sampling, theoretical saturation, and theoretical sorting were undertaken within the constraints of the current study's secondary data analysis. Theoretical sampling involves starting with data, building tentative hypotheses, and subsequently investigating these ideas through further empirical investigation (Charmaz, 2006). This process highlights the iterative nature of coding, analyzing, and obtaining data. Charmaz (2006) contends that memoing leads directly to theoretical sampling because it requires the researcher to have already identified their categories. For the current study, memo-writing assisted the use of theoretical sampling in order to delineate and develop the properties of the identified categories. As Charmaz (2006) recognizes "theoretical sampling is less of an explicit procedure than a strategy that you invoke and fit to your specific study... methods for conducting theoretical sampling vary accordingly" (p. 107). For the current study, the criterion of theoretical sampling was met through revisiting the interview transcripts from the primary study. After tentative ideas were constructed about the data, the researcher reviewed all of the interview transcripts from the Vancouver, BC sample to seek and collect pertinent data in order to expand and refine the coding categories.

The guiding principle behind theoretical sampling is theoretical saturation. Categories are 'saturated' when data no longer initiates fresh theoretical insights including new properties of the higher order theoretical categories (Charmaz, 2006). In assessing category saturation for the current study, I considered the following: comparisons made between data and categories, my understanding of these comparisons in relation to the theoretical categories, and openness to emergent conceptual relationships (Charmaz, 2006). The iterative approach to the current study's data analysis meant that categorical saturation was met at varying times for each of the six higher order categories and the associated subcategories.

3.5.3. Situational Mapping

In grounded theory, theoretical sorting, diagramming, and integrating are strategies used to develop an understanding of the study phenomena (Charmaz, 2006). Theoretical sorting involves creating and refining links between categories that prompt the researcher to make comparisons (Charmaz, 2006). For the current study, I used diagramming to provide a visual representation of the coding categories and subcategories. According to Charmaz (2006), diagramming enables the researcher to recognize the "power, scope, and direction of the categories in your analysis as well as connections among them" (p. 118). Adele Clarke (2003) offers situational maps and analyses to address postmodern theoretical concerns regarding the complexities of social life as supplementary to basic grounded theory. Clarke (2003) offers three kinds of analytic maps to assist researchers in recognizing the complexities that may otherwise be taken for granted: situational maps, social worlds/arenas maps, and positional maps. For the current study, situational maps were created for each participant that outlined the major human, nonhuman, discursive, and interactional elements involved in queer women's experiences seeking sexual healthcare from healthcare providers. I began by completing the template Clarke (2003) provides for the *ordered version* of the situational map identifying the following for each participant: individual human elements/actors, collective human elements/actors, discursive constructions of individual and/or collective human actors, political/economic elements, temporal elements, major issues/debates, nonhuman elements actors/actants, implicated/silent actors/actants, key events in situation, discursive constructions of nonhuman actants, sociocultural/symbolic

elements, spatial elements, and related discourses. Following Clarke’s (2003) advice to incorporate relevant categories for the situation of concern, the interactional element was added to the sociocultural/symbolic elements and the context for healthcare seeking was added as a separate category. In order to gain an understanding of the relationship between the human, nonhuman, and discursive elements across participants, I created an *ordered/working version* of Clarke’s (2003) situational map that integrated all of the participant’s individual ordered/working versions into an amalgamated map (see Table 3.2).

Table 3.2. Situational Map Ordered/Working Version

<p>Individual Human Elements/Actors Queer women Physicians Medical Office Assistants (MOA’s) Nurses Gynecologists</p>	<p>Nonhuman Elements Actors/Actants STI & HIV testing Pregnancy Tests Birth control PAP Smear Heterosexist sexual health questionnaire 10-15 minute doctor’s appointments Prescription of anti-depressants Hep A, Hep B, Hep C vaccinations Hypodermic needles Gloves Piercings</p>
<p>Collective Human Elements/Actors Walk-in clinics Community health centre University health centre Queer community LGBTQ community centre Centre for Disease Control</p>	<p>Implicated/Silent Actors/Actants Partner(s) Female sexual partner(s) Queer women Ovarian cancer screening Known sperm donors Bisexual men Kinky play party members</p>
<p>Discursive Constructions of Individual and/or Collective Human Actors Heterosexism Sexual orientation stereotypes LGBTQ doctors as more comfortable with LGBTQ patients MOA’s as gatekeepers Idealizing health images Ageism Sex/gender stereotypes Presumption of monogamy Sexual orientation discrimination</p>	<p>Discursive Construction of Nonhuman Actants Sexual health as part of general health Sexually active women require both STI Tests and pregnancy tests Heterosexually based sexual health questionnaires Medication to alleviate mental health struggle Sex positive; acceptance of sexual diversity</p>

<p>Political/Economic Elements Limitations of free health services - unable to accommodate more patients Economic status of queer women Canadian stance on homophobia Health care and mental health services included in university tuition Clinic barriers to having a known gay male sperm donor in Canada</p>	<p>Sociocultural/Symbolic/ Interactional Elements Inclusive sexual health questions Sexual health associated with reproductive health Holistic health care Feeling comforted by perception of HCP as LGBTQ Irrelevant sexual behaviour questions Feeling unsupported by doctor Doctor trying to relate depression to queerness Inclusive discussion of sexual health Anonymity Acceptance for diverse sexual practices Enacting heterosexism to gain rights</p>
<p>Temporal Elements History of sexual health involving reproduction History of exclusion of sexuality minorities from medical paperwork History of medicalization of homosexuality Trajectory of women's lives as including wanting and having children History of silence of diverse sexual practices</p>	<p>Spatial Elements Community Non-Profit Health Centre located in queer friendly neighborhood No visual queer-friendly identifiers</p>
<p>Major Issues/Debates (Usually Contested) Heterosexism Fertility options for queer women Requesting a hysterectomy Prescription medication “Risky” sexual activities</p>	<p>Related Discourses (Historical, Narrative and/or Visual) Heterosexual Sexual Health Discourse Women as reproductive bodies Mental health discourse Fit & healthy discourse HIV/AIDS risk discourse Weight loss discourse</p>
<p>Other Kinds of Elements Not having a GP (not knowing how to obtain a GP)</p>	<p>Context for Healthcare Seeking Urinary tract infection Genital rash; STD concern STI Testing Deep cut from self-harm Ovarian cancer testing Sexual health information seeking Medication prescription Seeking mental health support Fertility treatment & prenatal care</p>

I then created an *abstract situational map* in which I wrote down each of the human, nonhuman, and discursive elements on a large piece of paper in no particular organizational fashion. I engaged in Clarke's relational analyses by considering how each element was related to the other elements and I employed the process of memo-writing to document the nature of the various relationships I identified. Throughout this process, I began to acknowledge how my identified subcategories were related to the

over-arching categories and how the six categories were related to one another. The procedure of relational analyses can be likened to the type of grounded theory coding called axial coding. Axial coding relates categories to subcategories and specifies the properties and dimensions of a category (Strauss & Corbin, 1998 as cited in Charmaz, 2006). Axial coding seeks to reassemble the data that has been fractured during the initial coding phase (Strauss & Corbin, 1998 as cited in Charmaz, 2006). Clarke (2003) recommends diagramming to integrate relevant categories and subcategories as a means of axial coding to “open up” the data in a coherent manner. Situational mapping was used as a supplementary data analysis tool in conjunction with constructivist grounded theory and assisted with recognizing the relationships between the different study elements. Clarke (2003) qualifies the use of situational mapping as means to provoke the researcher to analyze more deeply through offering a fresh way to consider the data. For the current study, situational mapping was not used as a final analytic product, but more as a tool to assist with constructivist grounded theory methodology.

3.6. Quality of Research

3.6.1. Trustworthiness

Lincoln and Guba (1985) offer four tools for assessing the “trustworthiness” of qualitative research findings. Trustworthiness is the qualitative counterpart for the quantitative terms validity and reliability (Shenton, 2004). Lincoln and Guba (1985) identify the following criteria for evaluating the quality of qualitative research results: credibility, transferability, dependability, and confirmability. Both the primary study and the current secondary analysis meet criteria for trustworthiness.

Credibility, or “truth value” involves establishing confidence in the congruence of the findings with the multiple realities of the study participants (Lincoln & Guba). Shenton (2004) identifies site triangulation as one of the provisions for meeting credibility. The primary study incorporated site triangulation as a result of the two different cities, Vancouver, BC and Halifax, NS in which interviews were conducted, as well as the varying health institutions that provided the context for queer women’s recounted interactions with healthcare providers. According to Shenton (2004), the yielding of

similar results from different sites may contribute to increased credibility. Although the interviews conducted with queer women in Halifax, NS were not included in the current study, I did review the interview transcripts from the east coast Canadian sample both before and after the coding process and determined that similar interactional patterns and human rights constraints were found between participants from the two different cities. Furthermore, I collaborated with my primary supervisor in frequent debriefing sessions and engaged in memo-writing, both of which incorporated researcher reflexivity and thus contributed to the credibility of the current study.

Transferability, or applicability, refers to the quantitative concept of external validity, which is a problematic concept for qualitative research (Lincoln & Guba, 1985). As Shenton (2004) argues, because the findings of qualitative research are specific to a limited number of individuals within a particular context, it is unrealistic to expect generalizability. Lincoln and Guba (1985) suggest that providing detailed contextual information, such as the information from the primary study regarding the number of participants, the data collection methods, and the locations of the study etc. is sufficient to meet the transferability criteria. The comprehensive procedural information provided from the primary study meets the criteria outlined for transferability. The findings from the study are not intended to be generalizable; rather, they will deepen the understanding of the interactional elements present when queer women are interacting with healthcare providers within the context of their sexual health. The positivist notion of reliability, in which techniques are employed to ensure similar findings for research conducted within the same context, the same methods, and the same participant criteria, is problematized within the qualitative research approach (Shenton, 2004).

Shenton (2004) contends that increasing the dependability of a qualitative study relies on in-depth description of the research design so that future researchers could repeat the study, without the conditions of finding similar results. A detailed description of the research design and implementation from the primary study and from the current secondary data analysis, as well as reflective appraisal of the research process both contributed to developing a thorough understanding of the current study's methods.

Finally, the trustworthiness notion of confirmability is adequately addressed by my engagement in reflexivity throughout the research process. Confirmability is the qualitative criterion likened to the quantitative concept of objectivity (Shenton, 2004). Shenton (2004) contends that precautions must be taken in order to ensure that the research findings are the result of the experiences of participants and not simply the views of the researcher. Rather than try to maintain the objectivist standards of quantitative research, the current study acknowledges the constructivist assumption of the multiple realities of those involved in the research, including my personal reality as a researcher. Engagement in reflexivity throughout the research process and regular meetings with my supervisor allowed me to be aware of and transparent about my own biases and assumptions. Both reflexivity and transparency contributed to meeting the precautionary trustworthiness standards of confirmability in qualitative research.

3.6.2. Evaluation of Grounded Theory Studies

In line with her constructivist approach, Charmaz (2006) contends that evaluation criteria for grounded theory studies will be dependent upon many contextual factors. Charmaz (2006) outlines four general criteria for evaluating grounded theory studies: credibility, originality, resonance, and usefulness. Charmaz's (2006) conceptualization of credibility refers to the depth and scope of the data and the quality of the data analysis by means of systematic comparison between coding categories. Abiding by the grounded theory principles of theoretical sampling and theoretical saturation contributed to meeting the credibility evaluation criteria. Moreover, engaging in the constant comparative method throughout data analysis allowed for systematic comparison between personal observations of the data and analytical coding of the data. Originality refers to the coding categories providing new or fresh insights including the social and theoretical significance of the findings (Charmaz, 2006). Both the focus on sexual health and the application of a human-rights framework contribute to the originality of the current secondary data analysis. The well-documented and highly researched disclosure paradigm is expanded upon with the inclusion of numerous codes that document the interactional elements present in queer women's interactions with healthcare providers within the context of sexual health. The human-rights framework allowed for the recognition of inequity issues that are present for queer women specifically seeking

sexual health care from healthcare providers. The social implications for these findings will be outlined in the discussion chapter. The criterion of resonance denotes the fullness of the studied phenomenon, especially in terms of participant meaning-making (Charmaz, 2006). Resonance includes the linking of the individual experience to the larger social world when necessary and the applicability of the grounded theory to the participants or those who share the same experiences as the participants (Charmaz, 2006). Throughout the coding process, the analytic tool of memoing was used to document participant meaning-making. Furthermore, the inclusion of situational mapping allowed for relational analysis between the participants and the systems and institutions they were interacting with. Through these two analytic procedures, Charmaz's (2006) criteria of resonance were met. Usefulness signifies the practicality or helpfulness of the data analysis in terms of people's everyday experiences (Charmaz, 2006). The criterion of usefulness asks questions regarding the contribution of knowledge, including whether or not the study sparks further research. In terms of impact, the findings from the current study contribute to a more complex understanding of queer women's experiences seeking sexual healthcare from health care providers. Knowledge translation of the findings from this study may contribute to more inclusive and equitable sexual healthcare for queer women. Moreover, the analytic categories identified in the current study suggest that the interactional process between queer women and their healthcare providers extend beyond the element of disclosure and incorporates many other interactional elements. As such, the current study is deemed "useful" for a subset of the population.

3.7. Subjectivity of the Researcher

I have personal experience with the research phenomenon. Discussions with queer female friends and a literature review in this area provided initial motivation to pursue this research topic. In line with Charmaz's (2006) constructivist grounded theory, a reflexive stance was taken in which I continually reflected on my biases. Engaging in researcher reflexivity allowed me to reflect on my own experience, the decisions I made through the coding and categorizing process, and the interpretations I made of the data. I engaged in supervision to help me identify presuppositions and explore personal

reactions in an effort to minimize any negative influences on the study. For example, I would speak with Dr. Jordan about my interpretations of what I perceived as human rights violations in the interactions with healthcare providers the participants discussed. Through supervision with Dr. Jordan, I was able to more critically evaluate my stance on human rights violations and recognize the more nuanced forms of human rights constraints. Importantly, I engaged in reflexivity throughout the research process and consulted Dr. Jordan, in an effort to be transparent about personal responses to the material. Active personal reflection throughout the research process allowed me to question my reactions and call upon analytic tools to remain grounded in the data. One of the analytic tools I used to engage in reflexivity was memoing. The process of memo-writing allowed me to slow down and analyze my ideas about the identified codes and emerging categories. For example, through memoing I was able to attend my observations of the different dimensions of disclosure identified in this research – fearing disclosure, contemplating disclosure, and enacting disclosure tactics. Within the reflexive stance encouraged by constructivists, I reflected on my own interpretations, as well as the interpretations of the participants (Charmaz, 2006). This was especially important when one of the participants cited the illegality of her and her partner receiving fertility treatment with a known sperm donor as a same-sex couple. By reflecting on this participants' interpretation and engaging in information gathering with regards to the provincial and federal laws pertaining to fertility for same-sex couples, I was able to identify that the barrier to fertility treatment stemmed from clinic policy rather than the law. The structure of data analysis also aided in the focus on participants' interpretations. The interviews were analyzed using grounded theory's coding procedures including initial and focused coding. Using active words, such as *accessing*, *feeling*, *assessing*, *experiencing*, *considering* etc., to label the codes and eventually the categories and subcategories allowed me to stay close to the data and therefore helped in the process of reflexivity. My personal experience as a sexually fluid woman seeking sexual healthcare from healthcare providers allowed for sensitivity to this topic. I approached the investigative role with openness and curiosity but also with awareness of personal biases.

3.8. Chapter Conclusion

The current research seeks to gain an understanding of the interactional process between queer women and their healthcare providers within the context of sexual health. Constructivist grounded theory supplemented with situational mapping provided analytic tools for exploring this interactional process in depth. The findings chapter includes descriptions of the higher order categories identified from the analysis: healthcare space, relational healthcare dynamics, sexual healthcare interactions, human rights constraints, recommendations for healthcare providers, and recommendations for queer women. In describing these higher order categories, the relevant subcategories will also be described. Category and subcategory description will be yielded through presentation of rich examples of text from the participant transcripts and analytical interpretations based on the coding process.

Chapter 4.

Findings and Discussion

Queer women face barriers in their efforts to seek sexual healthcare and may also avoid interactions with healthcare providers because of negative experiences and/or misconceptions of their sexual health needs. The process of queer women's interactions with healthcare providers is poorly understood. The current study considers how queer women navigate access to competent and respectful sexual healthcare. Understanding experiences of and access to healthcare through a human rights framework, this study investigates ways women's rights to equal care is both enabled and constrained by means of healthcare systems and interactions with healthcare providers. Understanding the complex process of queer women's interactions with healthcare providers can inform clinical practice and consequently reduce the barriers to inclusive and appropriate sexual healthcare.

Constructivist grounded theory, supplemented with situational mapping, was used to analyze nine participant transcripts. This chapter presents the findings from the data analyses, along with an integration of previous research to help ground the current study. Coding and mapping resulted in the identification of four main categories: healthcare space, relational healthcare dynamics, sexual healthcare interactions, and navigating human rights, specifically the access to equitable, respectful, and competent healthcare. The recommendations for healthcare providers and the recommendations for queer women were identified based on the explicit recommendations from queer women. These categories will be discussed in this order, along with the subcategories identified within each larger category. This chapter begins with an explanation of the three-tiered contextual framework that was developed as a means to understand the categories identified for the process of queer women's interactions with healthcare providers when seeking sexual healthcare. The healthcare space, relational healthcare

dynamics, and sexual healthcare interactions categories are conceptualized as situated contexts in which queer women navigate rights to equal and respectful healthcare. The chapter concludes with a discussion of the recommendations categories in which queer women provide recommendations for healthcare providers and queer women in an effort to reduce discriminatory barriers and enhance inclusive and equitable healthcare interactions.

4.1. The Process of Women’s Interactions with Healthcare Provides When Seeking Sexual Healthcare

The process of queer women’s efforts to seek sexual healthcare from healthcare providers warrants an understanding of a three-tiered interrelated contextual framework: the healthcare space, the relational healthcare dynamics between queer women and healthcare providers, as well as the more focused interactions pertaining to sexual health. Different issues enabling or constraining queer women’s rights to health equity, such as experiencing heterosexism both systemically and interactionally, permeate these three contexts (see Figure 4.1).

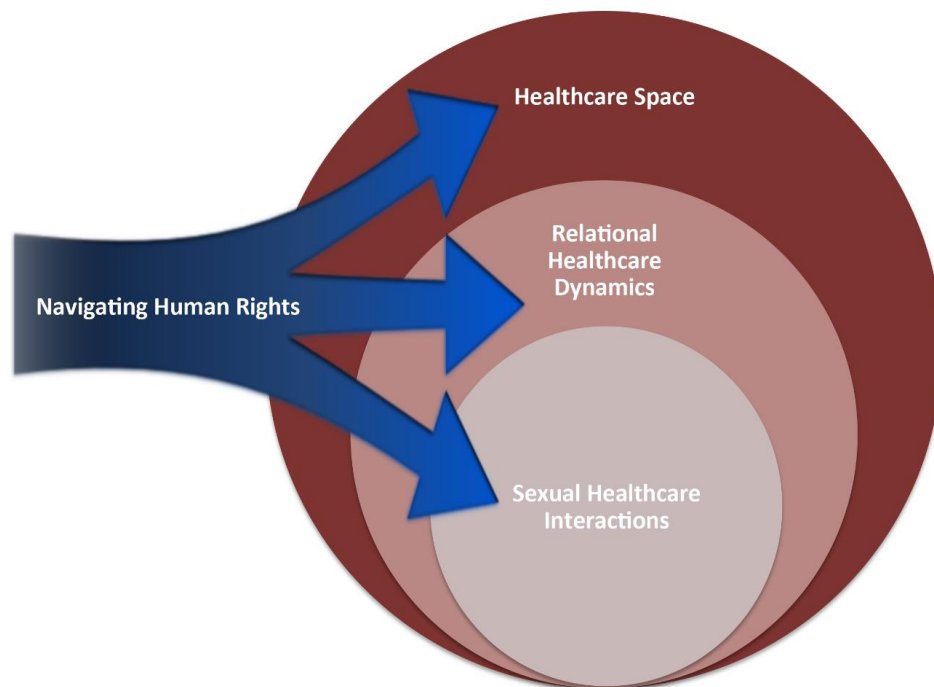


Figure 4.1. Three-Tiered Contextual Framework

Prevailing heteronormativity is present in all three situated contexts; queer women navigate their actions and interpersonal relational dynamics both in situations of inclusion and acceptance and situations of exclusion and discrimination. The current study offers a complex understanding of the process of queer women seeking sexual healthcare from healthcare providers as a situated context that is embedded within two larger contexts; queer women's human rights are limited or supported in various ways at each contextual level. The next section presents the findings and includes a discussion of the three situated contexts beginning with the broadest level, the healthcare space context, followed by the relational healthcare dynamics context, and then the more focused and specific sexual healthcare interactions context. After these sections, the findings from the navigating human rights category will be presented, along with a discussion of the constraints and access to equality for queer women within the three situated contexts.

4.1.1. Healthcare Space

The healthcare space context is the broadest level of the framework and the first context queer women encounter when seeking sexual healthcare. The healthcare space context includes the healthcare environments in which queer women access healthcare services, the physical locations of these different healthcare environments, as well as queer women's interactive relationships with these environments and physical locations. The current study employs a relational view of space in which space is constructed and includes the healthcare setting and the interactions between queer women and the healthcare setting. The healthcare settings include walk-in clinics, educational institution health centres, general practitioner's offices, hospitals, and the Centre for Disease Control (CDC). This context also includes the neighborhoods queer women access and seek healthcare services, for example, some queer women intentionally seek healthcare services in well-known queer friendly neighborhoods in Vancouver.

This context also includes the interactions queer women have with their healthcare space, such as engaging in the actions of gauging and assessing inclusivity and LGBTQ visibility of the healthcare space. Thus, space includes queer women's perceptions of the physical environments including the layout of waiting rooms,

advertising and informational displays and the types of furniture in healthcare settings. Moreover, this context recognizes the barriers that impede queer women's abilities to access the healthcare they need. The subcategories identified in the healthcare space category are: accessing and encountering barriers to accessing clinics, gauging queer inclusivity of clinics based on location, and assessing LGBTQ visibility.

Accessing and Encountering Barriers to Accessing Clinics

Queer women seek healthcare services from a variety of healthcare environments including walk-in clinics. At walk-in clinics, queer women do not usually have a regular healthcare practitioner, but rather seek healthcare services from whoever is on duty in any given day. Previous research supports the finding that women in same-sex relationships are significantly less likely to have a usual source of healthcare than women in opposite-sex relationships (Heck, Sell, & Gorin, 2006). This may mean that queer women are less likely to experience continuity of healthcare due to their health seeking from different healthcare providers. In the current study, Beth recalls an experience accessing a walk-in clinic, "I just went to a random, like, with one of my friends, we went to this random kind of walk-in clinic."

Some queer women intentionally seek different kinds of healthcare in different environments. For Amy and Alice, sexual healthcare is specifically sought in different healthcare environments. Amy discusses seeking sexual healthcare from a different clinic than the one she attends for her "regular stuff":

I go to the one clinic at [a university] where I work, it's interesting I've got the one clinic for my regular stuff and for the sexual health stuff I usually go to the [queer neighborhood] clinic cause I feel that's kind of actually a more comfy environment for me to talk about this stuff.

Amy's quote exemplifies that when some queer women feel constrained by the healthcare space, they will seek out other healthcare environments where they feel more comfortable to discuss their sexual health. For Alice, seeking sexual healthcare from the Centre for Disease Control (CDC) is tied to her identity as poly/kinky/queer:

If I wasn't queer, and poly and kinky and all that stuff, I would probably be more likely to go to my regular doctor... for my STI screening or whatever, because it is, like, even though, I've had really

positive experience with the CDC, it's something I do worry about, because you know, cause I really want to be honest about the things that I do, because I want to get the information, the best information that I can get... if I wasn't poly/kinky/queer... I would feel more comfortable just talking to my doctor, or, like a regular doctor.

In terms of barriers to accessing healthcare, previous research has found that compared to heterosexual women, lesbians and bisexual women are less likely to have health insurance and more likely to encounter difficulty obtaining necessary medical care (Diamant, Wold, Spritzer & Gelberg, 2000). Moreover, women in same-sex relationships are more likely to have unmet medical needs as a result of financial issues (Heck, Sell & Gorin, 2006). The current research supports and extends upon these findings by identifying the constraints queer women experience as a result of financial barriers, as well as insurance policies and extended healthcare benefits plans, which inhibit their ability to seek the healthcare they need. Beth notes the impact of these barriers on her ability to access the healthcare services she needs, "I'm going to get cut off of my student health plan as well as the health plan that I have through my mom's benefits...So not being a student, I won't have access to health coverage anymore." Another factor that influenced queer women's abilities to access the healthcare they needed was financial barriers in conjunction with a lack of extended healthcare benefits. Stephanie faced a tough financial decision when weighing the cost of mental health treatment against the cost of necessary living expenses:

It was hard to find [psychiatrists], just for the sheer fact that most of them are private and they cost a lot of money. And since I was, like working part time and pretty much, that was not enough to cover anything...I kept finding places, they're like 'Oh yeah, we do sliding scale. The cheapest is fifty five dollars an hour.' And I'm like, okay, fifty-five dollars is like a month's worth of food sometimes.

Stephanie's quote demonstrates that queer women face financial barriers and may even experience poverty, both of which may serve as barriers for queer women accessing necessary health and mental healthcare. Research demonstrates that lesbian women are consistently poorer than their heterosexual counterparts (Albelda, Badgett, Schneebaum, & Gates, 2009). Even though sliding scales may be offered as a means of reducing barriers to health care, the intersectionality of queer sexuality and poverty impede queer women's access to healthcare.

Gauging Queer Inclusivity of Clinic Based on Location

In terms of location of healthcare services, it appears as though queer women have a common understanding for two queer-friendly neighborhoods in Vancouver, BC. Queer women expect that healthcare providers in these areas will be educated about queer issues. Brenda states, “because of their location [within a well-known queer friendly neighborhood in Vancouver], they are almost forced to be somewhat more educated, I guess, on queer issues than if they were located somewhere else.” Queer women’s expectations that healthcare providers working in clinics located within these well known queer friendly neighborhoods in Vancouver will be queer inclusive and educated about queer issues may translate into healthcare seeking in these identified areas and healthcare avoidance in other unidentified gay-friendly neighborhoods. Queer women also noted differences in queer inclusive healthcare in larger urban areas compared to rural areas. Shelia commented, “I know lots of stories around health issues if you’re... in [small suburban city outside of Vancouver] or have a doctor with, you know, that’s not part of, you know, and urban center.” Shelia’s quote demonstrates that queer women may hold the belief that healthcare providers in rural areas might be less accepting and knowledgeable about queer health than healthcare providers in larger metropolitan areas. This wide spread perception and concern may mean that queer women are likely to seek healthcare services in urban areas than in rural areas.

Assessing LGBTQ Visibility

The second action that queer women actively engage in within the healthcare space context is assessing the environment for LGBTQ visibility. This may be one of the tactics queer women employ in order to gauge their level of safety as a member of a socially marginalized sexuality group. Steele, Tinmouth, and Lu (2006) suggest that lesbian women scan healthcare offices for visual in order to help them determine whether or not disclosure of their sexual orientation is safe or not. The authors recommend displaying visuals such as rainbow flags, pink triangles, posters with gay-positive and anti-discriminatory statements, as well as having LGBTQ pamphlets in order to communicate inclusion and safety for marginalized sexuality groups (Steele, Tinmouth, & Lu, 2006). The current study demonstrates that queer women notice nuances such as whether or not waiting room materials include brochures pertaining to

queer health issues or if posters and advertisements reflect same-sex relationships, as well as more discernible signs of inclusivity such as rainbow stickers. Visual signs of inclusivity in the healthcare space, or a lack there of, may impact queer women's healthcare seeking. Queer women may be more likely to seek out healthcare services in settings in which there are signs of inclusivity and in which they feel represented as a member of a socially marginalized sexuality group. Beth's quote demonstrates that queer women are under-represented by environments that perpetuate heteronormative stereotypes and contribute to queer erasure:

Um, other than the fact that there's nothing that would identify the office as remotely queer. Like I would notice that, like, that it's just like everywhere else... the pictures are all just of very normative folks...they're all thin...just like super feminine women, super masculine men.

As a queer woman, Beth's perception of the healthcare space as "normative" and lacking queer representation might constrain her efforts to seek healthcare due to the marginalization she feels when she cannot relate to the visuals displayed around her. For Brenda, on the other hand, queer inclusivity and safety within the healthcare space were quite obvious:

There's like queer stuff everywhere. You'd be like, yea, there's like, right in the front thing, where you talk with the nurse, there's like a Pride sticker, you know, like, yeah... it's very obvious... it's a homophobia free zone. I'm pretty sure they have that poster.

Brenda noted LGBTQ visibility in her healthcare space, which may translate into continued healthcare seeking in this inclusive environment.

The healthcare space context acknowledges that queer women attribute implicit meanings to their surroundings, as well as engage in interactive relationships with their healthcare environments as the first step in the process of seeking sexual healthcare. This context includes the types of healthcare environments queer women seek, as well as the barriers to seeking healthcare. Within the healthcare space context, queer women actively seek healthcare in queer friendly neighborhoods and assess LGBTQ visibility in an effort to determine safety and inclusivity.

4.1.2. Relational Healthcare Dynamics

The relational healthcare dynamics context is the second tier of the three-tiered framework for understanding the process of queer women's efforts to seek sexual healthcare from healthcare providers. This context is embedded within the healthcare space context, meaning that the relational healthcare dynamics between queer women and healthcare providers are situated within the larger healthcare space context. The relational healthcare dynamics context includes the interactions between queer women as patients seeking healthcare from healthcare providers. The subcategories identified within this context are: assessing gender and sexual orientation of the healthcare provider, three aspects of disclosure, lying to healthcare providers, feeling awkward, feeling cared for, being dismissed by healthcare providers, and experiencing healthcare providers as accepting and inclusive.

Assessing Gender and Sexual Orientation of Healthcare Provider

Assessment of the healthcare providers' gender and perceived, or known, sexual orientation impacts queer women's preferences and experiences interacting with healthcare providers. Based on the findings from the current study, queer women have a strong preference for female healthcare providers, which may contribute to their efforts to purposefully seek out female and avoid male healthcare providers. Queer women have different reasoning for their preference for female healthcare providers. Past research shows that lesbian women attribute characteristics such as openness, acceptance, and knowledge about lesbian lifestyle to female healthcare providers; characteristics including intolerance and homophobia are attributed to male healthcare providers (Geddes, 1994). In the current study, Brenda believes that female healthcare providers better understand women's health issues:

Hmm, I guess I prefer women but ah...women just seem to be more caring... male doctors don't seem, like this is stereotyping of course, don't seem to like really understand women's issues and the way that we respond... like PMS and stuff... like menstrual cramps cause they don't experience it.

Marilyn's reveals that her preference for a female healthcare provider is grounded in her perception of gender secession: "I would always prefer to have a

woman [HCP]... cause I think at heart, I'm a separatist." Some queer women prefer healthcare providers who are LGBTQ and will actively seek out LGBTQ healthcare providers and avoid healthcare providers who are not queer friendly. Previous research attributes the motivation for lesbian women to pursue seeking healthcare from LGBTQ doctors to the belief that they will not experience prejudice because of the shared experience of belonging to a marginalized group (Barbara, Quandt & Anderson, 2001). In the current study, Amy notes how her preference for LGBTQ healthcare providers in certain areas of health extends to other areas of health such as physiotherapy:

I definitely do [seek out queer healthcare providers] with like, other areas of health, so, I mean I'm with the clinic you know and for mental health for sure ah, maybe I should do that for physio cause there's a reason there's a queer business directory right.

Beth believes that a queer or a queer positive healthcare will understand her identity:

I'm less likely to seek out counselling services, unless I know that it's with either a queer or radically queer positive, um, person. Cause it's like, "What am I going to talk to this person about, if they're not, if they don't understand where I'm coming from in terms of my identity.

Disclosure

Another important aspect of the relational healthcare dynamics context is the interactional dimension of disclosure. Research shows that there can be benefits and consequences that result from disclosure of non-heterosexual sexual orientation to healthcare providers (Eliason & Schope, 2001; Bjorkman & Malterud, 2007; Boehmer & Case, 2004). The predominant theoretical framework for understanding different disclosure strategies for lesbian women is Hitchcock and Wilson's (1992) two-phase basic social process involving an anticipatory phase, in which the risk of self disclosure is calculated, and an interactional phase, in which different stances of disclosure or nondisclosure are taken. The findings from the current study identify three aspects of disclosure: fearing disclosure, contemplating disclosure, and enacting disclosure tactics. The two first aspects of disclosure are preliminary and can be compared to Hitchcock and Wilson's anticipatory phase, which recognizes the risk of disclosure (i.e. fearing

disclosure) and the assessment of information in the disclosure decision-making process (i.e. contemplating disclosure). Unlike Hitchcock and Wilson's two-phase framework for understanding disclosure, in which the anticipatory phase gives way to the interactional phase, the current study's findings do not support that queer women move through this process in a linear fashion. In other words, queer women do not necessarily fear disclosure before contemplating disclosure, followed by enacting disclosure tactics. The current study both supports and disrupts Hitchcock and Wilson's (1992) disclosure framework.

Fearing Disclosure

Three women spoke of their fear of disclosing their sexual orientation to healthcare providers. Marilyn succinctly stated, "there's a fear of coming out". Shelia recalls her fear of disclosing in the early 1990's:

I had only been out for a short period of time. So being young and having to sort of come out to doctors, and you know, 1993, that's pre-Ellen, right? Like it was a very different world back then, than it is today. So that was more of a, that was more of, there was a lot more fear around saying it...I was still trying to figure out what being gay meant.

Shelia's quote demonstrates that the fear of disclosure may have changed for some queer women over time. For Rhonda, fearing disclosure is grounded in her concern for confidentiality, as well as her healthcare providers' preconceptions of women, which may include the heterosexual assumption:

I finally told him [doctor]. Um, I'd been worried about coming out for a while, because um, mostly because I knew that he knew my mother at least a little bit on the professional basis... but also because I knew that he had certain preconceptions of who I was and of what women were.

Rhonda may have been afraid that her doctor would reveal her sexual orientation to her mother. The fear of broken doctor-patient confidentiality, along with the fear that Rhonda would be disrupting the preconceptions of her doctor, may translate into healthcare avoidance. It appears as though the fear of disclosure is complex and experienced by queer women for differing reasons.

Contemplating Disclosure

When contemplating disclosure, queer women consider the topic of conversation, as well as the perceived relevancy of their sexual orientation to their healthcare seeking. For Amy, her contemplation of disclosure arises during a discussion of her healthcare providers' family, "I notice that when [healthcare providers] bring up their family a lot and it's like I have the choice now to either out myself, I'm not sure how cool you are". Alice notes that she is not fearful of disclosing, which provides support for the understanding that disclosure is not a linear process always beginning with fear. For Alice, disclosure is only necessitated when it is relevant, "I'm not afraid to say that I am [queer]. Like, if it's relevant to whatever I am talking about, I'll say that". According to Fish (2006), the relevance of one's sexual identity to a health problem is more likely to prompt disclosure; health problems related to sexual behaviour are considered more relevant than other health issues. However, the notion of relevancy as a determining factor for disclosure has been problematized. Fish (2006) argues that the concept of relevance perpetuates a biomedical approach to lesbian and gay men's health; a holistic approach, on the other hand, includes disclosure as a means to provide comprehensive healthcare. Thus, in order for Alice to receive holistic healthcare, it would be important for her healthcare provider to enquire about her sexual orientation.

Enacting Disclosure Tactics

The current study identifies disclosure tactics, as opposed to the four disclosure or nondisclosure strategies outlined by Hitchcock and Wilson (1992). These authors identified the disclosure stances of passive disclosure and passive nondisclosure, in which lesbian women provide clues indicating their sexual orientation but do not directly affirm or deny their sexual orientation; active disclosure, in which lesbians specifically state their sexual orientation; and active nondisclosure, which is an interactional stance in which lesbian women either deliberately present themselves as heterosexual or go along with an imposed heterosexual assumption (Hitchcock & Wilson, 1992). This subcategory recognizes that queer women enact disclosure tactics based on their circumstances.

De Certeau (1984) draws an important distinction between a *strategy* and a *tactic*. Employment of a strategy involves the manipulation of power and is only possible when a subject can be isolated (de Certeau, 1984). Alternatively, a tactic is a “calculated action” determined by the absence of power and cannot be isolated from its context, but rather is dependent on the context (de Certeau, 1984). Queer women do not necessarily enter in to relational healthcare dynamics with a preconceived strategy to enact disclosure, but rather they are limited by the context of the conversation with their healthcare provider. Shelia illustrates this limitation, “Um, you know, and having to kind of say ‘You know, we need to take a step back because actually I don’t date men and I’m in a relationship with a woman’...That’s happened a number of times.” Shelia’s need to backtrack with her healthcare provider and clarify her relationship reveals the restriction on disclosure she experiences as limited to correcting her healthcare providers assumption of heterosexuality. For Rhonda, her disclosure tactic arose during a conversation about sexual health with her doctor, “[GP] said ‘Have you had a Pap smear?’ I said ‘No’. And she said ‘Are you sexually active?’ And I said ‘Well, yes, but I’m a lesbian”. Rhonda’s quote demonstrates that her disclosure tactic was implicitly tied to the context of the conversation of sexual health. As such, Rhonda may not have entered in to the healthcare interaction with an isolated strategy for disclosure, but rather she employed a tactic based on the healthcare topic.

The fear of disclosure may reduce queer women’s healthcare seeking efforts while disclosure contemplation may constrain queer women’s access to appropriate healthcare if they are relying on the concept of relevancy. The disclosure tactics queer women enact within the relational healthcare dynamic may result in continued healthcare seeking or healthcare avoidance, depending on the reaction of the healthcare providers. Beth experienced a negative reaction from a healthcare provider following disclosure, “The doctor was kind of, I did tell her I was queer, and she had a bit of a weird reaction.” This “weird reaction” may serve to inhibit Beth’s future healthcare seeking behaviours as a result of her feeling marginalized.

Lying to Healthcare Provider

The current study extends the notion of disclosure by considering queer women’s lying to healthcare providers as an extreme form of not disclosing aspects of their

identity in their efforts engaging in stigma management. Two participants discussed lying to healthcare providers for different reasons. Lying to healthcare providers means that queer women are intentionally withholding aspects of their identity and not relaying necessary information in order to receive the healthcare they need. For Amy, the stigma associated with having sex outside of the context of a relationship and having multiple sexual partners is so salient that she intentionally lies about her sexual relationships. Amy notes that she feels ashamed by the number of sexual partners she has and that this shame is the motivating force behind her reason to lie to her healthcare provider:

I lie because I still don't have the guts to say well you know I'm not in a relationship but I have casual sex, or I have someone who I have sex with once in a while... I'd lie about number of sexual partners cause I'd feel ashamed around that.

For Amy, lying to her healthcare provider about her current sexual relationships and her sexual history may mean that she does not receive the sexual healthcare she requires. Amy's quote highlights that an important role for healthcare providers is to signal their comfort with discussing sexual histories and sexual activity level by using inclusive language. Interestingly, Shelia reported lying to her healthcare provider in order to obtain hepatitis vaccinations, which can be associated with riskier sexual activities:

And I would always say, cause you're technically low risk, but I always lied cause I wanted them [Hep A, Hep B, Hep C vaccinations] anyway, don't ask me why. (laugh)...that was a complete lie but that's the only way you could get it [Hep A, Hep B, Hep C vaccinations]... But if you were in a high risk category, you could get it for free. Right? So that's why I definitely misrepresented myself.

Shelia intentionally misrepresents herself in order to get free access to vaccinations she believed she needed for her protection as someone engaged in self-identified "risky" sexual behaviours. Shelia's quote demonstrates a systematic problem with the healthcare delivery system in that financial access to care may be a barrier for queer women and as such, they are forced into situations in which they might have to lie in order to receive the preventative care they need.

Feeling Awkward

Some queer women feel awkward when interacting with healthcare providers for a number of reasons, which may negatively impact their healthcare experience and contribute to healthcare avoidance behaviours. Shelia recalls an experience as a teenager with her family doctor in which she felt awkward, “[Family doctor] just made me feel so awkward about myself and my body, like talking about sex at fifteen, when you’re, I was not a sexual kid.” Brenda recalled feeling awkward in a sexual healthcare interaction, “I had a super hot nurse one time, and was like ‘This is really awkward getting a Pap smear by a hot nurse’”. For Brenda, identifying as queer woman, and receiving a Pap smear from an attractive female nurse felt uncomfortable. Brenda’s experience may suggest that queer women’s efforts for health seeking could be supported by a choice in the gender of healthcare providers. Although the majority of queer women prefer female healthcare providers, as identified in the *assessing gender and sexual orientation of healthcare provider* subcategory, there may be specific situations in which they would prefer a male healthcare provider.

Feeling Cared For

Queer women’s health seeking efforts may be supported when they feel cared for by healthcare providers. Queer women reported feeling cared for when healthcare providers spent time with them and listened to their concerns. Queer women who feel understood by their healthcare providers may be encouraged to continue with their health seeking efforts. For Marilyn:

My GP is a great resource. I often find she will go to great lengths to explain stuff that maybe another specialist has said that I wasn’t clear about and they were rushing... and my GP will take a lot of time to answer questions... I really appreciate that, tremendously.

Alice echoes this caring aspect in saying, “I don’t feel rushed when I’m there [clinic]. Like I can talk about what I need to talk about or ask questions or whatever, and I don’t feel rushed”. Rhonda explains, “I actually feel like I’m being listened to”.

Being Dismissed by Healthcare Provider

Queer women are discouraged to seek out healthcare services when healthcare providers shrewdly dismiss them through communicating a lack of sensitivity and understanding. Queer women who are dismissed by their healthcare providers feel disenfranchised. Rhonda explained a common dismissal experience, “I’ve definitely had um, doctors telling me that, everything from not quite understanding that when a woman says she’s in serious pain when she gets her period, she’s not just being a dramatic, you know, drama queen.” Rhonda notes her healthcare providers have lacked an understanding for her issue and dismissed her experience of pain. Jordan recalls a time when she was literally dismissed from her healthcare providers office after engaging in a dialogue about the antibiotics she was prescribed, “I tried to discuss my own ideas about my health, to the point where I was once thrown out of the office, because I questioned the prescription of antibiotics from my doctor.” Rhonda and Jordan’s experiences of being dismissed by their healthcare providers demonstrate a dynamic of negotiating inequitable and disrespectful healthcare treatment, which may negatively impact their future healthcare seeking.

Experiencing Healthcare Provider as Accepting and Inclusive

Experiencing healthcare providers as accepting and inclusive may encourage queer women’s healthcare seeking efforts and contribute to better healthcare experiences. Marilyn notes that she appreciates her GP’s “lesbian positive attitude”. Shelia’s quote demonstrates an experience in which she felt accepted by her healthcare providers who included Shelia’s partner in their discussion and understood the decision to conceive as involving both partners:

[Doctors] understood where we were coming from there was no judgment all the way through, all the way through, on anybody’s level. Like they knew we were two women that were trying to get pregnant; that this was important. They talked to both Partner and I as a couple, they knew it was a couple decision.

Shelia’s experience with healthcare providers accepting her circumstances surrounding conceiving and including her partner in the process is the foundation for her recommendation, included in the recommendations for healthcare providers category,

for healthcare providers to respect the same-sex partners of patients. Overall, participants attributed acceptance and inclusiveness to healthcare providers who were lesbian positive, non-judgmental about sexual orientation and sexual practices; who acknowledged the partners of the patients and did not make assumptions, as well as healthcare providers who were accessible in terms of engaging in interactions with queer women in an equitable and respectful manner.

The relational healthcare dynamics context is embedded within the healthcare space context and recognizes the complexities of the interactions between healthcare providers and queer women. It is vital to understand the relational elements of queer women's interactions with healthcare providers because the sexual healthcare interactions context is situated within the healthcare interactions context.

4.1.3. Sexual Healthcare Interactions

The sexual healthcare interactions context is the third tier of the three-tiered framework for understanding the process of queer women's efforts to seek sexual healthcare from healthcare providers. The sexual healthcare interactions context is embedded within the relational healthcare dynamics context, meaning that interactions related specifically to sexual health are occurring within the broader healthcare dynamics between queer women as patients and healthcare providers. This context includes the following subcategories: receiving inadequate sexual health care, heterosexist sequencing of sexual health questions, experiencing exclusive and sex negative sexual healthcare, experiencing inclusive and sex positive sexual healthcare, perceiving healthcare provider as unaware and judgmental of diverse sexual practices, getting tested, and asking sexual health questions. Many of the subcategories identified within this context address the erasure of queer women's sexual health from mainstream sexual health knowledge and sexual healthcare.

Receiving Inadequate Sexual Healthcare

Receiving inadequate sexual health care limits queer women's access to appropriate care and contributes to their experience of inequitable healthcare. Amy's quote demonstrates her experience of inadequate sexual healthcare through the

assumption made by her healthcare provider that she did not require a certain type of STI testing:

I had been told that you don't need that [type of STI testing] right and I didn't want to tell her like I engage in these activities [risky sexual activities], that's actually put me at higher risk, I just didn't feel like I could do that... I've seen this happen to my partners too where people have been told well you don't need that without even asking you know o.k. what makes you think you might be at risk or you might want that.

Amy felt too uncomfortable to voice her concern that a certain type of STI testing was warranted given her level of risk. This quote highlights the dangers associated with healthcare providers acting upon assumptions, which can in turn silence queer women from openly discussing their sexual healthcare needs.

Stephanie experienced inadequate sexual health care when her healthcare provider ignored her sexual health following her disclosure of her sexual orientation; even though she had specifically sought sexual healthcare in terms of STI testing. Stephanie recalls this experience in which she received inadequate sexual health care:

He was kind of like, not wanting to bring up any of the sexual health stuff, even though that was like, why I was there, because he was supposed to give me the results to some of the [STI] tests...So I was like "Okay, sure whatever." And he's like "Hmm, hmm." Kind of like avoiding me...kind of like, looking away.

Stephanie's quote highlights the stigma she experienced upon disclosing her sexual orientation and how this related to her experience of receiving inadequate sexual healthcare. In her efforts to obtain sexual healthcare, Stephanie experienced inequitable treatment as a result of her healthcare providers' lack of competence and unprofessionalism in his reaction to her disclosure of her sexual orientation. The erasure of queer women's sexual health was perpetuated by the complete avoidance of sexual healthcare upon a non-heterosexual sexual orientation disclosure.

Heterosexist Sequencing of Sexual Health Questions

Queer women are further constrained by heterosexist sequencing of sexual health questions. During discussions of sexual history and current sexual activity, queer women are often asked about their use of contraception. This line of questioning demonstrates healthcare providers heterosexist assumption that sex is occurring within the context of heterosexual sex, which positions queer women as needing to explain their same-sex sexual practices under the weight of heteronormativity. This finding is supported by Fish and Bewley (2010) who reported that the heterosexual bias is most prevalent in sexual history taking. Assumptions of heterosexuality means that lesbian and bisexual women feel invisible and uncomfortable and as such, poses as a barrier for effective healthcare (Fish & Bewley, 2010). The queer women in this study encountered the barrier of heterosexism during their interactions with healthcare providers within the context of sexual healthcare. Jordan recalls a common line of questioning for women in which an affirmative answer to sexual activity is immediately followed by a question pertaining to contraception:

At some point he [physician] said, 'Do you use birth control?' And I said 'No'. 'Are you sexually active?' 'Yes.' It's classic right? Are you sexually active? Yes. Do you use birth control? No. And there was a double take right?

This “double take” from Jordan’s doctor suggests that a discrepancy in answering heterosexist sexual health questions renders a visibly surprising reaction. Shelia experienced a similar line of questioning when seeking healthcare for a urinary tract infection, “they ask those questions, ‘are you on birth control pills?’... and the assumptions they were making, ‘are you having unprotected sex?’”. Stephanie’s quote demonstrates a sexual health interaction that is riddled with heterosexism:

And they [doctors] start asking you questions... do you have a boyfriend right now? Are you actually having sex?... not sure how to answer these, what kind of sex are we talking about?...one time I was in a walk-in clinic, and the doctor there was like, 'Okay, well, um, you need to do, you want to do the STD tests and all that stuff?' And he's [doctor] like 'Well, when we do that, we're also going to do a test for pregnancy... You know, condoms aren't a hundred percent'.

Beginning the line of questioning with Stephanie being asked if she has a boyfriend not only implies an assumption of heterosexism, but it also an assumption of sex only occurring within the context of a relationship. The doctor's remarks about whether or not she is "actually having sex" implies that there is one universal way to define sex, which perpetuates the heterosexual norm and undermines the sex practiced by queer women. The assumption that a pregnancy test is required exemplifies the link between sexual health and reproductive health within heterosexist presumptions. Jordan and Stephanie's experiences of blatant heterosexism during interactions with healthcare providers within the context of sexual health demonstrates how queer women are marginalized and impacted by unequal sexual healthcare.

Educating Healthcare Provider

An action that queer women take within the sexual healthcare interactions is to educate healthcare providers. Some queer women who encounter healthcare providers who do not have knowledge about their specific sexual health issues provide relevant information. In these situations the power imbalance may actually be swayed in the favor of queer women. Typically, healthcare providers, as professionals in a position of authority and expertise, hold more power over their patients, and particularly their patients who are members of socially marginalized sexuality groups. Providing healthcare providers with sexual health education may actually allow queer women an opportunity to feel empowered. Alice's discusses her experiences of educating nurses at the Centre for Disease Control (CDC) about BDSM and kinky play practices of piercing, "And so I explained about piercing... I've actually educated a number of CDC nurses about that...There's been a few who knew exactly what I was talking about. And there's been a bunch that I tell them." For Alice, experiencing healthcare providers as open to and accepting of her diverse sexual practices may serve to encourage her to seek out sexual health services. However, Shelia found it difficult when encountering a healthcare provider who did not have the necessary knowledge for her health issue, "one of the challenges is you know, you sort of have to educate [doctors] about your issues...there's a lot they don't ask". This lack of healthcare provider competent knowledge exemplifies the systemic erasure of queer women's sexual health. For some queer women, providing healthcare providers with education about their health issues may impose on their ability to obtain equitable and appropriate healthcare services.

Experiencing Exclusive and Sex Negative Sexual Healthcare

Along with experiencing heterosexism, queer women's experiences of exclusive and sex negative sexual health care may serve to deter their efforts for sexual healthcare seeking. Experiences of feeling excluded translate into marginalization and a negative view of sexuality spouted by healthcare providers may contribute to internalized shame for queer women. Rhonda's quote demonstrates a clearly sex negative view from her healthcare provider with tones of sexism:

I think I was still a teenager I went to him [male doctor] one day, um, and he was asking if I was sexually active, which at that point I wasn't. But it was how he asked, it was 'So, are you getting into any mischief?' which, is just how he thought of women having sex, or of, maybe teenage girls having sex, I don't know.

Using the word "mischief" denotes a negative connotation for sexual activity. Moreover, because Rhonda was a teenager at the time of this interaction, this may contribute to the double standard women encounter in which they are demonized for sexual activity. For Amy, the assumption of sex occurring within the context of a monogamous relationship left her feeling too uncomfortable to share her sexual history:

Before when I've gone to a sexual health clinic, they always ask are you sexually active and I've said yes and they say how long have you been with your partner, and there's a lot of times I haven't been with a partner and I've been sexually active... I have casual sex, or I have someone who I have sex with once in a while and... I'm not upfront cause the question is framed in a way that it's not letting me be upfront."

Queer women may be deterred to seek sexual healthcare if they encounter experiences of marginalization and sex negativity.

Experiencing Inclusive and Sex Positive Sexual Healthcare

Experiences of inclusion and sex positivity may contribute to queer women's sexual healthcare seeking efforts and to equal access to appropriate healthcare. An inclusive and sex positive approach from healthcare providers allows for the recognition of diverse sexual practices and creates a safe space for queer women to discuss their sexual practices and sexual health concerns. Inclusivity is important given that research

supports the finding that lesbian and bisexual women have varied sexual histories with both male and female partners that include diverse sexual practices (Bailey, Farquhar, Owen, & Whittaker, 2003). In the current study, Jordan notes how healthcare providers can easily enact an inclusive approach when discussing sexual practices, “Do you have sex mostly with women; mostly with men or with both?” An open-ended question such as this demonstrates inclusivity by not imposing the heterosexual bias on queer women. For Alice, inclusivity and a sex positivity is demonstrated by healthcare providers being, “very open, very nonjudgmental and just really curious”. Healthcare provider inclusivity can also be established through providing queer specific sexual health information as can be seen in Rhonda’s quote:

[Female GP] said ‘Have you ever had a PAP smear?’ I said ‘No.’ And she said, ‘Are you sexually active?’ And I said ‘Well, yes, but I’m a lesbian.’ And she said ‘Oh, well here are our recommendations for women who have sex with women.’... it’s like ‘Wow. You have recommendations for women who have sex with women?’

Healthcare provider inclusivity, demonstrated by the use of open-ended questions and specific recommendations for queer women, supports the equal treatment for this socially marginalized sexuality group.

Perceiving Healthcare Provider as Unaware and Judgmental of Diverse Sexual Practices

Within the sexual healthcare interactions context, it appears as though queer women’s experiences of inadequate health care, heterosexism and exclusion and sex negativity are not the only barriers to equitable and appropriate sexual healthcare. Queer women who do not necessarily have these negative experiences may still avoid sexual healthcare seeking based on their perceptions of healthcare providers as unaware and judgmental of diverse sexual practices. For one participant, her perception of her healthcare provider as unaccepting of BDSM and kinky sexual practices limits her ability to openly discuss her sexual activity, which in turn impedes her ability to receive the sexual healthcare she requires. Jordan outlines her trepidation in the following quote:

And to believe that the doctor will actually not have any judgment, they will not tell you ‘Why the hell would you put needles into someone?’ Or ‘Why the hell would you whip someone until they bruise

blue and black?’ Right? Right? It’s like, that would be probably what I would expect from the average physician.

For Jordan, her perception that the average physician would be unaccepting and judgmental of diverse sexual practices means that she does not feel comfortable openly engaging in a discussion of her sexual practices. Amy also felt unable to open up about her kinky sexual practices, “I didn’t want to tell her [female doctor] I engage in these activities [piercing] that’s actually put me at higher risk, I just didn’t feel like I could do that”. Queer women who engage in diverse sexual practices such as kink and BDSM, may actively avoid seeking the sexual healthcare they need because of the fear of being judged by healthcare providers.

Getting Tested?

The erasure of queer women’s sexual health translates into a lack of understanding of the sexual health risks of queer women. Problematically, women who have sex with women have been inaccurately perceived to be at low-risk for STIs and cervical cytology screening initiatives (Fethers, Marks, Mindle & Estcourt, 2000). As a result of the systemic failure to recognize queer women’s sexual health, queer women have adopted misperceptions of their sexual health needs. Queer women’s perceptions and experiences interacting with healthcare providers discussing preventative sexual health screening initiatives, such as Pap smears, as well as STI and HIV testing impacts their healthcare seeking and avoiding behaviours. Queer women’s perceptions, which may be supported and/or contested by healthcare providers, about sexual health testing contribute to their decision-making process for accessing or resisting sexual health testing. Beth’s quote demonstrates her reasoning for avoiding sexual health testing:

I sort of discount certain issues around, um, sexual health, or even general health...because I discount certain issues that maybe a straight person, or a straight woman would have, in a heterosexual relationship...part of that is because I’m in a monogamous relationship. So I don’t, um, I’m not really concerned about getting, um, STD tests or things like that, or like pregnancy or anything. (laugh)... I’ve never had a PAP smear before. I still haven’t.

Beth reasons that because she is in a monogamous same-sex relationship, she does not need to obtain testing for sexual transmitted diseases (STD’s). For Beth, a history of

absence of preventative screening provides current support for the finding that lesbians have poor uptake of cervical screening (Bailey, Kavanagh, Owen, McLean, & Skinner, 2000; Kerker, Mostashari, & Thorpe, 2006). This is problematic because according to Marrazzo et al. (1998), routine Pap smear screening should occur just as regularly for women who have sex with women than women who have sex with men. Beth's lack of understanding of her sexual health needs illustrates a systematic failure of mainstream sexual health information that is directed towards heterosexual sexual activity. Beth's quote reflects the misconception that women who have sex with women are at low risk of STI's. Rhonda's recommendation from her gynecologist, on the other hand, may contribute to her access to sexual health testing:

[Gynecologist] recommendations were no different that she would have made if I was having sex with me[n]. 'Oh, you should still get a PAP smear anyway.' So I don't really feel that her recommendations were anything special. Just more felt like the 'Hey, oh my god, you're telling me that you're taking me seriously?' I think that was, for me a bigger issue.

Rhonda's perception was that she was not receiving specialized sexual health care; but that her gynecologist was validating her sexual health needs by offering an appropriate sexual health recommendation.

Asking Sexual Health Questions

Queer women's self-agency in asking healthcare providers sexual health questions demonstrates healthcare seeking behaviours. Amy takes initiative to approach nurses working on the street to ask sexual health questions:

I've actually gone in there just to ask around risky activities, so I've sat down and said you know this is, especially around things like kink where you're not having sex necessarily but you might still be, you know can you tell me about hepatitis and how it can be transmitted.

Amy acknowledges feeling comfortable with openly discussing her sexual health questions, "I went and talked to one of the street nurses... [she] let me ask [sexual health] questions which was just great because you're talking with someone who's working with real people." For Amy, her perception of street nurses as healthcare

providers who are interacting with “real people” creates enough safety for her to pursue sexual healthcare seeking. Beth also sought healthcare services in order to gain pertinent sexual health information:

I went and saw a doctor just like to get some information about, like ‘Do I need to [get a PAP smear] Like I’m not having, I’m in a monogamous same sex relationship. Is that going to be an issue for me?’.

Beth’s quote demonstrates the confusion that exists for queer women in terms of their sexual health needs. It appears as though both queer women and healthcare providers are unclear about the requirements of Pap smears as an appropriate preventative measure.

The process of queer women’s sexual healthcare seeking from healthcare providers requires an understanding of the two larger contexts, the healthcare space and relational healthcare dynamics, in which sexual healthcare interactions are situated. Within the sexual healthcare interactions context queer women encounter and engage in various interactions with healthcare providers in which their past experiences, their perceptions, and their actions all contribute to their healthcare seeking and avoiding behaviours.

4.1.4. Navigating Human Rights

Queer women navigate constraints of and access to human rights during the process of sexual healthcare seeking at each of the three contexts: healthcare space, relational healthcare dynamics, and sexual healthcare interactions. Attention to health as a human right draws attention to the impact of the social inequalities queer women are burdened with in their process of sexual healthcare seeking. According to Hunt and Backman (2008), a human rights framework centers on principles of nondiscrimination, equality, equity, participation, and access to health information. This approach to understanding health for queer women is vital given that unequal rights are central to the oppression and marginalization for minority sexuality groups. The navigating human rights category captures discrimination by means of heterosexism, stereotyping, weight-related stigma, and experiences of oppression related to low socioeconomic status. This

category also includes how queer women gain access to rights through their experiences of privilege, such as being cis-gender, belonging to the middle class, and having access to education. For one participant, privilege was gained through “going back into the closet” and presenting herself as heterosexual in order to obtain the fertility treatment her and her partner wanted. The current study demonstrates that the intersectionality of privilege and oppression is complex and multifaceted. Fish (2006) highlights the heterogeneity of LGBTQ communities and writes that, “one of the most pervasive stereotypes about lesbian, gay, bisexual, transgender and queer people is that they are white, able-bodied, and have large disposable incomes” (p. 52). Previous research shows that attending to identity intersectionality, such as minority ethnicity, low class, and non-heterosexuality reveals greater health disparities than the consideration of each axis of inequality on its own (Veenstra, 2011).

Experiencing Heterosexism Systemically

Queer women experience discrimination through heterosexism at both the systemic and interactional levels. Within the current three-tiered framework for understanding the process of queer women’s sexual healthcare seeking, systemic heterosexism occurs within the healthcare space context. Queer women experience systemic heteronormativity through medical forms and systems that lack inclusion of their same-sex partners and, for one participant, clinic policies that inhibit fertility treatment with a known sperm donor. Shelia outlines a common experience of systemic heterosexism, “when you come in [to a health clinic]... there’s not queer women’s health information; there’s no acknowledgement of it...there’s no effort to make inclusivity”. Shelia also experienced systemic heterosexism in her efforts to seek fertility treatment with her partner:

You can’t have the donor of choice, you want, you can’t sign consent, even if he’s, and he had already done all the tests, like he’s HIV negative...So we had tried going to an initial clinic, a couple of initial clinics right? And then had said ‘Oh, we’re lesbians and this is what we’re doing [trying to conceive with a known sperm donor]’ and they’re like ‘We can’t help you’... a whole piece around my partner being left out that process because of the laws.

Shelia discusses attending numerous clinics and having similar interactions with healthcare providers. Shelia's experience demonstrates systemic heterosexism as a result of the policies of the health clinics her and her partner attended. Shelia mentions the legality of her partner being able to be present in the fertility process; more on this will be discussed in the *going back into the closet* subcategory.

Marilyn encountered systemic heterosexism as a result of a healthcare documenting system that did not accommodate her as next of kin for her partner:

The pressure I felt to kind of be nice, because I wanted to get the paperwork done because [Partner] needed treatment... I was having to much around with the clerk and the forms and I think there was just no, I think the problem was probably, like maybe to do with the clerk, but also the system just did not have a category to put me into, as her next of kin.

For Marilyn, trying to complete her partner's medical paperwork, within a heterosexist system, served as an obstacle in her efforts to support her partner who needed medical treatment. This obstacle arose through a medical documenting system that lacked inclusion for same-sex partners. Moreover, Marilyn mentions that despite being excluded by the medical paperwork, she felt the pressure to be nice to the clerk so that the necessary paperwork could be completed for the needed treatment for her partner. This highlights how queer women might be in situations in which they are unable to call attention to the systemic lack of inclusivity and instead have to negotiate "playing nice" with healthcare providers in order to receive necessary care, all while experiencing discrimination. Experiences of systemic heterosexism impacts queer women's ability to receive equal healthcare treatment for themselves and for their partners. The current research supports Stevens' (1995) finding that the structure of healthcare delivery itself is rooted in heteronormativity resulting in lesbian women feeling marginalized by a lack of inclusion in written forms, health brochures and posters, advertisements, and reading materials in the waiting room.

Experiencing Heterosexism Interactionally

Queer women also experience heterosexism at the interactional level, which permeates the relational healthcare dynamics context and the sexual healthcare

interactions context. Healthcare providers perpetuation of heteronormativity, through enacting the heterosexist assumption, disenfranchises queer women and contributes to their experiences of marginalization. Identification of this subcategory supports the finding that discrimination and inequality are enacted through the negative attitudes healthcare providers have towards lesbian patients (McNair, 2003). The quotes within this subcategory demonstrate that negative healthcare provider attitudes can translate into discriminatory interactions with queer women. This can be seen in Marilyn's quote, "I've definitely had issues with people telling me that I couldn't possibly know that I'm a lesbian...and by people I mean doctors". Amy succinctly sums up her experience with interactional heterosexism, "I'm always read as straight monogamous by other healthcare providers which kind of bugs me." Rhonda's quote demonstrates not only the assumption of heterosexuality, but fixed heterosexuality; in other words, an assumption of a heterosexual sexual orientation as stable over time, "Male doctors say that 'of course I'll get married to a man and have kids'." For Amy and Rhonda, these experiences of interactional heterosexism impact their access to equitable healthcare as a result of the discounting of their queer sexual orientation and the privileging of heterosexuality.

Being Stereotyped

In their process of sexual healthcare seeking, queer women also experience discrimination as a result of stereotyping from healthcare providers' generalizations based on appearances and the female gender. Moreover, queer women experience intersections of stereotyping in which they face discrimination on multiple levels. This human rights constraint occurs at both the relational healthcare dynamics and the sexual healthcare interactions levels. Stephanie's quote demonstrates her experience of being stereotyped as either straight or gay based on the length of her hair, "Now that my hair is long, people [healthcare providers] assume that I'm straight... when I had short hair, everyone thought I was gay." For Rhonda, her experience of being stereotyped is grounded in an assumption of what it means to be a woman:

I said 'Look, I don't want to be taking birth control pills anymore. I want a hysterectomy.'...And he [male doctor] said 'No. You're going to have a couple kids and come back when you're thirty five.' And I said

'I'm not going to have kids. I will never have kids.' And he says 'Ach, you will. Trust me, all women have kids.'

Through the gender stereotype that all women are going to have children, Rhonda's doctor conveys his belief that women will perform within the normative social roles as mothers. Even when Rhonda refutes this stereotypical claim, her doctor insists that she will abide by the traditional social role as a woman to want children and to become a mother. Experiences of discrimination through stereotyping mitigate queer women's experiences of equitable healthcare at both the general interactional level and more specifically at the sexual healthcare interactional level. This subcategory supports Stevens' (1994) finding that "instantaneous assumptions", whereby healthcare providers employ unexamined prejudicial stereotypes, alienate lesbian women through a constant state of stress.

Experiencing Weight-Related Stigma

Queer women also encounter discrimination in the relational healthcare dynamic context through experiences of weight-related stigma. According to previous research, obese women are both held accountable for their weight and rejected on account of their weight (Rothblum, 1992). Rothblum (1992) argues that obese women should be recognized as an oppressed minority group. This past research, along with the numerous experiences of queer women in this study encountering weight-related stigma, supported the identification of this subcategory. Healthcare providers disrespect queer women through their insensitive weight-loss recommendations, despite the fact that queer women are seeking healthcare that is not weight related. This is evidenced by Marilyn's quote:

Having gone along with the cult of 'must be thin, not matter what your body type', that makes women stay away from medical care too, too often. You're told "Oh, well if you weren't fat."...I remember the time I dropped a blender on my toe and broke it. And the doctor went on about how I shouldn't be fat. You know, and I was like in agony from my broken toe. Talk about inappropriate...

It appears as though some healthcare providers may be quick to make recommendations for queer women to lose weight, even for Shelia in her first appointment:

I remember going to this clinic near my house, just like a walk-in clinic, and I had this other doctor, who basically I mean, I'm a bulimic kid, I was pretty sporty but I wasn't overweight by any stretch. He said to me "You're overweight." And I was like fifteen, sixteen and I know, was maybe a hundred and twenty five pounds or something. You know, like I've always been, I've never been scrawny, but I've always played lots of sports.

Shelia's description of her teenage self struggling with bulimia and encountering a snap judgment from a healthcare provider of being overweight demonstrates an experience of weight-related stigma with potentially dangerous implications. The implications of the doctors' insensitive comment could have added more pressure to Shelia, who was already struggling with disordered eating behaviours. Alice notes, "A lot of people say 'lose weight', they always tell you to lose weight...I went to the doctor...they said...'try to lose weight'". This quote demonstrates that healthcare providers who advise their patients to lose weight may echo societal ideals of weight loss. Experiences of weight-related stigma negatively impact queer women's access to equitable healthcare as a result of the shaming imposed on them by healthcare providers.

Intersecting Privilege and Oppression

Queer women appear to be cognizant of their positionality in terms of their experiences of privileges and oppressions and the intersectionality of privilege and oppression. The intersectionality of privilege and oppression highlights the complexity of identity and is a reminder to attend to the multiple identities, such as racial identities, embodied by individuals (Young & Meyer, 2005). The recognition of participants' various sources of power and lack of influence demonstrates insight into how queer women may both experience and navigate interactions with healthcare providers within the relational healthcare dynamic context. Queer women's recognition and use of their places of privilege may contribute to their healthcare seeking behaviours, whereas queer women's acknowledgement and experiences of oppression may constrain their healthcare seeking efforts. Jordan recognizes her privilege as being "within the norm" of gender:

I think my experiences with health care would definitely be affected by the fact that I am still within the boundaries of gender. Even though I am on the masculine side, I am not into the transgendered realm, and I think transgendered people have it absolutely the hardest... the fact that I am still within the norm definitely helps.

For Jordan, her gender normativity contributes to her ability to receive access to equitable healthcare. She recognizes that transgender individuals do not have this privilege and therefore may experience further constraints on their human rights when seeking healthcare. Rhonda recognizes her privilege as a white person, "I just go with white, you know, privileged white person". And Shelia acknowledges her privilege associated with socioeconomic status and education, "I certainly am like, you know, sort of a middle class, even a slightly upper middle class lesbian but professional and privileged in the sense that I'm educated". I have power in my position". Marilyn speaks of her lack of privilege related to growing up and identifying as working class:

Lack of privilege, yeah. Yeah. Ah, I grew up working class, and um, identify still as a working class woman, with pride. And it's interesting, cause my partner grew up working class too, and although she didn't have the level of poverty we had in my family.

For Marilyn, her experience of childhood poverty and identification as working class may serve as barriers to accessing equitable healthcare. Marilyn speaks about her pride associated with growing up in a working class family and identifying as a working class woman. This provides further support for the complexity of identity in terms of intersecting privilege and oppression. Although Marilyn experienced poverty as a child and thus inherently experienced a lack of opportunities due to financial constraints, she was proud of her working class background.

Going Back Into the Closet

Aside from queer women's recognition of various forms of privilege in their efforts to gain rights in their access for healthcare, one participant presented herself as involved in a heterosexual relationship as a tactic to receive equitable healthcare. For Shelia, "going back into the closet" and pretending she was heterosexual meant that her and her partner could gain access to the fertility treatment they needed to conceive. Shelia's enactment of a heterosexual relationship with her and her partner's sperm

donor fragmented the experience of conceiving as a couple because her partner had to be left out of the fertility process. Enactment of heterosexuality was necessary in order to gain access for Shelia and her partner to have a child in the way that they wanted to.

So, me and the sperm donor, had to present, and this is where it's anonymous, had to present at another clinic, anonymously, as a married couple, not as a married couple but as a heterosexual couple, to get served. So that whole experience, my partner wasn't able to come to any of that. I had to do it on my own or he would come with me, because you have to pretend that you're together otherwise we couldn't get his sperm. So we had to present as a heterosexual couple with fertility problems to be able to utilize their services...So going to the clinic, so the sperm donor and I presented as a heterosexual couple which has its own hilarious stories, cause I think they asked me when his birthday is and I wouldn't remember. Kind of, I mean, they're like what kind of law does he practice and I'm like "Fuck, I don't know". Corporate?...I had to fake it, actually showing up with this, you know, him and I go into this meeting with the doctor and be like "Hey honey".

Shelia's quote demonstrates a healthcare experience in which she was only able to receive fertility treatment by pretending she was heterosexual thereby compromising her sexual identity and her relationship with her partner. Reading Shelia's description of the barriers and lack of inclusion her and her partner faced in their process of conceiving prompted a thorough investigation of the fertility laws in Canada and clinic policies associated with same-sex partners presenting with a known sperm donor. Despite all of the legislation pertaining to sperm donation, surrogacy, and co-parenting, federal and provincial law does not directly address the issue of a same-sex couple presenting at a clinic with a known sperm donor for fertility treatment. The B.C. Family Law Act specifies the definition of a "donor" but the law focuses on parentage, not conception (Family Law Act, 2011). The Assisted Human Reproduction Act, which is recognized by the Parliament of Canada stipulates that "persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status (Assisted Human Reproduction Act, 2004). Shelia's description of the discriminatory barriers she faced during her and her partner's process of gaining fertility treatment did not seem congruent with the illegality of such discrimination based on sexual orientation. Communication with Dr. Michelle Walks, a queer feminist and medical anthropologist whose research focuses on queer

reproduction, provided valuable insight. Dr. Walks explained that although there is no law against using the sperm of a known donor, there are clinic policies on the use of “fresh” sperm. According to Dr. Walks, “clinics have chosen to legally protect themselves from the accidental infecting of clients with HIV and other infections found in fresh samples, by saying that they either need to test and freeze the sample for use 6 months down the road (if clean), or by avoiding use of fresh donation except with legally married or cis-heterosexual partnered couples (M. Walks, personal communication, September 24, 2015). Clinic policies reason that if heterosexual couples are already sexually active than they could not say they were infected via the clinic fertility treatment (M. Walks, personal communication, September 24, 2015). In sum, it appears as though Shelia and her partner encountered systemic barriers due to clinic policy in their efforts to seek fertility treatment, rather than discriminatory law. Shelia and her partner navigated clinic fertility policies by enacting heteronormativity in order to conceive in their preferred manner. In the current study, these systemic barriers are situated within the healthcare space context. Shelia’s confusion about the legality of seeking fertility treatment with a known sperm donor is warranted in light of the lack of legislation addressing this issue, as well as the seemingly biased clinic policies pertaining to fertility treatment. Enacting heteronormativity to gain rights actually demonstrates a constraint on human rights within the relational healthcare dynamics context.

Constraints on the right to equality of healthcare for queer women occur within each of the three contextual tiers: healthcare space, relational healthcare dynamics, and sexual healthcare interactions. Attention to discrimination by means of heterosexism, stereotyping, weight-related stigma, and experiences of oppression related to low socioeconomic status assist in a comprehensive understanding of the sexual healthcare seeking process.

This research contributes to existing research by providing both healthcare providers and queer women with recommendations for better healthcare experiences. The recommendations for healthcare providers center on providing more inclusive, knowledge-based, and holistic healthcare for queer women. The recommendations for queer women include approaches to obtain more equitable and quality healthcare within

each of the three-tiered situated contexts: healthcare space, relational healthcare dynamics, and sexual healthcare interactions.

4.1.5. Recommendations for Healthcare Providers

This category consists of subcategories endorsed by participants as recommendations for how healthcare providers can engage with queer women in an effort to deliver better and more equitable healthcare services. The recommendations include healthcare provider attitudes, such as being open and not making assumptions; healthcare provider knowledge, specifically healthcare providers increasing their knowledge about queer issues; healthcare providers treatment of queer patients, such as recognizing patient self-agency, respecting patients' partner(s) and considering complex identities, specifically cultural identities; and healthcare providers adopting inclusive and holistic approaches to healthcare. The majority of these recommendations apply to the relational healthcare dynamics context and the sexual healthcare interactions context, with the exception of the enacting inclusive health recommendation which applies to the healthcare space context.

Being Open

Fish and Bewley (2010) contend that health care practitioners committed to human rights principles have developed appropriate communication skills with lesbian and bisexual women. These communication skills include conveying attitudes of openness and acceptance, as well as non-pathologizing attitudes towards lesbian and bisexual women. The current study supports these findings with queer women's recommendation for healthcare providers to be more open. Brenda notes this recommendation especially within the context of sexual health, "[Healthcare providers] kind of have to be open. Like when you're dealing with people, especially when you have to deal with like everyone's genitalia and stuff." Alice further endorses this recommendation within the context of sexual health with her suggestion that healthcare providers "not be judgmental when [kinky sexual practices] come up...or be shocked." The current study extends on the findings from previous research by recommending that healthcare providers extend open and nonjudgmental attitudes towards sexual healthcare.

Not Making Assumptions

Healthcare providers are recommended to not make assumptions about patients' sexual orientation and be aware that not all patients are heterosexual (Bjorkman & Maletrud, 2009; Campbell, 2013). Participants in the current study endorse this recommendation, as well as the recommendations that healthcare providers recognize sexual and gender diversities and diverse sexual practices for queer women. Rhonda highlights the importance of recognizing diversity:

The second thing is to not assume that everyone is going to fit into your neat little boxes... You've got everyone from your gays and lesbians, your cross-dressers, you drag queens, your um, gender fluid people, your um, I don't know, your sparkly people. And if you fit into one of those boxes, great, good for you, that's wonderful but we don't all.

Shelia addresses the sexual diversity for lesbians as including histories of heterosexual sex. According to Bailey, Farquhar, Owen, and Whittaker (2003) lesbians have sexual histories that include sexual activity with men. Shelia speaks to this sexual diversity:

I think a lot of it, and this isn't, I don't know if this is so much my experience or just my general comment is lots of lesbians, you know, I guess including myself, although a rarity, have slept with men or do sleep with men. So when somebody says a lesbian, you know, I think that just has to be, I think you have to go beyond the label.

Becoming Knowledgeable About Queer Issues

This subcategory was one of the most significant in terms of the number of queer women who recommended that healthcare providers become more knowledgeable about queer issues. Bjorkman and Maletrud (2009) argue that in order for lesbians to obtain quality care, healthcare providers need to have specific knowledge of lesbian health issues. Furthermore, healthcare practitioners need to improve their knowledge of the sexual health needs of LGBTQ patients (Campbell, 2003). Queer women endorse the recommendation that healthcare providers become more knowledgeable about queer-related health issues. Alice recommends that healthcare providers "get education...sometimes you just don't want to have to explain. So being

educated on, um, the different ways people express their sexuality, or different issues they have.” For Alice, informed healthcare providers would relieve the burden as a patient to provide education. The current findings include the recommendation from two participants that better training and healthcare provider education will help healthcare providers become more knowledgeable about queer health issues. Jordan specifies where this healthcare provider education should begin, “the rules have to be introduced at the level of medical schools training, when basically the knowledge about sexual minorities is built into the curriculum...mandatory for every student to be exposed to.” Inclusion of lesbian and gay health issues into medical school education will benefit queer patients, as well as provide a basis for inclusion for lesbian and gay medical students (McNair, 2003).

Recognizing Patient Self-Agency

This subcategory identifies queer women’s recommendation for healthcare providers to recognize patient self-agency within the relational healthcare dynamics context. According to Anderson (1996), technological advances in healthcare have meant that patients are required to take a more active role in their healthcare management. This in turn has influenced the evolution of the patient-healthcare provider relationship; patients collaborate more now with healthcare providers than they once did (Anderson, 1996). Queer women recommend that healthcare providers work in partnership with their patients and recognize patient authority and capability in terms of their personal health. For Beth, recognition of patient self-agency is important, as well as the recognition that the appropriate healthcare support is needed from healthcare providers. Beth advises healthcare providers to “recognize queer folks as experts on their own health experiences but that obviously, who obviously need access to the resources and the knowledge of doctors and health practitioners.”

Respecting Patients’ Partner

In an effort for queer women to receive better healthcare, one participant recommends that healthcare providers respect their queer patients’ partners. Shelia recounts a meaningful experience in which she felt her partner was included:

I also think that for me, what I'd say is respecting your partner as part of your family has meant a lot to me in that moment. You know, like when somebody presents as 'This is my partner, my wife' or whatever. That's really important to acknowledge that and not just talk to the one person as if that person isn't there, but is there."

Queer patients may feel better supported both through the presence of their partner in the healthcare experience, as well as through the acceptance, inclusion, and respect of their partner from healthcare providers.

Considering Cultural Identities

Amy recommends that healthcare providers recognize complex identities including intersecting oppressions such as socially marginalized sexual identities and cultural identities. Amy addresses how the distribution of power in healthcare provider and queer patient relationships may be impacted by these complex and intersecting identities in her recommendation:

Being aware that people have complex identities and that they have health care needs and like for me, I have a cultural piece which makes it very hard for me when there's someone in authority to you know to contradict them and I think it's not just culture, but that's a piece and you if you're a health care provider know that a person might have that there, you know how you open up space for them to speak out if they need to.

For Amy, it is important that healthcare providers are aware of diverse patient identities in order to assess what their responsibility is to create a safe and open space for their patients who may feel disempowered. In the current study, this recommendation is directed towards the relational healthcare dynamics context, but it may also be applicable to the more specific, sexual healthcare interactions context.

Enacting Inclusive Health

The recommendation for healthcare providers to enact inclusive health is grounded in participant experiences of feeling marginalized as a result of systemic heterosexism. Previous research suggests that healthcare services are designed and distributed under the premise of heteronormativity (Stevens, 1995). The trickle down effect of systemic heterosexism means that queer patients encounter this bias when

interacting with healthcare providers and when completing medical forms. Jordan specifies the recommendation for inclusion within the context of sexual health, “questions about protection and STD’s not being gender based or sexual orientation based.” Jordan recommends healthcare providers adopt inclusive language so as not to further marginalize their queer patients. Amy extends this recommendation systemically to the healthcare space context:

I’d love to see changes in standardized forms. I hate the M F boxes, I hate them. And I feel, often it’s the very first thing you do and I feel like I really misrepresented myself with that first tick.

Amy addresses the detrimental impact of the heteronormative binary that can be demonstrated through medical forms that do not employ open-ended questions regarding gender identity. This is problematic for individuals who experience gender as more fluid and may identify with different aspects of gender at different times. This recommendation applies to the healthcare space context.

Taking a Holistic Approach

Two participants recommend that healthcare providers consider health more holistically and not just as a strategy to manage illness. This subcategory supports Miller, Rosga, & Satterthwaite’s (1995) suggestion that a human rights-based approach to health for lesbians should include recognition of a “whole person” analysis that includes both individual dynamics and social relations, as well as basic human needs. Brenda contends that, “[Healthcare providers] have to just not be looking at the problem but be looking at the whole person, and be looking at how it’s connected and how it affects the whole.”

4.1.6. Recommendations for Queer Women

Recommendations from previous research that addresses the discriminatory treatment of queer women focus on what healthcare providers can do in order to create safe and inclusive spaces for their patients. The current research supports these recommendations and also provides recommendations for queer women who are seeking equitable healthcare. This category includes four subcategories: feeling

confident and expecting to be treated well, assessing clinical experience, bringing an advocate to appointments, and building a community movement around health. These recommendations can be applied to all three situated contexts, but are most relevant to the relational healthcare dynamics context.

Feeling Confident and Expecting to be Treated Well

The majority of the study participants recommend that queer women approach interactions with healthcare providers with confidence and the expectation to be treated well. Jordan recommends that queer women “come with the assumption that you deserve the best medical treatment the[y] have to offer and you demand it, you will get it.” Marilyn echoes this expectation and contends that she expects “some effort will be made to help me feel more comfortable because I’m a lesbian.” Marilyn’s expectation for healthcare providers to provide extra support for her may help address the barriers she faces and the risk of inequitable treatment as a member of a socially marginalized sexuality group. Rhonda addresses the impact of sexism and how it may serve to silence women in interactions with healthcare providers:

Fuck the patriarchy...I think as young women, we’re taught to always defer, defer to expertise... if I were to give young lesbians advice, it would just be you know, stop thinking that other people know better than you. If you think you know what’s right for you, then you do it.

Rhonda encourages lesbian women to take control of their health by confidently conveying their opinions to healthcare providers. Rhonda may be suggesting that although healthcare providers are experts in their professions, women are experts of their bodies.

Assessing Clinical Experience

This recommendation encourages queer women to assess their experiences with healthcare providers and cautions queer women about the negative healthcare experiences they will encounter before finding a suitable healthcare provider. Stephanie outlines her recommendation for queer women to gauge their experiences with healthcare providers:

You might not have the best experience at first... you just gotta work with it... if it's a bad experience to the extent that you feel you should leave, do not be afraid to leave... if it's a bad experience to the extent that you think you can repair it by clarifying a couple of details, don't be afraid to do that as well.

This recommendation encourages queer women to take active roles as patients and also suggests that ruptures in patient-healthcare provider relationships have the potential to be repaired if queer women feel comfortable enough to be assertive with their healthcare providers.

Bringing an Advocate to Appointments

Two participants recommend that queer women bring someone with them, such as an advocate, to their appointments with healthcare providers. This recommendation would allow for queer women to have an ally alongside them. Shelia contends that:

A lot of people aren't comfortable. So if you can't go by yourself bring somebody else who will be your advocate – your friend, your family, whomever... you have a right to bring somebody in there with you, to ask the questions and to take the information down.

Shelia reminds queer women that they have the right to bring an advocate to their health appointments and that this might be helpful in terms of queer women obtaining the information they need. Beth notes that queer women will have to identify this avenue of support because it is “not something that a doctor is going to tell you to do”.

Building a Community Movement Around Health

This recommendation encourages queer women to mitigate sole responsibility and potential isolation in their experiences of healthcare by building a community movement around health. Beth suggests that queer women share their healthcare experiences with the queer community in order to receive support and practical advice. Beth recommends queer women:

Start with the community, like, the queer community. And start with everybody sort of contributing their experiences, like working with the experiences within the queer community. Like, what have people's positive experiences been? And why has that worked? Like is there a

good doctor around?...so build like a community movement around health.

By following Beth's recommendation for queer women to come together within the queer community to discuss their positive and negative healthcare experiences, queer women may be able avoid potentially negative experiences by seeking out queer-positive healthcare providers located within safe and inclusive healthcare spaces.

4.2. Chapter Summary

From the nine interview transcripts six main categories were identified, each containing subcategories that illuminated different aspects of the healthcare space, relational healthcare dynamics, sexual healthcare interactions, navigating human rights, and recommendations for healthcare providers and recommendations for queer women. Based on the findings, three of the categories were conceptualized as a situated contextual framework for understanding the process of queer women's interactions with healthcare providers when seeking sexual healthcare. The healthcare space, relational healthcare dynamics, and sexual healthcare interactions categories are presented as a three-tiered situated contextual framework in which the navigating human rights category permeates each of the contexts. The current study provides an understanding for queer women's interactions with healthcare providers within the context of sexual health as a process that begins with the healthcare space context and then proceeds to the relational healthcare dynamics context and then to the more specific sexual healthcare interactions context. Queer women navigate both access and barriers to their human rights, in terms of discrimination, (in)equality, and inclusiveness at each of the three contextual tiers. Queer women provide recommendations for healthcare providers and other queer women to enhance equitable, inclusive, and overall improved healthcare services for this socially marginalized sexuality group. The current study's findings of the barriers and facilitators to equitable healthcare services appear to be congruent with previous research on LGBTQ individuals' interactions with healthcare providers and extends these findings specifically to sexual healthcare interactions. Constructivist grounded theory, supplemented with situational mapping were useful in exploring this process and resulted in a framework for understanding queer women's interactions with

healthcare providers within the context of sexual health was identified. Moreover, recommendations for healthcare providers and queer women were provided in an effort to enhance queer women's interactions with healthcare providers.

Chapter 5.

Conclusion

The current study explored and provided an understanding of the process of queer women's interactions with healthcare providers within the context of sexual healthcare. This research is vitally important in light of the systemic erasure of queer women's sexual health prevalent in both academic research and clinical healthcare practice. Erasure of queer women's sexual health, coupled with prevailing heteronormativity translates into barriers for equitable sexual healthcare for queer women. Research shows that queer women's negative experiences interacting with healthcare providers who enact heterosexism and discrimination translates into delayed or avoided medical treatment (McNair, 2003). Thus the aim of the current study was to identify the barriers to and facilitators of equitable sexual healthcare for queer women. The concluding chapter of this thesis provides a summary of the current study, addresses the limitations and strengths of the methods employed to explore the research phenomenon, offers recommendations for future research, and discusses the practical implications of the study findings at both the systemic and interactional levels of healthcare delivery.

5.1. Study Summary

The current study employed constructivist grounded theory, supplemented with situational mapping, to explore the process of queer women's interactions with healthcare providers within the context of sexual healthcare. A human-rights framework allowed for the recognition of inequity issues, as well as instances of inclusivity, that are present when queer women seek sexual healthcare from healthcare providers. Through secondary data analysis, nine participant interviews were analyzed and ten situational maps were created, one for each participant and one amalgamated situational map

encompassing the major human, nonhuman, discursive, and interactional elements across all participants. From the coding and mapping procedures the core process of navigating human rights was identified as operating throughout three contexts: healthcare space, relational healthcare dynamics, and sexual healthcare interactions. Two additional categories were identified based directly on participant's recommendations to facilitate more competent and inclusive healthcare for queer women - recommendations for healthcare providers and recommendations for queer women. The current study developed a three-tiered interrelated contextual framework to gain a complex understanding of the process of queer women's interactions with healthcare providers within the context of sexual healthcare. The healthcare space, relational healthcare dynamics, and sexual healthcare interactions categories are understood as situated contexts; queer women's human rights, in terms of equitable and competent healthcare, are limited or supported in various ways at each contextual level. The findings from this study suggest that the process of queer women's efforts to seek sexual healthcare necessitates an understanding that the sexual healthcare interactions context is situated within the relational healthcare dynamics context, which itself is situated within the healthcare space context. Within this three-tiered situated contextual framework, these contexts are interrelated with one another and permeated in different ways by queer women's navigation of both access and barriers to equitable healthcare.

5.2. Limitations and Strengths

As with all research, the current study has both limitations and strengths. In this section, I will present these aspects of the research in relation to the use of secondary data analysis, trustworthiness, the human rights approach and focus on sexual health to the research, and researcher reflexivity.

5.2.1. Limitations

The current study involved secondary data analysis from Dr. Mary Bryson's primary study, which explored how queer women experience health and healthcare. Secondary data analysis limited certain aspects of the constructivist grounded theory method employed to analyze the interview transcripts from the primary study,. The

sample size of nine participants for the current study may be viewed as relatively small. Nine of the nineteen interview transcripts from the primary study's Vancouver sample of queer women met the inclusion criteria of the current secondary data analysis - discussions of interactions with healthcare providers within the context of sexual healthcare. This limitation extended to the grounded theory principles of theoretical sampling and theoretical saturation. Theoretical sampling, which involves simultaneous targeted data collection and data analysis is guided by theoretical saturation, which occurs when data no longer initiates fresh theoretical insights (Charmaz, 2006). Both theoretical sampling and theoretical saturation were limited by secondary data analysis. For example, there was only one participant who spoke of "going back in to the closet" in relation to seeking fertility treatment with her same-sex partner. Had the current study not been confined to secondary data analysis, there may have been the opportunity to collect more data focusing on this specific issue.

More generally, secondary data analysis limited the opportunity to ask participants more specific questions pertaining to their sexual health than were asked by the interviewers in the primary study. As such, queer women's discussions of interactions with healthcare providers within the context of sexual health may not have been to the level of detail had I conducted the interviews myself.

Finally, the trustworthiness provision of member checks, which contribute to the criterion of credibility, could not be carried out because of the limitation of secondary data analysis. Therefore, the emerging codes, categories, and overall processural understanding of queer women's efforts to seek sexual healthcare from healthcare providers were not verified with the participants from the primary study.

5.2.2. Strengths

The qualitative approach does not aim to identify generalizable truths about the phenomena being examined. Instead, the constructivist grounded theory method is designed to address how participants construct meanings while situating the studied phenomenon within embedded larger contexts (Charmaz, 2006). The supplemented situational mapping method aims to capture and discuss the complexities of the

research phenomenon and acknowledge interrelationships and variations (Clarke, 2003). Thus, one of the strengths of the current study is the complex and holistic understanding it offers of the process of queer women's interactions with healthcare providers within the context of sexual health. This study extended beyond the limited disclosure framework, which focuses on how queer women either reveal or hide their sexual orientation, and offers a processural understanding that recognizes the situated contexts wherein these interactions take place. Moreover, the current study discusses the interrelationships between these contexts while addressing how queer women navigate equity and inequity within each contextual level.

My review of the literature suggests that the current study is the only research to date that distinctively applies a human-rights framework to exploring the interactions with queer women within the specific context of sexual health. Previous research has explored these different aspects either individually or in combination at a more general level. For example Fish and Bewley (2010) used a human rights-based approach to examine how lesbian and bisexual women's health can be considered as a health inequity. Although this study may be seen as similar to the current study, the difference lies in the current study's specific focus on sexual health. This focus is warranted due to the on-going misunderstandings of queer women's sexual health, the lack of competent and equitable sexual healthcare that is delivered to queer women, and the weight of heteronormativity that is most potently apparent in the context of sexual health.

Engaging in reflexivity through memo-writing, consulting with my primary supervisor, Dr. Jordan, throughout the coding process, using active words for coding and categorizing, and reflecting on my own personal experiences seeking sexual healthcare as a sexually fluid woman, contributed to the overall trustworthiness of the current study. I acknowledged my assumptions and recorded my reactions to the data in order to identify my personal biases that may have impacted the analysis had I not taken these precautionary steps. For example, I was initially more attuned to recognizing constraints of queer women's human rights, such as inequity and inadequate sexual healthcare. Through engaging in reflexivity, I became aware of this bias and was sensitized to identify instances supporting queer women's human rights, such as healthcare provider

efforts of inclusion and acceptance. Reflexivity contributed to the credibility and dependability, and thus the overall trustworthiness, of the current study.

5.3. Recommendations for Future Research

Compared with the extensive research that has been conducted on the sexual health of men who have sex with men (MSM), relatively little has been published about the sexual health risks and STI prevalence among women who have sex with women (WSW) (Gorgos & Marrazzo, 2011). Thus, in order to combat the erasure of queer women's sexual health, future studies should focus on the sexual health behaviours, risks, and needs of queer women.

Furthermore, there needs to be additional research focusing on queer women's interactions with healthcare providers. For the most part, the research to date focusing on queer women's interactions with healthcare providers has been limited to the disclosure framework, which explores how queer women either reveal or hide their sexual orientation. Although disclosure is an important and recurrent aspect that queer women must navigate in their interactions with healthcare providers, as the current research shows, it does not tell the whole story. Future primary research focusing on the interactions between queer women and healthcare providers within the specific context of sexual health may extend upon the findings of the current study and contribute to a better understanding of this process. Primary research with this focus will address the current study's limitations with regards to the use of secondary data analysis.

Research conducted from human rights or social justice frameworks will contribute to a more in-depth understanding of the barriers and facilitators to equitable, inclusive, and competent sexual healthcare for this socially marginalized sexuality group. Additional research could build upon the categories identified in the current study in which queer women's human rights, such as equitable and competent sexual healthcare, are supported. This type of research could be used to inform inclusive sexual health practices amongst healthcare providers and thus mitigate the harmful impact of discriminatory and heterosexist sexual healthcare.

5.4. Implications of the Research

In addition to having implications for further research in this field, the findings from this study have implications for clinical practice and queer women's efforts to seek healthcare based on both the direct recommendations from the study participants and based on the data analyses. In line with the current study's processural understanding of queer women's interactions with healthcare providers within the context of sexual health, the findings from this study pose implications for healthcare delivery at the broader systemic level as well as the interactional level. The implications for clinical practice and queer women's health seeking behaviours identified in this section could improve queer women's experiences seeking sexual healthcare through the delivery of equitable and competent healthcare.

5.4.1. Implications Directly From Study Participants

Recommendations for Healthcare Providers

The recommendations queer women offered for the ways in which healthcare providers can enhance the healthcare experience and care of queer female patients have direct implications for clinical practice. The participants made explicit recommendations for healthcare provider attitudes, such as being open and not making assumptions. Stevens (1994) provides support for these attitudes with the finding that experiences of non-care were conveyed by healthcare providers who acted on instantaneous assumptions, which frequently portrayed prejudicial stereotypes. As such, healthcare providers should adopt open attitudes towards queer patients and challenge their assumptions, that may be rooted in stereotypes of the identities, behaviours, sexual practices, values, etc. of their queer patients in an effort to increase equitable and respectful healthcare

In terms of healthcare provider knowledge, study participants endorsed the recommendation that healthcare providers become more knowledgeable about queer issues. This recommendation included becoming knowledgeable about specific health risks of queer women, as well as gaining an understanding of the barriers and difficulties queer women face as members of a socially marginalized sexuality group. One

participant recommended that healthcare providers seek out health information that is produced by queer people, as well as participate in educational opportunities that related to queer health. This recommendation is supported by Bjorkman and Malterud's (2009) finding that medical knowledge pertaining to the specific health concerns of lesbian women is an essential aspect of healthcare providers' abilities. Thus, healthcare providers, and I would argue anyone who is interacting with queer women in the health and mental health fields, should seek out learning opportunities to become more knowledgeable about the specific issues faced by this population. For example, as I have done myself, healthcare providers could attend workshops delivered by local health authorities and non-profit organizations that offer queer competency training.

Queer women recommended that healthcare providers increase their equitable and respectful care of queer patients by recognizing patient self-agency, respecting the partners' of their patients, and considering complex identities. In terms of recognizing patient self-agency, one queer woman advised that healthcare providers acknowledge queer people as experts on their own health. This can be interpreted as redistributing the power in a relationship in which healthcare providers typically have authority over their patients. Based on this recommendation, it is important for healthcare providers to acknowledge the voices of their queer patients and allow for the communication of their concerns, feelings, and beliefs in an effort to make themselves known in the healthcare interaction. Respecting queer patients' partners is another explicit recommendation from one queer woman. Healthcare providers should acknowledge and include the partners of their patients in order to convey their acceptance and recognition that a patients' partner may be a vital support in the healthcare interaction. The recommendation for healthcare providers to consider the cultural identities of their queer patients speaks to the intersectionality of identities. Identifying as LGBTQ is one aspect of queer women's identities, and although it may be an important aspect, it should not be considered in isolation. Healthcare providers must consider the other aspects of queer women's identities, such as race, ethnicity, physical ability, education level, class or socioeconomic status, and gender identity, which may impact the barriers they face and influence their interactions with others.

The participant recommendations for healthcare providers to adopt both inclusive and holistic approaches to healthcare highlight the desire for equality, as well as the extension of healthcare beyond the aspects of health and illness. Inclusive health is enacted through the use of gender-neutral language and discussions of sexual health that are not grounded in assumptions of heterosexism. Holistic healthcare means considering the “whole person” and not just the degree of risk or pattern of illness. Healthcare providers must become aware of their queer patients in a way that conveys understanding of their health as one aspect of the many interrelated aspects of their lives.

Recommendations for Queer Women

Importantly, this study contributes to this field of research by providing recommendations for the ways in which queer women can enhance their equitable healthcare. Study participants provided explicit recommendations for queer women’s healthcare seeking behaviours. The most endorsed recommendation was for queer women to approach healthcare interactions with confidence and the expectation to be treated well. This recommendation suggests that queer women challenge the perception that they cannot receive equitable and competent healthcare because of their socially marginalized sexuality. Enacting confidence and the expectation that they will be treated well may contribute to enhancing their healthcare experience through the anticipation of this kind of treatment. Interestingly though, this recommendation seems somewhat paradoxical to how the study participants entered in to their interactions with healthcare providers. Through analysis of the interview transcripts, I identified that queer women were not necessarily confident themselves when interacting with healthcare providers, as demonstrated by their timidity, apprehension, vulnerability, and relative lack of power in the medical system. Although these qualities are somewhat expected given the weight of heteronormativity, the erasure of queer women’s sexual health, and the inequitable treatment of this socially marginalized sexuality group, it is interesting that queer women make this recommendation for their peers.

The recommendation for queer women to assess their clinical experience involves engaging in a decision-making process in relation to whether or not a negative healthcare interaction leads to termination of the relationship or provides an opportunity

to rebuild the relationship. Queer women warn other queer women that they will encounter numerous negative experiences interacting with healthcare providers and rather than being deterred by this, they recommend that queer women continue to seek healthcare from different healthcare providers until they encounter a positive experience.

Queer women recommend their counterparts to bring someone, such as an advocate, to their healthcare appointments in order to have an ally present. Based on systemic heteronormativity and the inequities experienced by queer women, bringing an advocate may serve to mitigate these barriers to equitable healthcare.

Finally, one queer woman builds upon the previous recommendation by advising queer women to reduce the isolation of their experiences seeking healthcare by sharing their experiences with the queer community. Developing a peer group for queer women, with a focus on healthcare experiences, would allow for both support and practical advice based on sharing personal experiences. In this way, queer women may be able to develop a network of support, as well as a list of resources including identifying local inclusive healthcare clinics and centres, as well as names of healthcare providers who communicate acceptance and knowledge about queer health issues.

5.4.2. Implications From Study Analyses

In addition to the implications for clinical healthcare practice and queer women's healthcare seeking efforts identified directly by the study participants, clinical healthcare practice implications at the systemic and interactional levels are provided based on data analyses. In line with the contextual framework presented in the current study for understanding queer women's efforts to seek sexual healthcare, the following two sections outline the implications from the research at two different but interrelated contextual levels. The first section addresses the research implications at the broader systemic level of healthcare policy and the following section addresses the implications for healthcare providers at the interactional level.

Systemic Level Healthcare Implications

The findings from the current study, congruent with existing literature (Stevens, 1995), suggest that healthcare systems and policies are structured through the prevailing normalizing of heterosexuality, thus perpetuating the invisibility of socially marginalized sexualities. This heterosexist structuring obstructs queer women's abilities to receive equitable and competent healthcare. The current study highlights systemic heterosexism through different levels of misinformation and confusion created by inattention to queer women's sexuality. Exclusive language used on medical forms, the lack of inclusion of queer women's partner's in healthcare interactions, and for one participant, fertility clinic policies that prohibit fertility treatment with a known sperm donor, all demonstrate heteronormativity at the systemic level. Study participants affirmed the invisibility of queer women in healthcare by discussing the lack of visual signs of inclusion such as posters that depict same-sex couples and educational resources that lack appropriate sexual health information for women who have sex with women. Moreover, healthcare-documenting systems must be upgraded with inclusion in mind so that same-sex partners can be listed as next of kin and the removal of gender pronouns so that queer women are not continuously marginalized.

Findings from the current study also shed light on the disruption of continuity of healthcare for queer women who attend walk-in clinics and interact with different healthcare providers, rather than having a regular healthcare practitioner. For the most part, queer women described their healthcare seeking efforts with different healthcare providers in walk-in clinics. Continually interacting with different healthcare providers may enhance their sense of safety and self-agency; alternatively, it may contribute to the stress and fear associated with disclosure. Furthermore, the lack of relationship building with one healthcare provider who can increase their health and personal knowledge of a regular patient, may mean that queer women are not receiving holistic healthcare. Re-evaluating healthcare systems that perpetuate inconsistent healthcare delivery and exploring options for more consistent healthcare may increase the equitable and competent healthcare, and specifically sexual healthcare of queer women.

Interactional Level Healthcare Implications

At the interactional level, healthcare providers must challenge their heterosexist assumptions and present attitudes of openness and inclusiveness in order to disrupt the perpetuation of discriminatory and marginalizing interactional patterns. The findings from the current study show that healthcare providers' heterosexual assumptions mitigate supportive and inclusive interactions with queer women. In terms of sexual healthcare delivery, healthcare providers can enact more inclusive language when gathering sexual history and sexual behaviour information. Healthcare providers are advised to use open-ended questions and adopt the counselling psychology tactic of using their patient's own words. For example, if a queer woman speaks of her relationship with her "partner", healthcare providers should not assume that she is referring to someone who identifies as male. Instead, healthcare providers can repeat this word until they are certain of the gender identity of their patients' partner. One of the study participants highlighted an easily adoptable inclusive sexual behaviour question that healthcare providers are encouraged to implement. Jordan relayed the sexual behaviour question she was asked by a healthcare provider – "Do you have sex mostly with women; mostly with men, or with both?". An open-ended question such as this demonstrates inclusivity and diversity by not imposing the heterosexual bias on queer women and by recognizing variable sexual practices, including sex with men. Another version of an inclusive sexual behaviour question that healthcare providers can adopt is – "What are the genders of your sexual partners?". Both of these questions disrupt heteronormativity and the gender binary and are trans inclusive.

The knowledge produced by this study could be used to inform workshops. These workshops could provide information on the interactional stances of inclusivity versus exclusivity. Practical information, such as how healthcare providers can engage their patients in discussions of sexual health in an inclusive, nonjudgmental, and non-discriminatory approach, could be provided. Furthermore, these workshops could serve as an opportunity to increase the visibility of queer women's sexual health and provide an open forum for healthcare providers to discuss their difficulties or the barriers they face when trying to engage in inclusive interactions with queer women. This knowledge could also be translated to mental healthcare providers, who could gain insight about how to incorporate inclusiveness in their interactions with queer clients.

The implications of this study's findings at the interactional level, in terms of adequate queer knowledge and strategies to promote inclusivity can be extended to counselling psychology practitioners as allied healthcare professionals. Queer women encountering barriers of heteronormativity in conjunction with experiences of discrimination during their sexual healthcare seeking efforts may experience increased stress as a result of marginalization. Furthermore, because of the stigma associated with non-heterosexual sexual identities, queer women may experience internalized homophobia and may subsequently experience feelings of guilt and shame. Counsellors should be aware of these experiences for queer women and consider providing psycho-education and support in relation to these oppressive and disempowering experiences. Incorporating feminist principles of analyzing sources of power and privilege in psychotherapy may be helpful in emphasizing how power inequities in women's lives contribute to presenting issues (Mahalik, Van Ormer, and Simi, 2012) of stress and shame. In this way, queer women may begin to recognize the external factors and societal norms that are contributing to their mental health concerns. Counselling psychology practitioners should be aware of not recreating the same power inequities in the therapeutic setting (Mahalik, Van Ormer, and Simi, 2012) that exist at the systemic healthcare level. Moreover, reading this study will help sensitize counselling psychology practitioners to the barriers to equitable healthcare that queer women face within the context of sexual health. With this knowledge, counsellors can help queer women recognize instances of disrespectful healthcare, which may help alleviate internalized self-blame and empower queer women to seek equitable sexual healthcare.

5.5. Conclusion

The current study aimed to gain a more complex understanding of the process of queer women's interactions with healthcare providers within the context of sexual healthcare. A human-rights framework was implemented to aid in the understanding of this process and identify both constraints on and enabling of equitable and competent healthcare. Constructivist grounded theory, supplemented with situational mapping, were employed to analyze nine participant transcripts. Through the data analysis process four main categories were identified: healthcare space, relational healthcare

dynamics, sexual healthcare interactions, and navigating human rights. Direct participant recommendations led to the identification of two categories: recommendations for healthcare providers and recommendations for queer women. The process of queer women's efforts to seek sexual healthcare was understood through a three-tiered situated contextual framework in which the healthcare space formed the broadest level and encompassed the relational healthcare dynamics context; the sexual healthcare interactions context was the inner most situated context. Thus, the current study proposes an understanding of queer women's interactions with healthcare providers as a process that involves interrelationships between the healthcare space context, the relational healthcare dynamics context, and finally the sexual healthcare interactions context. This study contributes to existing research by extending beyond the disclosure framework and exploring the interactions between queer women and healthcare providers; moreover, a focus on queer women's sexual health contests the invisibility of queer women's sexual health in academia and clinical practice. The findings from this research provide information on the barriers and facilitators to equitable and competent sexual healthcare for queer women.

References

- Anderson, H. (1996). A reflection on client-professional collaboration. *Families, Systems & Health, 14*(2), 193-206. doi:10.1037/h0089814
- Assisted human reproduction act, Section 8 (2004).
- Bailey, J. V., Farquhar, C., Owen, C., & Mangtani, P. (2004). Sexually transmitted infections in women who have sex with women. *Sexually Transmitted Infections, 80*(3), 244-246. doi:10.1136/sti.2003.007641
- Bailey, J., Farquhar, C., Owen, C., & Whittaker, D. (2003). Sexual behaviour of lesbians and bisexual women. *Sexually Transmitted Infections, 79*(2), 147-150. doi:10.1136/sti.79.2.147
- Barbara, A., Anderson, R., & Quandt, S. (2001). Experiences of lesbians in the health care environment. *Women & Health, 34*(1), 45-62. doi:10.1300/J013v34n01_04
- Barker, M., Iantaffi, A., & Camel, G. (2008). Kinky clients, kinky counselling? the challenges and potentials of BDSM. In L. Moon (Ed.), *Feeling queer or queer feelings?: Radical approaches to counselling sex, sexualities and gender* (). New York; London: Routledge.
- Barnes, H. (2012). Health needs of lesbians. *Primary Health Care, 22*(6), 28.
- Bauer, G. R., & Welles, S. L. (2001). Beyond assumptions of negligible risk: Sexually transmitted diseases and women who have sex with women. *American Journal of Public Health, 91*(8), 1282-1286. doi:10.2105/AJPH.91.8.1282
- Bjorkman, M., & Malterud, K. (2007). Being lesbian – does the doctor need to know?: A qualitative study about the significance of disclosure in general practice. *Scandinavian Journal of Primary Health Care, 25*(1), 58-62. doi:10.1080/02813430601086178
- Bjorkman, M., & Malterud, K. (2009). Lesbian women's experiences with health care: A qualitative study. *Scandinavian Journal of Primary Health Care, 27*(4), 238-243. doi:10.3109/02813430903226548

- Boehmer, U., & Case, P. (2004). Physicians don't ask, sometimes patients tell: Disclosure of sexual orientation among women with breast carcinoma. *Cancer*, 101(8), 1882-1889. doi:10.1002/cncr.20563
- Breslow, L. (1999). From disease prevention to health promotion. *Jama*, 281(11), 1030-1033. doi:10.1001/jama.281.11.1030
- Brogan, D., Frank, E., Elon, L., & O'Hanlan, K. A. (2001). Methodologic concerns in defining lesbian for health research. *Epidemiology*, 12(1), 109-113. doi:10.1097/00001648-200101000-00018
- Bryson, M. (2002). Me/no lesbian: The trouble with 'troubling lesbian identities'. *International Journal of Qualitative Studies in Education*, 15(3), 373-380. doi:10.1080/09518390210122872
- Campbell, S. (2013). Sexual health needs and the LGBT community. *Nursing Standard*, 27(32), 35.
- Certeau, M. D. (1988). *The practice of everyday life*. Berkeley, Calif; London: University of California Press.
- Charmaz, K. (2008). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (3rd ed.). Los Angeles: Sage Publications.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, Calif; London: Sage Publications.
- Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction*, 26(4), 553-576.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles: SAGE Publications.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The sage handbook of qualitative research* (4th ed.). Los Angeles, CA: Sage.
- Diamant, A., Wold, C., Spritzer, K., & Gelberg, L. (2000). Health behaviors, health status, and access to and use of health care - A population-based study of lesbian, bisexual, and heterosexual women. *Archives of Family Medicine*, 9(10), 1043-1051. doi:10.1001/archfami.9.10.1043
- Eliason, M. J., & Schope, R. (2001). Original research: Does "Don't ask don't tell" apply to health care? lesbian, gay, and bisexual people's disclosure to health care providers. *Journal of the Gay and Lesbian Medical Association*, 5(4), 125-134. doi:10.1023/A:1014257910462

- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129-136. doi:10.1126/science.847460
- Evans, A. L., Scally, A. J., Wellard, S. J., & Wilson, J. D. (2007). Prevalence of bacterial vaginosis in lesbians and heterosexual women in a community setting. *Sexually Transmitted Infections*, 83(6), 470-475. doi:10.1136/sti.2006.022277
- Family law act, Chapter 25 (2011).
- Fethers, K., Marks, C., Mindel, A., & Estcourt, C. (2000). Sexually transmitted infections and risk behaviours in women who have sex with women. *Sexually Transmitted Infections*, 76(5), 345-349. doi:10.1136/sti.76.5.345
- Fish, J., & Bewley, S. (2010). Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities. *Health & Social Care in the Community*, 18(4), 355-362. doi:10.1111/j.1365-2524.2009.00902.x
- Fish, J. (2006). *Heterosexism in health and social care*. New York; Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.
- Gamson, J. (2003). Sexualities, queer theory, and qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed.,). Thousand Oaks, Calif: Sage.
- Gamson, J. (1995). Must identity movements self-destruct? A queer dilemma. *Social Problems*, 42(3), 390-407. doi:10.1525/sp.1995.42.3.03x0104z
- Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research* Transaction Publishers.
- Gorgos, L. M., & Marrazzo, J. M. (2011). Sexually transmitted infections among women who have sex with women. *Clinical Infectious Diseases*, 53(suppl_3), S84-S91. doi:10.1093/cid/cir697
- Heaton, J. (2008). Secondary analysis of qualitative data: An overview. *Historical Social Research / Historische Sozialforschung*, 33(3 (125)), 33-45.
- Heck, J. E., Sell, R. L., & Gorin, S. S. (2006). Health care access among individuals involved in same-sex relationships. *American Journal of Public Health*, 96(6), 1111-1118. doi:10.2105/AJPH.2005.062661
- Henderson, H. J. (2009). *Why lesbians should be encouraged to have regular cervical screening*. Chirchester: Faculty of Sexual and Reproductive Healthcare. doi:10.1783/147118909787072315

- Hitchcock, J. M., & Wilson, H. S. (1992). Personal risking: Lesbian self-disclosure of sexual orientation to professional health care providers. *Nursing Research*, 41(3), 178-183. doi:10.1097/00006199-199205000-00010
- Hunt, Ruth & Fish, Julie. (2008). *Prescription for change: Lesbian and bisexual women's health check 2008*. ().
- Hunt, P., & Backman, G. (2008). Health systems and the right to the highest attainable standard of health. *Health and Human Rights*, 10(1), 81-92.
- Bailey, J. V., Kavanagh, J., Owen, C., McLean, K. A., & Skinner, C. J. (2000). Lesbians and cervical screening. *British Journal of General Practice*, 50(455), 481-482.
- Jairam, J., & Bauer, G. (2008). Are lesbians really women who have sex with women (WSW)? methodological concerns in measuring sexual orientation in health research. *Women & Health*, 48(4), 383. doi:10.1080/03630240802575120
- Kerker, B. D., Mostashari, F., & Thorpe, L. (2006). Health care access and utilization among women who have sex with women: Sexual behavior and identity. *Journal of Urban Health*, 83(5), 970-979. doi:10.1007/s11524-006-9096-8
- Kollman, K., & Waites, M. (2009). The global politics of lesbian, gay, bisexual and transgender human rights: An introduction. *Contemporary Politics*, 15(1), 1-17. doi:10.1080/13569770802674188
- Laumann, E.O., Gagnon, J.H., Michael, R.T., & Michaels, F. (1994). *The social organization of sexuality: Sexual practices in the united states*. Chicago: University of Chicago Press.
- Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning*, 15(3), 255-262. doi:10.1093/heapol/15.3.255
- Lewis, A. (2011). When three is not a crowd: The practice of polyamory. *Counselling Australia*, 11(1)
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, Calif: Sage Publications.
- Long-Sutehall, T., Sque, M., & Addington-Hall, J. (2011). Secondary analysis of qualitative data: A valuable method for exploring sensitive issues with an elusive population? *Journal of Research in Nursing*, 16(4), 335-344.
- Mahalik, J. R., Van Ormer, A. E., & Simi, N. L. (2012). Ethical issues in using self-disclosure in feminist therapy. *Research Gate*, 189. doi:10.1037/10343-009

- Marrazzo, J. M., Coffey, P., & Bingham, A. (2005). Sexual practices, risk perception and knowledge of sexually transmitted disease risk among lesbian and bisexual women. *Perspectives on Sexual and Reproductive Health*, 37(1), 6-12. doi:10.1111/j.1931-2393.2005.tb00035.x
- Marrazzo, J. M., Koutsky, L. A., Stine, K. L., Kuypers, J. M., Grubert, T. A., Galloway, D. A., Handsfield, H. H. (1998). Genital human papillomavirus infection in women who have sex with women. *The Journal of Infectious Diseases*, 178(6), 1604-1609. doi:10.1086/314494
- McNair, R. (2003). Lesbian health inequalities: A cultural minority issue for health professionals. *Medical Journal of Australia*, 178(12), 643-645.
- McNair, R. P. (2005). Risks and prevention of sexually transmissible infections among women who have sex with women. *Sexual Health*, 2, 209.
- McNair, R. P., Hegarty, K., & Taft, A. (2012). From silence to sensitivity: A new identity disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations. *Social Science & Medicine*, 75(1), 208-216. doi:10.1016/j.socscimed.2012.02.037
- Miller, A. M., & Rosga, A. (1995). Health, human rights and lesbian existence. *Health and Human Rights*, 1(4), 428-448.
- Mollon, L. (2012). The forgotten minorities: Health disparities of the lesbian, gay, bisexual, and transgendered communities. *Journal of Health Care for the Poor and Underserved*, 23(1), 1-6. doi:10.1353/hpu.2012.0009
- O'Flaherty, M. (2007). *The yogyakarta principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity*. Unpublished manuscript.
- Platzer, H., & James, T. (2000). Lesbians' experiences of healthcare. *Nursing Times Research*, 5(3), 194-202.
- QMUNITY. (2013). Queer terminology - from A to Q. Retrieved from http://qmunity.ca/wp-content/uploads/2015/03/Queer_Terminology_Web_Version__Sept_2013__Cover_and_pages_.pdf
- Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services*, 36(4), 651-677. doi:10.2190/3MW4-1EK3-DGRQ-2CRF
- Ripley, V. (2011). Promoting sexual health in women who have sex with women. *Nursing Standard (Royal College of Nursing (Great Britain)1987)*, 25(51), 41.

- Rothblum, E. D. (1992). The stigma of women's weight: Social and economic realities. *Feminism & Psychology, 2*(1), 61-73. doi:10.1177/0959353592021005
- Spade, D. (2011). *Normal life: Administrative violence, critical trans politics, and the limits of law*. Boston: South End Press.
- Steele, L., Timmouth, J., & Lu, A. (2006). Regular health care use by lesbians: A path analysis of predictive factors. *Family Practice, 23*(6), 631-636. doi:10.1093/fampra/cml030
- Stevens, P. E. (1994). Lesbians' health-related experiences of care and noncare. *Western Journal of Nursing Research, 16*(6), 639-659. doi:10.1177/019394599401600604
- Stevens, P. E. (1995). Structural and interpersonal impact of heterosexual assumptions on lesbian health care clients. *Nursing Research, 44*(1), 25-30. doi:10.1097/00006199-199501000-00006
- Tjepkema, M. (2008). Health care use among gay, lesbian and bisexual Canadians. *Health Reports, 19*(1), 53.
- Veenstra, G. (2011). Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health, 10*(1), 3-3. doi:10.1186/1475-9276-10-3
- Waites, M. (2009). Critique of 'sexual orientation' and 'gender identity' in human rights discourse: Global queer politics beyond the Yogyakarta principles. *Contemporary Politics, 15*(1), 137-156. doi:10.1080/13569770802709604
- Whiteside, M., Mills, J., & McCalman, J. (2012). Using secondary data for grounded theory analysis. *Australian Social Work, 65*(4), 504-516. doi:10.1080/0312407X.2011.645165
- Young, R. M., & Meyer, I. H. (2005). The trouble with "MSM" and "WSW": Erasure of the sexual-minority person in public health discourse. *American Journal of Public Health, 95*(7), 1144-1149. doi:10.2105/AJPH.2004.046714

Appendix A.

Primary Study: Recruitment Posters

LBTQ Women, Care Providers and Health Care: A Research Study

How do LBTQ women in Vancouver experience health care?
How do health care providers experience their work with queer
women?

Explore these and other questions in a research study titled:

*Health care practices and relationships: The experiences of queer
women and primary care providers*

If you:

**Are you an LBTQ woman who has accessed health services in
Vancouver**

Are 18 years old or over

Have lived in Vancouver at least 2 years...

We want to hear your story!

**We are seeking women to participate in a one-on-one interview
60-90 minutes long. If you may be interested, please contact us
for more information:**

**This research team is led by Dr. Lisa Goldberg, Dalhousie University, and funded by
CIHR.**

Dr. Mary Bryson

Director, Centre for Cross-Faculty Inquiry in Education

Appendix B.

Primary Study: Interview Consent Form

LBTQ Women

Title: Health care practices and relationships: The experiences of queer women and primary care providers

Introduction

You are invited to participate in an interview. This interview is one part of a research study examining how queer (lesbian, bisexual, transgender, queer – LBTQ) women in Vancouver and Halifax experience health care and how providers experience their work with queer women. Dr. Lisa Goldberg, a faculty member at Dalhousie University, is leading this study. Her work is supported by a research team. Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about the risks, inconvenience, or discomfort which you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with a member of the research team. Participation in the interview will take 60-90 minutes of your time.

Contact Information:

Dr. Mary Bryson
Director
Centre for Cross-Faculty Inquiry in Education

Purpose of the Study

The purpose of this study is to learn more about the health care experiences of queer women and their primary health care providers.

Study Design

In Vancouver, 20-25 LBTQ women, 15-20 nurses and 15-20 general practice physicians will participate in one-on-one interviews. Some of these participants may also choose to take part in focus groups (group interviews) later.

Who can Participate in the Study

Women who self-identify as lesbian, bisexual, transgender or queer and have accessed health care services in Vancouver can participate. You must have lived in Vancouver at least two years and must be 18 or over.

Who will be Conducting the Research

Dr. Lisa Goldberg, Principal Investigator, from Dalhousie University will lead this research project in Halifax. Co-Investigators Drs. Brenda Beagan, Dalhousie University; Mary Bryson, University of British Columbia; Cressida Heyes, University of Alberta; Susan Atkinson, Dalhousie Family Medicine; and a group of graduate student research assistants will be on the research team. If you agree to participate, you will be interviewed by Dr. Mary Bryson and Linda Dame, Graduate Research Assistant.

What you will be asked to do

You are being asked to take part in an interview. In the interview you will be asked questions about your health care experiences. This interview will be recorded and later typed up. The interview will take place at a time and location that is convenient for you. Below, you will be asked if anonymous quotes from this interview can be used in publications from the research study.

Confidentiality and Anonymity

Anonymity: Your name will not be used in anything that is written or presented about this research. The research team will not tell anyone your name. An identification number was assigned to you when you first contacted the research team about possible interest in the study. The one file that links your ID number and your name is kept in a locked drawer in the research team office at the university.

Confidentiality: The digital recording of your interview will be stored on the research team computer. It will be in a hidden file in the computer and will be password protected. The typed up version of your interview will also be stored on the computer, and password protected. Your name will not be in it, and anything that identifies you that you may say during the interview will be changed or taken out when your interview is typed up. All data collected during this study will be securely stored at Dalhousie University for five years after the last publication is complete. The research team will

keep everything you say private.

Your Rights

You can choose not to answer any question that is asked. You can take a break at any time. You can stop the interview at any time. At that time you can tell the interviewer if you want the recording of your interview erased, or if we can still use what you have said so far. You can receive a copy of the final report. You can ask research team members any questions you want to about the study.

Possible Risks and Discomforts

It may be uncomfortable, or even painful, talking about your experiences with health care, as an LGBTQ woman. Keep in mind that you do not have to talk about anything you do not want to.

Possible Benefits

The study will not help you directly, but it could provide a better understanding of the health experiences of queer women and their health care providers. This may contribute to developing best practice guidelines, educational curricula, and continuing education for primary care providers.

Compensation/Reimbursement

To reimburse any expenses and show respect for your time, you will be given an honorarium consisting of gift certificates for local stores or theatres totalling \$20.

Contact for concerns about the rights of research participants:

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at [REDACTED] or if long distance e-mail to [REDACTED]

I have read the consent form about this study. All my questions have been answered at this time and I agree to be part of this study. I know that I am free to stop being part of this study at any time. I have been given a copy of this signed consent form.

_____ I consent to having this interview recorded

_____ I consent to the research team including anonymous quotations from my

interview in publications and presentations from this study.

Participant's Signature

Date

Researcher's Signature

Date

_____ I would like to receive a summary of the final results of this study.

Contact information:

Appendix C.

Primary Study: Interview Guide

[This is intended to be a guide, rather than a script. The interviewer will follow participants' lead, exploring these general topics but not always in this order. Ideally the participant's narrative will unfold with fewer questions rather than more.]

1. Can you tell me about how you identify yourself, in terms of being 'queer'? (Probes: explore gender identity and sexual orientation)
2. What is your health like, overall? (Probe: chronic conditions, physical and mental health, reproductive/sexual health, etc)
3. Can you tell me about your experiences with health care providers? (Probes: who do you go to for health care? Why? How often and when? Explore preventative and acute care.)
4. Tell me about the last time you saw your family physician [or another provider mentioned]. If I were following you with a video camera, what kinds of things would I have recorded, visually and audibly? (Probe: try to get her to describe the taken-for-granted. Who is in the waiting room, what images are portrayed, how do staff address her, what routine questions is she asked about relationships and health practices, etc)
5. In terms of 'coming out' and what that has been like for you, can you talk a little about that in the context of your health care experiences? (Probes: how 'out' to your providers? How do/did you decide? How has this been received? In what ways is the 'coming out' experience ongoing? What emotions attach to this? For transgender women also ask about decisions concerning reassignment and hormone use; how they 'tapped into' appropriate health care.)
6. How, if at all, would you say the gender and sexuality of your health care provider affects your experience of health care? (Probe: do you seek out particular attributes in a provider? Why?)
7. Some (LBTQ) women find their health care practitioners are well-informed about relevant issues, some find they constantly have to educate health professionals. What has your experience been concerning this? (Probe: to what extent are issues beyond sexual health seen as relevant?)
8. To what extent would you say your understanding of 'family' has been respected in your health care experiences? (Probe: paperwork, labels used, rules about visitors etc) [For transgender women: To what extent would you say your gender identity has been respected in health care? (Probe: health care forms used, labels used by staff, other)]
9. Can you describe a really positive experience you have had with a health care provider? (Probe: what made it positive?) What about a really challenging experience?
10. In what ways do you think your experiences of health care might be different if you weren't (use her language for LBTQ)? How do you think other aspects of your self – your race, age, culture, class, education level etc – have affected your health care? (Probe: try to draw out privilege, too)
11. Can you talk a little about how being (use her language for LBTQ) affects your health or ill health, your overall well-being? (Probes: ask about nutrition and exercise; social, spiritual, mental, sexual, and physical health; lifestyle choices; substance use, etc. Have these things changed over time?)
12. If you had a chance to provide advice to health care professionals working with queer women, what kinds of things might you want them to know? If you could advise other women like yourself about health and health care, what might you say to them?
13. Is there anything else you would like to add?