

# “Automatic assumption of your gender, sexuality and sexual practices is also discrimination”: Exploring sexual healthcare experiences and recommendations among sexually and gender diverse persons in Arctic Canada

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## Abstract

Sexual and mental health disparities are reported in Arctic Canada as in other Arctic regions that experience shared challenges of insufficient healthcare resources, limited transportation, and a scarcity of healthcare research. Lesbian, gay, bisexual, transgender, and queer persons (LGBTQ+) report sexual and mental health disparities in comparison with their heterosexual and cisgender counterparts, and these disparities may be exacerbated in rural versus urban settings. Yet limited research has explored sexual healthcare experiences among LGBTQ+ persons in the Arctic who are at the juncture of Arctic and LGBTQ+ health disparities. We conducted a qualitative study from May 2015 to October 2015 with LGBTQ+ persons in the Northwest Territories, Canada that involved in-depth individual interviews with LGBTQ+ youth ( $n = 16$ ), LGBTQ+ adults ( $n = 21$ ), and key informants (e.g. coaches, teachers, nurses, social workers, and healthcare providers) ( $n = 14$ ). We conducted thematic analysis, a theoretically flexible approach that integrates deductive and inductive approaches, to identify and map themes in the data. Findings reveal geographical, social, and healthcare factors converge to shape healthcare access. Specifically, the interplay between heterosexism and cisnormativity, intersectional forms of stigma, and place limited LGBTQ+ persons' sexual healthcare access and produced negative experiences in sexual healthcare. Limited healthcare facilities in small communities resulted in confidentiality concerns. Heteronormativity and cisnormativity constrained the ability to access appropriate sexual healthcare. LGBTQ+ persons experienced LGBTQ+, HIV, and sexually transmitted infections stigma in healthcare. Participants also discussed healthcare provider recommendations to better serve LGBTQ+ persons: non-judgment, knowledge of LGBTQ+ health issues, and gender inclusivity. Findings can inform multi-level strategies to reduce intersecting stigma in communities and healthcare, transform healthcare education, and build LGBTQ+ persons' healthcare navigation skills.

## KEYWORDS

Arctic, healthcare experiences, healthcare preferences, intersectionality, LGBT, rural, stigma

## 1 | INTRODUCTION

Lesbian, gay, bisexual, transgender, queer, and other sexually and gender diverse persons (LGBTQ+), have poorer health outcomes than their heterosexual counterparts (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Jackson, Agénor, Johnson, Austin, & Kawachi, 2016; Marti-Pastor et al., 2018). Social and structural contexts shape health outcomes (Hatzenbuehler, Jun, Corliss, & Austin, 2014) and healthcare utilization among LGBTQ+ populations (Parkhurst, 2014). It is well established that stigma and discrimination contribute to LGBTQ+ persons' poorer mental health outcomes (Bostwick, Boyd, Hughes, West, & McCabe, 2014), such as elevated depression and suicide risks (Marsack & Stephenson, 2017; Sutter & Perrin, 2016), and sexual health disparities, including higher HIV (Government of Canada, 2016) and sexually transmitted infection (STI) rates (Logie, Navia, & Loutfy, 2015; Puckett, Newcomb, Garofalo, & Mustanski, 2017). These health disparities have also been reported among LGBTQ+ youth (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017). Meta-analytic findings suggest that the stress associated with LGBTQ+ stigma in rural places may contribute to depression and suicidal ideation (Marsack & Stephenson, 2017). Healthcare providers play a significant role in shaping access to and uptake of healthcare services among LGBTQ+ youth (Hoffman, Freeman, & Swann, 2009) and adults (Alencar Albuquerque et al., 2016). Improved health outcomes and quality of healthcare are linked with LGBTQ+ persons' disclosure of sexual and/or gender identities to healthcare providers (Coker, Austin, & Schuster, 2010).

LGBTQ+ persons' healthcare experiences are largely unexplored in the Arctic. The Arctic region, spanning eight countries with over four million residents, has geographical and cultural differences and similarities across its regions and people (Larsen & Fondahl, 2015). Insufficient healthcare resources, limited transportation, a scarcity of healthcare research, and historical and ongoing colonization of Indigenous peoples, are shared experiences not only across Arctic regions but also across other global regions (Allen, Levintova, & Mohatt, 2011; Law, Rink, Mulvad, & Koch, 2008). The Arctic region constitutes 40% of Canada's landmass with 200,000 residents (Government of Canada, 2018) and spans three territories (Yukon, Northwest Territories, Nunavut) as well as Nunavik (an autonomous part of the province of Quebec) and Nunatsiavut (an autonomous part of the province of Labrador and Newfoundland). Persons living in the Northwest Territories (NWT) experience sexual and mental health disparities, including chlamydia prevalence 10 times the national average, and suicide rates 11-fold the national average (Public Health Agency of Canada, 2015). There is an urgent need to understand LGBTQ+ persons' experiences and priorities in accessing

**What is known about this topic**

- There are sexual and mental health disparities in the Arctic region that spans eight countries with over 4 million residents.
- Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons report sexual health disparities: yet their sexual healthcare needs are underexplored in the Arctic.
- Intersectional stigma compromises LGBTQ+ persons' sexual healthcare access and outcomes.

**What this paper adds**

- Geographical, social, and healthcare factors converge to shape sexual healthcare access among LGBTQ+ persons in Arctic Canada.
- LGBTQ+ persons experience the intersection of LGBTQ+, HIV, and sexually transmitted infections stigma in healthcare.
- Healthcare providers can adopt non-judgmental and gender inclusive approaches and acquire knowledge of LGBTQ+ sexual health issues to better serve LGBTQ+ persons.

healthcare given that Arctic LGBTQ+ persons are at the nexus of LGBTQ+ and Arctic health disparities (Logie & Lys, 2015; Public Health Agency of Canada, 2015).

Limited research has explored the healthcare experiences, and needs, of LGBTQ+ persons living in Arctic Canada (Corosky & Blystad, 2016; Healey, 2016; Law et al., 2008; Logie et al., 2018). A study with young women in the NWT reported that they avoided accessing sexual healthcare services, including STI testing, because of fears of healthcare provider judgment and a lack of confidentiality (Lys & Reading, 2012). A study with community leaders and Inuit youth in Nunavut reported a lack of trust in healthcare providers, and these concerns were also discussed in relation to sexual and gender diversity (Corosky & Blystad, 2016).

Healthcare providers may hold biases towards LGBTQ+ persons and may not be educated on their needs (Coker et al., 2010; Sevelius, Patouhas, Keatley, & Johnson, 2014). A lack of healthcare provider competence with LGBTQ+ persons present barriers to healthcare access (Alencar Albuquerque et al., 2016; Coker et al., 2010; Ross et al., 2016; Sevelius et al., 2014), including for HIV and STI testing (Kaufman et al., 2007; Whitehead, Shaver, & Stephenson, 2016). This may be exacerbated in rural settings. A recent systematic review of predominantly U.S. studies found

that rural residency among LGBTQ+ persons was associated with: lower likelihood of disclosing sexual orientation/gender identity, healthcare access barriers, negative healthcare provider attitudes and treatment, and the perception that providers lack competence with LGBTQ+ issues (Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2016).

Barriers to accessing healthcare contribute to health disparities in the Arctic Canada generally (Corosky & Blystad, 2016; Lys & Reading, 2012) and among LGBTQ+ persons at large (Elliott et al., 2015; Hafeez et al., 2017; Jackson et al., 2016; Marti-Pastor et al., 2018). Studies that centre the perspectives, experiences, and priorities of LGBTQ+ persons regarding their healthcare are largely absent in Canada's Arctic. This study aims to fill knowledge gaps regarding the sexual healthcare experiences and recommendations of LGBTQ+ persons in the NWT, Canada (Jessen, Leston, Simons, & Rink, 2016; Logie & Lys, 2015).

## 2 | METHODS

This community-based research project was conducted in collaboration with an Indigenous youth sexual health agency in the NWT, in collaboration with a range of NWT youth, sexual health, and LGBTQ+ community agencies and programs. The NWT has a population of 44,000 persons with nearly half (46%) living in the capital city of Yellowknife. The NWT's population includes 50% Indigenous peoples (First Nations, Inuit, Métis), 44% of persons are white, and 5.5% are ethno-racial minorities. This qualitative study involved in-depth interviews with LGBTQ+ youth, LGBTQ+ adults, and key informants living in the NWT.

### 2.1 | Data collection

A purposive sample of participants were invited to participate by peer researchers and other LGBTQ+ identified persons living in the NWT; we specifically aimed to recruit participants who identified as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+), or other sexual and/or gender diversity, as well as key informants who had experience working with LGBTQ+ persons in various capacities (e.g. coaches, teachers, nurses, social workers, and healthcare providers). There may, however, exist be overlap between these identities, as many LGBTQ+ adult participants also had work experience with LGBTQ+ people. We aimed to recruit both LGBTQ+ youth (aged 15–24) and LGBTQ+ adults (aged 25 and over). Key informants were purposively selected by community collaborators due to their in-depth knowledge and experience working with LGBTQ+ persons across sectors (e.g. education, healthcare) and in many NWT communities, they thus added specialist knowledge of community attitudes in diverse settings (Payne & Payne, 2004). We also conducted snowball sampling by asking participants to share study information with their social networks, and venue-based sampling through LGBTQ+ and youth related agencies' communications. Participants were recruited via word of mouth, or information shared verbally or via email through community agencies (sexual

health, LGBTQ+ such as NWT Pride) and listserves. We conducted interviews from May 2015 to October 2015.

Interviews were conducted in a community agency or a location identified by the participant as a private space. Ethics approval was received from the University of Toronto and the Aurora Research Institute, NWT. All participants provided written consent to the PRA before participation. We followed ethical procedures to allow adolescents 15–17 to provide consent without mandating parental consent in line with: (a) community collaborator recommendations, (b) epidemiological data that show high rates of STI infection among young persons in the NWT, and (c) research recommendations that youth as young as 14 are capable of providing informed consent to participate in sexual health research, and requiring parent consent is inconsistent with inclusiveness and may silence youth voices (Flicker & Guta, 2008).

Peer research assistants (PRA) refer to persons with a shared lived experience with participants, often thought to reduce power imbalances in the research process (Roche, Guta, & Flicker, 2010). PRAs ( $n = 2$ ) on this study included LGBTQ+-identified young adults (between 20 and 24 years old) from the NWT, were trained in interviewing skills and signed confidentiality agreements. Interviews were 60–90 min, semi-structured and aimed to explore LGBTQ+ persons' experiences accessing healthcare, and preferences and recommendations for healthcare provision, in the NWT. Sample questions include: "Where do you seek sexual health care?"; "What's important to you in seeking sexual healthcare?" PRA (including MRZ) and Arctic sexual health experts (CLL, NM, KM) co-authors provided input into question development based on informing sexual health provision in the NWT, and evaluated the interview guide for content and face validity. Key informants were asked questions such as: "What is your experience working with LGBTQ+ persons? Can you describe sexual healthcare seeking experiences for LGBTQ+ persons in your community?"

### 2.2 | Analysis

All interviews were digitally recorded and transcribed by PRAs. Once transcripts were checked for accuracy they were uploaded to the qualitative data analysis software, NVivo 11. We used a thematic analysis approach to discern and classify emerging patterns within interview data that made use of both inductive and deductive analytic strategies (Attride-Stirling, 2001; Braun & Clarke, 2006). Integration of these analytic strategies allowed us to stay close to the data while also operationalizing a conceptual framework that considers how heterosexism, stigma, and place interface to shape LGBTQ+ persons' healthcare experiences. Our analysis involved a close reading of interview transcripts to develop an initial coding framework. Initial coding was undertaken by LD who developed a framework after coding one-third ( $n = 18$ ) of interview transcripts. NS further developed the coding framework and applied analytic codes to all transcripts ( $n = 51$ ). CHL conducted a third reading and coding across transcripts. Through an iterative process, the transcripts were re-read, coded, and re-organized as

	LGBTQ youth (n = 16)	LGBTQ adults (n = 21)	Key informants (n = 14)
Sexual identity			
Straight/heterosexual	–	–	14
Lesbian	3	4	–
Gay	4	6	–
Bisexual	3	6	–
Pansexual, queer, fluid, and other	6	5	–
Gender identity			
Cisgender woman	5	9	11
Cisgender man	3	8	3
Transgender spectrum (genderqueer, bigender, trans, genderless, gender questioning)	8	4	–
Race/ethnicity			
White	12	13	10
Indigenous	2	3	3
Racialized/Non-White	2	5	1

**TABLE 1** Socio-demographics of participants by group (by numbers, not percentages)

thematic categories were created and relationships between categories were identified. For instance, we identified initial codes of LGBTQ+ stigma, HIV stigma, and STI stigma, these codes were collated into a theme of healthcare stigma, that was then included in a larger thematic map of sexual healthcare barriers that also included heteronormativity and confidentiality concerns. PRA (MRZ) and Arctic sexual health expert (CLL, NM, KM) co-authors conducted member-checking and input into theme development.

### 3 | FINDINGS

#### 3.1 | Participant characteristics

Participants (n = 51) included LGBTQ+ youth aged 16–24 (Canadian Census categorizes youth as aged 15–24 (Gaudet, 2007)) (n = 16), LGBTQ+ adults aged 25 years and older (n = 21), and key informants (n = 14). Including these diverse participant groups enabled us to gain varied perspectives on the issues impacting LGBTQ+ persons' healthcare experiences. Participants lived across the NWT, including in Yellowknife (n = 31), Fort Smith (n = 10), Hay River (n = 6), Inuvik (n = 3), and Behchoko (n = 1). Table 1 illustrates how participants identified across a spectrum of sexual and gender identities.

Findings reveal how geographical, social, and healthcare factors converged to shape healthcare access among LGBTQ+ persons in the NWT. Limited healthcare facilities in small communities resulted in confidentiality concerns. Heteronormativity constrained the ability to access appropriate sexual healthcare. LGBTQ+ persons experienced stigma associated with LGBTQ+ identities, HIV, and STI-in healthcare. Participants also discussed recommendations for healthcare providers in the NWT to better serve LGBTQ+ persons:

non-judgment, knowledge of LGBTQ+ health issues, and gender inclusivity (Table 2).

#### 3.2 | Place and healthcare access

Two key aspects of place emerged as important in shaping healthcare access: physical access, and issues of confidentiality, anonymity, and privacy. Participants discussed geographical access, the limited number of health clinics, and long wait times as barriers to accessing sexual healthcare services:

Getting tested in the North isn't always the easiest, it's not super accessible, especially when you try to make a doctor's appointment but you can't get one for six weeks, which isn't always the case, but sometimes. There's no sexual health clinic, so you can't just drop in and get tested for anything. Youth K

Increasing ease of access to sexual healthcare was discussed by LGBTQ+ youth and adult participants. In some cases, participants also discussed having to travel out of province, "down south" (Youth V), to receive care. One trans participant (Adult P) discussed having to travel to a southern province to receive care during their gender transition:

I find that just the fact that I had to be flown to Edmonton for an assessment is pretty crazy. We should have professionals here that can help in one sense or another, like what if I needed immediate care? I'd be fucked. Luckily, I had good personal supports here so that wasn't an issue.

**TABLE 2** Overview of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) participant and key informant descriptions of sexual healthcare experiences and recommendations in the Northwest Territories

Illustrative quotations
Place and healthcare access
Physical access
"Location, location, location (laughs)! Our public health offices are out of the way. A lot of youth don't have an excuse to go across town to our industrial area to see public health to have a test administered." (Adult K)
Issues of confidentiality, anonymity, and privacy
"I know our medical staff are confidential and wouldn't say anything, but it's the kids trusting that that would be the case, they don't trust that." (Key Informant A)
Heterosexism and cisnormativity in sexual healthcare
(nurses and doctors should) "not assume that everybody who comes across as straight is straight, and that they might have different needs because they're not straight." (Key Informant C)
(my doctor) "totally just assumed I was sleeping with a man, which was really funny to me, because like, nope!" (Youth K)
Stigma in sexual healthcare
(transgender health is) "not something as healthcare providers that we're really caught up to. We don't really know the right language to use all the time, the right questions to ask and that would feel extremely discriminating against you if you were trying to access services for some reason and someone couldn't even identify what it is you needed to be there for." (Key Informant F)
"I do feel that just in the encounters I've had as a client of healthcare, that there seems to be a judgment or perception that since I identify as queer that I'm probably more promiscuous, I probably have more partners, I'm probably not practicing safe sex...". (Adult A)
Recommendations for sexual healthcare provision
Confidentiality and non-judgment
"The school nurse... she only comes once a week. If I have anything I want to talk to her about I just go to her and just ask her what's going on and talk to her about birth control. She's really good, she's really discreet and she's not a judgmental bitch, basically." (Youth N)
LGBTQ+ specific knowledge
(for LGBTQ+ persons accessing healthcare): "knowing that they're going to go in there and the person is going to be welcoming. That they're going to be made to feel that the way that they feel and their questions are valid. And that there's a wide variety of information available that's relevant to them." (Adult E)
Gender inclusive care
"I think a practitioner who makes sure they are educated in LGBTQ+ healthcare needs and someone who truly comes from a point of compassion and non-judgment, and asks those questions that can be missed, like not assuming someone's sexual orientation... [and] ask, "What pronoun do you prefer?" at the beginning of the appointment. And asking "Do you have sex with men, women, or both". That's a question that often gets forgotten and tends to get assumed, and I think it's quite rude to just assume." (Adult I)

Living in smaller communities often requires that community members interact with people they know when accessing sexual healthcare services. Key informant N explained that: "people are scared that people know. Your results go anywhere in the hospital, and people read them and then they come over for dinner to your house."

Difficulties in anonymously accessing sexual healthcare produced concerns about whether confidentiality would be maintained by healthcare providers. A LGBTQ+ youth explained that a central factor in accessing sexual health services is that "doctors have that confidentiality thing, so they won't go talking about my exploits to everyone I know" (Youth S). Privacy impacts how and when LGBTQ+ persons access services:

Knowing that their privacy is going to be respected, but I can't guarantee that it will. I know that legally it should, and it must, but I also know that I have become privy to information that I shouldn't have because someone was talking when they shouldn't have and not respecting their secrecy or privacy that they should have with their job (Adult C).

While participants expressed the fear of privacy violations, they rarely reported such instances.

### 3.3 | Heterosexism and cisnormativity in sexual healthcare

All participant groups discussed the pervasiveness of heterosexism and heteronormativity (assumptions and expectations of heterosexuality) (Rich, 2003) in healthcare settings as well as cisnormativity, referring to the assumptions and expectations that all persons are cisgender (non-transgender) and experience alignment between their physical sex and gender identity (Bauer et al., 2009).

Participants discussed how service providers assume that patients are heterosexual and cisgender. Adult A spoke about how these assumptions limit healthcare access and reflected on their own experiences as a youth:

Your doctor may assume that you're female, and say "okay let's talk about your sexual practices, do you sleep with a lot of men?" Just that automatic assumption of your gender, and the automatic assumption of your sexuality, and the automatic assumption of your sexual practices is also discrimination. It limits access to healthcare, and that affects health...when I was a young queer kid, and I felt like when I went to the doctor, my doctor was discriminating against me because of my sexual orientation, or gender identity, I would stop going to the doctor.

The above participant experiences illustrates how heterosexism and cisnormativity are perpetuated in healthcare settings in ways that present barriers to healthcare uptake. When heterosexist assumptions are made by healthcare providers it impacts the kind of care that patients receive. Adult I, who worked in a public health setting, discussed the experience of one of their patient's accessing STI testing from another healthcare provider:

I had a gentleman that I saw who identifies as gay... and he was going to his family doctor because he wanted to get testing done. His doctor kept talking about his female partners. He felt too uncomfortable to be like, "Well actually, I have sex with men." The assumption was already there. And then that could change the education and the teaching and testing that was provided.

Healthcare provider assumptions and treatment varied between LGBTQ+ persons. For instance, persons who identified as cisgender (cis) may be treated better than trans-identified participants, and gender-conformity may also play a role in shaping the experiences (and visibility) of sexually diverse persons:

At the end of the day, people are people and what might be safe for one person is not safe for another. What might be safe for a femme, lesbian cis woman, going to see a doctor and being totally cool and that doctor being fine might be completely different for someone like me who is noticeably not femme, not cisgender. (Youth H)

The above narrative highlights how "femme" lesbians may be perceived as gender conforming and in turn may experience safer healthcare spaces than those that are gender non-conforming, trans, and/or non-binary.

### 3.4 | Stigma in sexual healthcare

Stigma associated with LGBTQ+ identities as well as HIV and STI-emerged across all participant groups as a factor that shaped how and when LGBTQ+ persons accessed sexual healthcare. Stigma refers to the ways by which individuals, populations, and/or identities are devalued and lose status and power in social and institutionalized processes (Campbell & Deacon, 2006; Herek, 2002; Link & Phelan, 2001). Stigma is multi-dimensional, including *perceived stigma*, ways in which people expect and perceive rejection and devaluation; *enacted stigma*, including acts of mistreatment and violence (Herek, 2002, 2007, 2009); and *internalized stigma*, the ways persons experience shame and accept negative socio-cultural attitudes towards a group(s) to which they belong (Meyer, 2003). Stigma is intersectional: multiple social identities interact to produce distinct experiences of marginalization and opportunity (Logie, James, Tharao, & Loutfy, 2011).

Adult U highlighted how LGBTQ+ perceived stigma presents a barrier to healthcare access in the NWT:

They [LGBTQ+ people] are at a high risk because a lot of the time they don't want to seek healthcare services. They don't want to discuss or divulge to the healthcare provider their sexuality...they're scared that if they tell someone that it will get out to the community. I think it's the same aspect for everyone in small communities, but I think that because of that stigma that the queer community don't seek healthcare near as much as the rest of the population.

Participants discussed instances of experiencing enacted stigma within healthcare settings. Adult P recounted experiencing enacted stigma while seeking healthcare related to their gender transition process:

I'm looking at getting a hysterectomy, and so when I was talking to a doctor, [they] were like "oh [doctor's name] referred this". I said it so incredibly bluntly, "Why is he on there? He is not to have anything to do with my health whatsoever" because I had such a bad experience with him when it came to like, assessing. I had to get some sort of body assessment for my top surgery and he kept focusing on my breasts. It's like, "fuck off already, you're being fucking weird, you're making me feel like shit when this is supposed to be a really great experience for me" and couldn't wrap his brain around the fact that I was going to have the surgery.

Some participants discussed how when they do openly identify as LGBTQ+ in healthcare settings, assumptions, and stereotypes are made about their sexual practices and risks. Youth K discussed feeling judged by a nurse when accessing contraception, suggesting that reproductive health stigma is another barrier to navigate:

There's nothing worse than feeling judged by your healthcare provider...when I went to get a prescription for birth control, I had a male nurse practitioner, and I could totally be reading this wrong, but the way he said it, it was just like so much disdain. I just felt so weird, and then he left and my doctor came in and it was fine, but it just made me so uncomfortable. Here I am trying to be proactive, and I'm getting judged.

Participants also discussed the intersection of LGBTQ+ stigma with HIV and STI stigma. While some participants discussed HIV and STI stigma interchangeably, others articulated a distinction between HIV and STI stigma. HIV stigma was described as being exacerbated among LGBTQ+ youth. LGBTQ+ adult participants in particular offered that HIV stigma was related to the history of discrimination and

shame directed at gay and bisexual men. Adult F articulated how these stereotypes create HIV testing barriers:

I would not be surprised if LGBTQ+ people or gay or trans youth, going into a doctor's appointment feel like, instantly on edge about having to request that kind of thing [HIV testing]. There are not even ancient examples of how people blamed diseases on those groups...there is still a very reasonable fear of that kind of attitude because it has been very prevalent in our history.

HIV stigma may impact how LGBTQ+ youth access services, whereby some youth participants indicated that they would be more likely to seek out and receive STI testing than HIV testing. As Youth P revealed, they would be more likely to receive an STI test "cause like I know that they're [STIs are] curable, right? If you catch them early on? STI doesn't have a bad kind of stigma on it as much as HIV."

Shame and fear stemming from HIV and STI-related stigma were identified as barriers to testing. Adult E connected internalized stigma and feelings of shame to LGBTQ+ youth's sexual health services access: "the biggest barriers that I see are around feeling comfortable and feeling empowered to go and ask for these things. I think that they are available, but I think that it feels scary and shameful to go and get tested." Finding ways to provide non-judgmental HIV and STI testing services may reduce this stigma and in turn facilitate access. Adult A, also a healthcare provider, expressed that it goes a long way when "doing the STI testing or HIV testing, being really aware of language and not perpetuating that discrimination and stigma against those particular tests. Treating it like any other test and making sure people don't feel like you're judging them." These narratives suggest that LGBTQ+ stigma and HIV and STI stigma converge to shape healthcare experiences, and may contribute to fear and shame in accessing sexual healthcare.

### 3.5 | LGBTQ+ persons' recommendations for sexual healthcare provision

Three key recommendations for healthcare provision included non-judgment, LGBTQ+ specific knowledge, and gender inclusive services. First, non-judgment and comfort when working with LGBTQ+ persons were the most commonly described recommendations by LGBTQ+ youth. Youth A and L stressed the importance of healthcare providers behaving professionally and non-judgmentally in efforts to make patients comfortable. Youth Q also discussed the importance of healthcare providers who are non-judgmental and sex positive:

I would ideally like to see people who are not afraid or trained to talk to people about their sexual lives and not be afraid to or not judge- ...as somebody who's giving you or screening you for STIs, automatically you should be containing your own judgements. I think one reason why queer youth might not often go

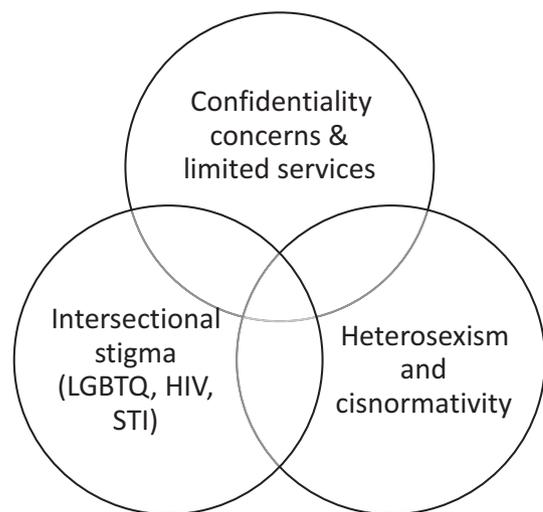
to sexual health clinics to get screened is that they are afraid that they will be too different or too weird or that people will kind of judge them.

Healthcare providers' knowledge of LGBTQ+ specific health issues was a salient factor in building trust, confidence, and enhancing healthcare access. Youth N described that it was important that:

Whoever I'm seeing is knowledgeable and can answer questions and stuff. Who knows what they're doing, basically, is a big thing for me, because if they don't know what they're doing I'm not going to be put at ease. And who has done it before, who has helped different types of people.

Others discussed wanting to feel that there is LGBT+ relevant health information available. Knowing in advance if healthcare providers were knowledgeable about LGBTQ+ issues emerged as important in making the healthcare decisions:

Let's say I'm a young lesbian questioning and who is looking at becoming sexually active, am I going to go to Public Health if I have questions if I don't know that they're LGBTQ+ friendly? How comfortable are they going to be going to a place where they're not sure how it's going to be reacted to? If they're just coming out and they have questions and it's like, well how do you protect yourself, as a lesbian, from sexually transmitted diseases? And what are the concerns that would be different than if you were with somebody of the opposite gender? I think that knowing that they could have somebody that they could talk to that would support them in their questions, it would



**FIGURE 1** Conceptual framework of the juncture of place, heterosexism and cisnormativity, and intersectional stigma experienced by lesbian, gay, bisexual, transgender, and queer persons accessing sexual healthcare in the NWT, Canada

probably make it easier for them than just going to a place not knowing even how it's going to be reacted to in the first place. (Adult J)

Gender inclusive services were recommended, including a focus on gender queer and non-binary persons' needs. One recommendation (Adult A) was for intake forms to move beyond gender binaries and allow for self-identification:

It would be cool if you could ask youth, and not in an invasive way, like "This is a questionnaire we give everyone who comes to the hospital, because we do admissions on everyone, could you describe your gender" or "how would you describe your sexual identity or orientation?" You know, if a kid doesn't want to answer that, they don't want to answer that, but for a youth who is maybe experiencing those things, and that could be contributing to some of their mental or emotional wellbeing being because they haven't been asked that before, or haven't had a chance to express that...

The above narrative also highlights the positive mental health benefits of LGBTQ+ inclusive healthcare provision. Youth E discussed the importance of receiving sexual health information tailored for gender queer persons:

Someone who is sensitive to the fact that I am a gender queer human, and who would be knowledgeable if I'm like, "hey so like what about this thing?" or "what are my odds of this?", that they would be well versed in like, "lesbian sex" or woman on woman sex that they would be able to be like "this is high risk, this is low risk, and this is why there's a risk". That would be super cool frankly.

Providing gender inclusive care that offered persons the option to identify both sexual practices and gender pronouns was discussed as central to competent LGBTQ+ healthcare. Addressing healthcare providers' attitudes and knowledge gaps, in addition to producing healthcare systems that are sexually and gender inclusive could improve LGBTQ+ persons' healthcare experiences.

## 4 | DISCUSSION

This study's exploration of LGBTQ+ persons' experiences accessing healthcare in the NWT revealed interconnected dimensions of marginalization. The first dimension was place, that included both *geographical* issues of limited services, as well as *social* issues of confidentiality in small communities. These issues were interconnected: limited service availability reduced the options of accessing services that might be more confidential. The second dimension was heterosexism and cisnormativity, where participants discussed the ubiquitous assumptions that they were heterosexual and cisgender; these assumptions

converged with the perceived lack of confidentiality to render it difficult to disclose sexual/gender identities to healthcare providers who they (or their families) may know. Finally, intersectional stigma targeting LGBTQ+ identities, HIV and STIs presented a barrier to healthcare access. This stigma intersected with place, where participants feared accessing HIV/STI testing, and with heterosexism, where participants were afraid to disclose same sex sexual practices and in turn did not receive tailored care. A conceptual framework that integrates these analytic dimensions is illustrated in Figure 1.

The study findings corroborate prior research that highlights healthcare barriers for LGBTQ+ persons in general (Elliott et al., 2015; Logie, 2012), LGBTQ+ persons in rural areas and persons in Arctic Canada (Corosky & Blystad, 2016). For instance, researchers identified healthcare barriers among rural LGBTQ+ persons including stigma, limited healthcare provider knowledge, geographical challenges, and heterosexism (Rosenkrantz et al., 2016). Our findings build on this knowledge by highlighting the importance of considering intersectional stigma targeting LGBTQ+ identities as well as HIV and STI, and cisnormativity. Findings align with conceptualizations of space as socially produced and shaped by social relations and social structures (Hassan et al., 2018; Parker et al., 2017). Narratives of invisibility discussed by participants in this study corroborate the heterosexism and cisnormativity in healthcare reported in prior LGBTQ+ health research (Logie, 2014).

Findings can inform Arctic healthcare. Participants identified several actionable areas for healthcare providers to improve healthcare for LGBTQ+ persons: non-judgment, LGBTQ+ specific knowledge, and gender inclusivity. Prior work in Eastern Canada explored how LGBTQ+ persons' comfort in healthcare is connected with feelings of provider non-judgment and competence and suggested that healthcare providers and clients might navigate pathways through shared discomfort to improve their relationships (Harbin, Beagan, & Goldberg, 2012). Navigation through discomfort may be more plausible than seeking new healthcare providers in contexts—such as the NWT—with limited health resources. Others have underscored the need for healthcare providers to learn LGBTQ+ persons' health needs *and* to challenge heterosexism and cisnormativity in healthcare settings (Baker & Beagan, 2014). Institutionalized changes, such as LGBTQ+ affirmative intake forms, have the potential to improve LGBTQ+ healthcare in the NWT. At the organizational level, healthcare systems can enact changes such as implementing the Human Rights Campaign's Healthcare Equality Index to achieve a designation as "Leader in LGBT Healthcare Equality" (Eckstrand, Lunn, & Yehia, 2017; Rosa, Fullerton, & Keller, 2015). Participant narratives underscore an urgent need for access to gender affirming care as there are limited options in the territory.

There are several study limitations, including a lack of Indigenous and ethno-racial diversity within the participant sample, precluding an exploration of ethno-specific needs and experiences in healthcare. Study challenges recruiting Indigenous LGBTQ+ participants may reflect increased marginalization within LGBTQ+ spaces. Sample size did not permit an in-depth analysis of the unique needs between lesbians, gay men, bisexual men and women, and trans persons; future research could further explore these diversities to inform tailored healthcare.

Most participants lived in Yellowknife, the largest urban area of the NWT; the needs of more rural Arctic LGBTQ+ persons warrant further exploration. We focused on the NWT due to funding constraints; future research can explore LGBTQ+ persons' sexual healthcare experiences in other Arctic regions. The alignment between this study's findings and prior research with LGBTQ+ persons, however, supports the validity of findings. The study has several strengths: it is among the first Arctic studies to centre LGBTQ+ persons' voices regarding sexual healthcare experiences. The study also provides examples of healthcare provider-patient communication, filling a literature gap (Rosenkrantz et al., 2016). Finally, we heed the call for strength-based, solution-focused research with LGBTQ+ persons (Coker et al., 2010) by eliciting their sexual healthcare recommendations.

LGBTQ+ persons in the NWT experience the interplay between social norms where LGBTQ+ persons, HIV, and STI are stigmatized, with healthcare systems that expect and assume heterosexual/cis-gender identities. These experiences of marginalization are amplified in Arctic geographical spaces where people experience limited anonymity and healthcare choices. These findings can inform social ecological approaches (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013) to advance LGBTQ+ health: multi-level strategies can challenge community intersectional stigma, transform healthcare education to recognize and affirm LGBTQ+ identities, and build LGBTQ+ persons' healthcare navigation skills systems to advance health and rights.

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