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Lesbian, Gay, Bisexual, Trans and Queer + (LGBTQ+) Experiences while Accessing Healthcare and Social Services within Brantford/Brant County

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LESBIAN, GAY, BISEXUAL, TRANS AND QUEER + (LGBTQ+) EXPERIENCES WHILE ACCESSING HEALTHCARE AND SOCIAL SERVICES WITHIN BRANTFORD/BRANT COUNTY

BY

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Abstract

The purpose of the qualitative study was to better understand how Brantford/Brant County LGBTQ+ community members experience accessing healthcare and social services. Over one month I interviewed 8 LGBTQ+ community members and conducted a focus group with 4 Trans and Gender non-conforming individuals. An intersectional feminist and critical Trans politic analysis was used to understand how LGBTQ+ community members experience accessing care. The results reveal that LGBTQ+ community members experience structural violence through oppressive administrative practices. Specifically, heteronormative and homonormative behaviors and assumed heterosexuality and/or gender, which creates a climate where LGBTQ+ people do not feel safe seeking healthcare and/or social services and thus do not feel like they belong. In addition, using examples that participants shared this research problematizes a rights based approach and recommends a restructuring of the LGBTQ+ movement to be more inclusive to all LGBTQ+ community members.

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Acknowledgements

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CHAPTER 1: INTRODUCTION

Introduction

As a Queer community member and local activist, I come to this research with a
desire to learn about how members of the Brantford/Brant County LGBTQ+ community
experience accessing healthcare and social services and if they are being treated equitably
within those services. Access to healthcare and social services for LGBTQ+ populations
outside of large urban settings is a generally underexplored area of research (Harcourt,
2006) and much of the existing literature about the population relies on data from major
metropolitan settings (Bell & Valentine, 2005). According to Sears (2005), only a small
portion of the LGBTQ+ population actually has access to such spaces because of factors
such as geographic location, socioeconomic status, class, age, gender, and ability, for
example. Therefore, one might argue that the experiences of LGBTQ+ populations in
smaller communities is a needed area of research because these communities may be
isolated from dominant LGBTQ+ culture and political movements (Marple & Latchmore,
2005).

Because of the limitations of a human rights perspective which examines rights
but not necessarily the challenges in experiencing those rights, this research aims to dig
deeper into the actual experiences of the Brantford/Brant County LGBTQ+ population in
order to better understand how access to these services may or may not be positive. While
in Canada, LGBTQ+ populations have the right to access unbiased healthcare and social
services (Government of Canada: Justice Laws , 1982; Governemnt of Canada, 1985
(amended 2014); Ontario Human Rights Commission, 2011), the question remains as to
whether members of the LGBTQ+ communities are treated equitably. It is worth asking

about their experiences accessing these types of services. Obtaining information about how LGBTQ+ people currently experience these two systems in smaller communities will ideally contribute to improved inclusivity and services for members of the LGBTQ+ community in Brantford/Brant County, and in other similar communities.

Scope of the Problem and Rationale

In Canada, Lesbian and Gay rights as understood through the passing of legislation have been largely achieved and Trans rights are well on their way. Although marriage equality and hate crime laws have been in place for a number of years, LGBTQ+ populations still experience homophobia, biphobia, transphobia and inequalities at alarming rates, particularly in the form of structural violence enacted through oppressive administrative policies and procedures. The first empirical study to explore the needs of the LGBTQ+ population in Brantford/Brant County was undertaken (Wildman, 2014). The needs assessment survey (n=38) collected descriptive data related to age, sexual orientation, gender identity, ethnicity, socio-economic status, access to healthcare and social services, safety, and community. Just over half (58%) of respondents indicated feeling completely comfortable disclosing their sexual orientation or gender identity to their healthcare providers; 61% stated that they were unaware of their physician's knowledge or sensitivity around LGBTQ+ health needs; 55% stated feeling comfortable accessing social services (Wildman, 2014). These results highlight that nearly half of Brantford/Brant County's LGBTQ+ community members do not feel completely comfortable with accessing healthcare or social services. This is concerning because there is a large probability that the people who participated in the survey (self-

selecting) were well-connected and were not the most marginalized members of Brantford/Brant County's LGBTQ+ population. I say this because the survey was distributed at Brantford Pride celebrations, during peer led groups, at a community health centre, and at social service agencies, and therefore, it can be assumed that the survey reached a portion the LGBTQ+ population who are, to some degree, already connected to services and to the larger LGBTQ+ community. For those members of the LGBTQ+ community who are not as well-connected, it could be that a greater number may not feel completely comfortable.

Upon completing the previous quantitative research it became clear that a further qualitative study would be a significant asset, in terms of the Brantford/Brant County community and all smaller communities where LGBTQ+ research data does not exist. Obtaining qualitative data helps to move the local research beyond numbers, which provide numerical evidence with regards to whether or not people feel comfortable accessing healthcare and social services, to actually acquiring knowledge about the LGBTQ+ community's experiences of accessing healthcare and social services.

Theoretical Framework

This research is informed by theoretical frameworks that both complement one another and strengthen my understanding of LGBTQ+ access to healthcare and social services within Brantford/Brant County. Using an intersectional feminist lens combined with critical theory and a queer critical Trans politic allows the research to be examined through multiple lenses, which makes it possible to investigate the research topic from many different angles, seeing how intersections of marginality work together on a

structural level to create and maintain inequalities and to assess whether or not

Brantford/Brant County LGBTQ+ community members are experiencing intersecting

levels of structural violence.

CHAPTER 2: LITERATURE REVIEW

Introduction

There are a number of important areas of research pertinent to informing this study. The first area of scholarship that is examined is the research on LGBTQ+ communities and the importance of this research on a local level. Next, the research that explores heteronormativity, gender normativity and homonormativity is reviewed as it is relevant to providing a greater understanding of the structures in the world and our institutions that operate to keep the majority of the LGBTQ+ community marginalized. Lack of access to healthcare and social services, and lack of belonging are investigated in order to determine why these experiences are in fact a reality for many LGBTQ+ people. The next section explores patriarchy and the role it plays in creating and maintaining inequalities. Rights and their limitations are investigated to establish the rights that exist and what their shortcomings are, particularly because rights are often equated with the achievement of equality. Finally, mircoaggressions are explored to establish how they operate on a systemic level to covertly discriminate against LGBTQ+ populations. All these themes are being explored because they work together to create and maintain inequalities experienced by the LGBTQ+ population.

LGBTQ+ Communities and Culture

There is no way to get an accurate account of the size of the LGBTQ+ population in Canada, but it has been estimated in Canada and the United States that 1.7-10 percent of the population falls somewhere on the LGBTQ+ spectrum (Statisics Canada, 2015;

Peterkin & Risdon, 2003, p. 4; Kinsey, 1948). However, there are a significant number of challenges in estimating the size of the LGBTQ+ population including the fact that people would have to feel comfortable and safe disclosing information about their sexual orientation or gender identity. Furthermore, surveys that are often used to gather this data use varying definitions and survey methods, which have resulted in a wide range of estimates (Gates, 2011). Given this wide range of estimates, it means that in the province of Ontario there are up to 1.25 million LGBTQ+ people (Daley & MacDonnell, 2011).

Existing literature about LGBTQ+ populations is largely urban centered (Bell & Valentine, 1995; Baker 2011), focusing on cities such as Toronto, Montreal, and Vancouver where LGBTQ+ communities and culture have been built (Warner, 2002). The literature suggests that the LGBTQ+ movement has lost its roots and is now entrenched in the capitalist market, particularly, LGBTQ+ space (Sears, 2005; Drucker, 2015), which might be true in large urban settings where only a portion of the population lives or even has access to. This is not the case for LGBTQ+ people and space within smaller communities where commodified forms of LGBTQ+ culture do not exist. In smaller communities LGBTQ+ space must be taken up in different ways such as in the temporarily creating LGBTQ+ space within heteronormative space for the purposes of gathering and creating community, as seen in the works of other researchers (Gray, 2007; Marple & Latchmore, 2005; Morris, 2015; Marple L. , 2005). Warner (2002) suggests that LGBTQ+ space applies to any place that LGBTQ+ people gather in large numbers, and where they are able to determine what is acceptable behavior and what is not, rather than the dominant heterosexual society determining it for them. Furthermore, Marple (2005) suggests that it is difficult, from an urban perspective, to understand rural

LGBTQ+ spaces because in larger urban settings there is an obsession with being "out" as an LGBTQ+ space, which is linked to pride. Historically, the narrative of the rural LGBTQ+ person has been migration to the city, as a part of the "coming out" journey (Halberstam, 2003; Weston, 1998). Presumably this assumption that all LGBTQ+ people have access or even a desire to migrate to large cities aids in the lack of literature available about the population outside such places.

The over-focusing on LGBTQ+ populations in large cities means that people in smaller communities and rural settings are made invisible (Marple L. , 2005), and marginalized at another level, while also being isolated from urban LGBTQ+ culture (Marple & Latchmore, 2005). Therefore, using an estimate of 10%, for Brantford/Brant County it means that there are up to 12,900 LGBTQ+ people (Wildman, 2014) who may not have access to LGBTQ+ community and may anticipate and/or face barriers to accessing health programs and services (Daley & MacDonnell, 2011) as well as accessing social services such as counselling.

Heteronormativity and Gendernormativity

For LGBTQ+ populations, access to health care and social services is about more than geographic location or training individual service providers; it is about gender and space and how space is dominated by gender compliance and heteronormativity, or how heterosexuality and gender are normalized and naturalized through social actors, policy and institutional systems (Mule, et al., 2009). As Roth (2004) explains, gender itself is a social institution, which "permeates and organizes all aspects of social life, and in doing so organizes inequalities (p. 147). Gender and gender inequalities affect how the

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LGBTQ+ community access healthcare and social services, particularly those who do not perform gender in a way that is socially accepted.

Heteronormativity refers to the dominance or normalization of heterosexuality though institutional structures through which heterosexuality is privileged and heterosexuals learn to see, read and think straight (Pease, 2010; Berlant & Warner, 1998). Heteronormativity operates through our everyday lives and governs both gender and sexuality (Martin, 2009), but we are not born thinking heterosexuality is normative, nor are we born able to choose our gender because it is constructed rather than naturally occurring. It has been argued that gender is learned and upheld through repetitious acts. For example, Butler (1992) argues that "gender is an impersonation . . . becoming gendered involves impersonating an ideal that nobody actually inhabits" (p.85). In the same article, she makes an important distinction stating that although gender is performed, it is not chosen, and people are trapped in the repetition of oppressive and painful gender norms" (Butler, 1992, pp. 83-84).

Heterosexuality and gendernormativity are reproduced by the structural institutions that created them in the first place. While children learn norms first from their parents, those norms were enforced and continue to be enforced upon them by structural institutions throughout their lives. Ultimately, the creation and circulation of heteronormative and gendernormative values, such as heterosexuality and gender compliance are enforced and maintained through heteronormative and gendernormative people and systems which create conditions of exploitation, violence, and poverty through the othering of LGBTQ+ populations on the grounds of protecting the dominant from "others" (Spade, 2015). The term gender compliance is used to say that gender is enforced through the same or similar

social actors and systems of power that heterosexuality is. Gender compliance is about performing gender in a way that is based on an individual's assigned gender at birth and that which is deemed socially acceptable. Similarly to notions about heterosexuality, people learn to perform gender from their parents, neighbors, friends, social institutions through what is deemed appropriate or not, through being policed and accepted or ostracized (Pascoe, 2007; Spade, 2015). People learn what is deemed to be normal and what is not and often act accordingly. It is important to note that norms are not rules, but rather, subtleties in the way that the dominant group behaves, which makes assumptions about how everyone else should behave or how they should be. Norms "achieve the overall purpose of producing security for some populations and vulnerability for others" (Spade, 2015, p. 5) and thus create marginalization. These enforced norms are maintained through power, which Foucault explains, exist in all relations (Foucault, 1978). If power is understood as something that does not stem from any one person or thing, but rather as something that is constantly being exercised from all points of any relationship (Foucault, 1978), then it is possible to understand how heteronormativity and gendernormativity are enforced through people, perhaps even unknowingly, and through social institutions and systems. For example an LGBTQ+ identified person may access a doctor or counsellor who is completely accepting and inclusive at one time and then have a completely different experience at the same organization at another time. This happens because norms are inconsistently applied (Spade, 2015).

Homonormativity

Homonormativity refers to the normalization of a select group of LGBTQ+ people, namely white wealthy Gay and Lesbian people. Drawing on the work of Duggan (2002), Drucker states that "if heteronormativity is the institutionalization of heterosexuality through the implicit assumption that people are straight unless otherwise labelled, homonormativity is a mindset that does not "contest dominant heteronormative assumptions and institutions but upholds and sustains them" (Drucker, 2015, p. 20). In later work, Duggan (2003) added a very important distinction, stating that heteronormativity and homonormativity do not amount to the same thing in society because there is no structure for LGBTQ+ life. In other words a Gay or Lesbian person who marries, buys a house, and maybe has children can now be deemed as 'normal' because they can fit within heteronormative ideals, which makes them homonormative. Where LGBTQ+ people were all once deemed 'abnormal or deviant', a divide within the population has been created through the normalization of some, which inevitably further marginalizes many. Further, homonormativity demobilizes the LGBTQ+ movement because those who experience the least marginalization, such as white wealthy cisgender gay people, become complacent and happy just to fit into what is deemed as 'normal society'. However, they also tend to have the most access to power and resources and their complacency privatizes and depoliticizes the movement (Drucker, 2015). Sears (2005) points out that the significant demobilization of the movement has left many LGBTQ+ people behind. He states that those who have benefited the most "are people living in committed couple relationships with good incomes and jobs, most often white and especially men" (Sears, 2005, p. 93). This is also the group that can most participate

in LGBTQ+ culture and spaces that have been carved out by the most wealthy members of the population (Sears, 2005), However, people who suffer multiple marginalizations such as poor people, racialized people, street youth, or those who are unable to escape small towns to access LGBTQ+ culture and spaces in big city capitalist markets, are less likely to find inclusive services and are left behind and out in the cold by the homonormative LGBTQ+ population (Sears, 2005). The leaving behind of some members of the LGBTQ+ population creates divides within population and often the oppressed becomes the oppressors by policing themselves and others LGBTQ+ people to comply with dominant norms (Frye, 2009).

Lack of Access

Access to healthcare and social services for LGBTQ+ populations outside of large urban settings, is a generally underexplored area of research (Harcourt, 2006). Much of the existing literature about the population is urban centered, relying on data collected from metropolitan settings (Bell & Valentine 1995). However, only a small portion of the LGBTQ+ population actually has access to such spaces because of factors such as geographic location, socioeconomic status, class, age, gender, and ability for example (Sears, 2005). Further, the experiences of LGBTQ+ populations in smaller communities are areas of research that are vital because it is in these communities where the population is isolated from dominant LGBTQ+ culture and political movements (Marple & Latchmore, 2005) that exist in large urban settings, or that we typically read, hear, and know about. There is strong evidence to show that the LGBTQ+ populations experience "significant health inequalities, with well-documented negative health impacts that

include increased risks for chronic disease and mental health concerns" (Daley &

MacDonnell, 2011). LGBTQ+ people face every day threats to their health and these

threats have been linked to the heterosexism, biphobia, and transphobia that are

embedded within all social institutions "and which contribute to social exclusion, stigma

and discriminatory dynamics, as well as invisibility and lack of health provider

knowledge and comfort" (Mayer, et al., 2008, p. 989). In a study conducted by Trans

Pulse, 10% Ontario's Trans population who had accessed medical care in their felt gender

had their care ended prematurely or denied altogether (Bauer & Scheim , 2015).

Although there is not much data in this area, some research suggests that LGBTQ+

"populations suffer disproportionately from a range of conditions and are at

disproportionate risk for others, including obesity, depression, anxiety, substance use and

abuse, tobacco use, HIV and other sexually transmitted infections, some cancers, and

inadequate cancer screenings" (Wheeler & Dodd, 2011, p. 308; Whitehead, Shaver, &

Stephenson, 2016; Harcourt, 2006). Even in situations where LGBTQ+ service seekers

may not experience structural violence in the form of homophobia, biphobia or

Transphobia the risk of it is very real and the expectation of stigma or discrimination

causes LGBTQ+ populations to withhold from utilizing primary care (Whitehead,

Shaver, & Stephenson, 2016). Further, in smaller communities evidence suggests that

help-seeking processes are influenced by a lack of positive LGBTQ+ social networks

and services, a fear of anti-LGBT bias and poor understandings of mental illness

(Willging, Salvador, & Kano, 2006).Whitehead et al. (2016) define stigma as "the

negative regard, inferior status, and the relative powerlessness that society collectively

accords to any non-heterosexual [or non-cis-normative] behavior, identity, relationship,

or community" (pg. 2). Thus, finding out whether or not LGBTQ+ community members

within Brantford/Brant County are facing this stigma, will help to establish if they are experiencing structural violence.

When healthcare and/or social service providers make assumptions about gender or sexuality in the questions they ask patients or clients, LGBTQ+ service seekers anticipate that disclosing their sexual orientation or gender identity will negatively affect the care that they receive (Wheeler & Dodd, 2011). Discrimination has a major impact on the needs and experiences of the LGBTQ+ population, which leads to marginalization in both the delivery of health care and social services and also the neglect of this population in public health research (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009). Further, the impact of stigmatization and discrimination experienced by the LGBTQ+ population presents a potential for uneven care, or the avoidance of seeking care altogether (Wheeler & Dodd, 2011; Willging, Salvador, & Kano, 2006).

In a 2015 Manitoba study, almost all LGBTQ+ women participants indicated experiencing homophobia/transphobia when accessing healthcare (CBC New, 2016). The women in the study cited experiences ranging from not being looked in the eye by service providers, to providers behaving uncomfortably, to a doctor who read bible verses to the patient (CBC New, 2016). These are very alarming findings.

In rural areas or smaller communities access to health care and/or social services is affected by a lack of social networks and resources (Whitehead, Shaver, & Stephenson, 2016), which will be discussed further in the "Belonging" section of this proposal. Whitehead et al. (2016) also list the limitations of "service providers in caring for sexual and gender minority groups, and the pivotal role that social supports—that is, family and

close peers—play in informal help seeking and help giving" (pg. 871). Although family and peers play a role in help seeking and help giving, it is important not to put too much blame on individual service providers, however lacking in LGBTQ+ knowledge they may be, because it is vital to recognize that service providers are a part of a much greater institutional problem of systems of power and control, which will be addressed further in this manuscript.

Lack of Belonging

Belonging is a fundamental human need. Humans search for emotional and ontological security, meaning that individuals seek out "people, places, relationship, and ways of being that provide the physical and emotional security, the wholeness as individuals and as collectives" (Knopp, 2004, p. 123), and the solidarity that is denied, in a heterosexist world. For some LGBTQ+ people this means relocating and/or reinventing the spaces lived in and their meanings; however, both of these options require a tremendous amount of privilege, such as class, race, ability, gender, and/or male privilege (Knopp, 2004). When LGBTQ+ individuals are not afforded such privileges and when one does not have the ability to leave or create a space for them, having a sense of belonging becomes complicated. When one does not see themselves represented in the spaces they enter and/or does not feel like they are part of a group, community, or society but are instead on the outside, accessing services becomes something much bigger than just entering a space. People feel as though they belong when they are, or perceive themselves to be, immersed within groups (Easterbrook & Vignoles, 2013). For LGBTQ+ people living in heteronormative society, especially those residing outside

large urban settings, where LGBTQ+ space and community might not be available, feelings of belonging and safety, or lack thereof, are directly linked to health disparities through minority stress. Drawing on the works of hooks (2009) LGBTQ+ populations endure trauma by having to navigate heteronormative systems. For example, fear of and constantly having to out oneself as LGBTQ+, or fear of or actually being attacked because of sexual orientation or gender identity are both examples of trauma, which can lead to Post-traumatic Stress Syndrome. Another example is if a Trans individual enters a doctor's office, sees no LGBTQ+ representation anywhere in the waiting room, no inclusive pamphlets or posters and is asked to fill out a form that only provides them with the option to choose male or female, there is a huge possibility that they will not feel like they belong in that space and likely will not feel comfortable disclosing who they are with staff and physicians. This particular service provider may or may not be problematic, but the heteronormativity of the space places undue stress on the service seeker. Sexual or gender minority stress comes from both experienced violence, by way of discrimination, and ostracism, and the expectation of such experiences (Morandini, Blaszczynski, Dar-Nimrod, & Ross, 2015). Similarly, in their definition of stigma Whitehead et al. (2016) discuss three domains: anticipated stigma, which is the concern for possible future instances of discrimination; internalized stigma, which refers to the devaluation of one's self based on the phobias of others; and enacted stigma, which refers to actual experiences of discrimination (pg.2). In Canada LGBTQ+ populations have largely "been excluded from mainstream health promotion research, policy and practice" (Mule, et al., 2009, p. 2). Mule, et al. (2009) state that LGBTQ+ exclusion from Canadian public health research policy and practice is due to the methodologies used; citing that most LGBTQ+ research is conducted through community-based participatory action

methodologies, where participants can define their health and wellbeing needs (pg. 3).

Conversely, Health Canada uses epidemiological methods, which rely on individual level

aggregated survey data (Mule, et al., 2009). This approach is problematic because it

individualizes a systemic issue, making it possible to overlook systematic inequalities. It

fails to acknowledge the affects that heteronormativity has on the chances LGBTQ+

populations have in accessing health care. This lack of inclusivity makes certain that the

LGBTQ+ population do not see themselves represented in the services they access, and

thus are often left feeling like they do not belong.

Patriarchy

The basic definition of patriarchy is that it is a system of male domination

"because power and authority are in the hands of adult men" (Shaw & Lee, 2009, p. 6).

This simplistic definition implies that all men are created equal, which is not the case.

bell hooks brought the complications of this simplistic definition of patriarchy to light

when she started using the term "white supremacist capitalist patriarchy", meaning that

patriarchy is "interlocking systems of domination that define our reality" (Jhally, 1997).

hooks understands this phrase to mean that systems of gender, race, class, etc. work

simultaneously throughout our lives and in order to understand what is being

experienced, it has to be examined from many different lenses (Jhally, 1997). In the

context of this research LGBTQ+ access to healthcare and social services is examined

through multiple lenses. For example, recognizing that Trans men who identify as

heterosexual or to take it a step further, Black, Trans men do not experience privilege in

the same way that white heterosexual or even Gay men or Lesbian women do. It is also

vital to recognize the role that sexism plays in this research, for example lesbians experience violence from homophobic sources, as well as misogynist and neither is mutually exclusive. Gender and sexuality, as well as race, class, ability, age, etc. are overlapping systems of inequality rather than competing forces (Meyer, 2012). Further, while patriarchy is a dominating force, it does not work equally for all men, particularly for racialized men, Trans men and Gay men who do not perform masculinity in a socially acceptable way. Therefore, patriarchy must be thought as a continuum, meaning that some, predominantly white gay men benefit from patriarchy much more than racialized gay men, who may benefit more than Trans men. As we dive into the findings dominance or white supremacist capitalist patriarchy and its benefits will become a contributing factor in accessing care and the treatment LGBTQ+ community members receive from service providers.

LGBTQ+ Rights and Their Limitations

In Canada, Lesbian, Gay and Bisexual people have had protection rights within the Canadian Human Rights Act, which prohibits discrimination based on sexual orientation and section 15 of the of the Canadian Charter of Rights and Freedoms states that all individuals are equal regardless of religion, race, national or ethnic origin, colour, sex, age or physical or mental disability (The Government of Canada, 2013). The Ontario Human Rights Code also makes it illegal to discriminate or harass someone because of their sexual orientation. This right covers harassment and discrimination in "employment, services and facilities, accommodation and housing, contracts and membership in unions, trade or professional associations" (Ontario Human Rights Commission, 2011). The

Ontario Human Right's Commission states that "employers, housing providers, service providers and others must make sure that their environments and services are free from discrimination and harassment. They must take action if they know or should have known about harassing behaviour based on sexual orientation or a same-sex relationship. This action includes not allowing the use of homophobic language, even if nobody complains about it" (Ontario Human Rights Commission, 2011). The difficulty with the wording of these examples provided by the Ontario Human Rights Commission it that it assumes harassment or discrimination is verbal or perhaps physical as well, which will be addressed further in the findings section of this paper.

Trans people currently do not have any rights protections under the law. However, in May 2016 Bill C-16 was introduced and if passed "…would ensure that Canadians will be free to identify themselves and to express their gender as they wish while being protected against discrimination and hate" (Mas, 2016). If the legislation is passed it will become illegal to discriminate against someone because of their gender identity or expression (Mas, 2016). In a research study by Trans Pulse, which was conducted to inform Human Rights Policy, 24% of Trans participants indicated that they have been harassed by the police (Bauer & Scheim , 2015). Although Trans people are not explicitly mentioned in the current Human Rights protections, all LGBTQ+ populations are as entitled as any other Canadian citizen to equitable access to health care and social services. However "despite the criterion for universality and accessibility that anchors health care delivery in Canada... LGBTQ+ people do not always receive equitable access" (Daley & MacDonnell, 2011, pp. 1-2). LGBTQ+ populations have the right not to be discriminated against, and to marry, yet still face discrimination and

marginalization. As previously mentioned, many LGBTQ+ rights have been achieved

under Canadian law, yet "the dominance of a heteronormative paradigm has resulted in

LGBT individuals experiencing stigmatization and discrimination" (Wheeler & Dodd,

2011, p. 307). It is clear that the rights-based approach has had limited success. If humans

need to belong and in order to belong they must be amongst their people, group or

community and see themselves represented, then having the right to have these things,

without actually being able to access them, is little more than lip service. When the

notion of space is brought into the theoretical framework in relation to power, then space

materializes power, meaning that "it is the dimension of social relations through which

power and knowledge become actualized within the world" (Baker, 2011, p. 40). This

means that homophobia and heterosexism operate through the production of space. Baker

states that "the production and experience of everyday space serves to reinforce

heterosexual hegemony in that educational, religious, legal and medical discourses work

to degrade and constrain the public presence of queerness" (Baker, 2011, p 40). If space

materializes power and the production of space is meant to uphold hegemonic

heterosexuality then it would appear that it does not much matter if LGBTQ+ populations

have the right to access equitable services because they still inhabit spaces meant to keep

them marginalized.

According to a Statistics Canada's report, in 2012 the majority of hate crimes

reported were racially or ethnically motivated (Allen, 2014). However, LGBTQ+ people,

while the numbers overall are down, experienced disproportionate rates of violence, at

67% of reported hate crimes being violent in nature (Allen, 2014). In spite of these

numbers the Alberta Hate Crimes Committee claims that there is a lack of quantifiable

hate crime statistics because Canada does not have a uniform definition of a hate crime,

citing the Canadian Association of Police Chief's definition being quite different than the

Canadian Centre for Justice Statistics recommended definition: "hate crime is a criminal

violation motivated by hate, based on race, national or ethnic origin, language, colour,

religion, sex, age, mental or physical disability, sexual orientation or any other similar

factor" (Alberta Hate Crimes Committee, 2012). The Canadian Department of Justice

cites similar issues, describing differing hate crime definitions throughout police forces

across the country (Ministry of the Attorney General , 2015). These concerns imply that

there are issues with using statistical data as evidence because the lack of a uniform

definition may cause confusion when it comes to what constitutes a hate crime. It is also

important to note that hate crimes on the basis of sexual orientation or gender identity are

often subtle and unreported (Nadal, Rivera, & Corpus, 2010, p. 218). Further, Spade

(2015) writes about anti-discrimination/hate crime laws discussing their individualized

nature: "an individual rights framework that emphasizes harm caused to individuals by

other individuals…" (pg. 9). In other words if LGBTQ+ discrimination is looked at

through hate crime laws than we see an LGBTQ+ person experience a crime, perhaps

because of their sexual orientation and we may also see the perpetrator of that crime

criminalized but we do nothing to address where that bias came from systemically. This

approach misses how power functions: "we need to shift our focus from the individual

rights framing of discrimination and hate violence and think more broadly about how

gender categories are enforced on all people in ways that have particularly dangerous

outcomes for Trans people" (Spade, 2015, p. 9). Structural violence is perpetrated

through these systems of power and although Spade is specifically writing about the

Trans population, this theory can be applied to the LGBTQ+ population, as well as to all marginalized groups.

An individualizing rights based approach is superficial, causing marginalized groups to strive for equality through rights but as Spade (2015) discusses, this approach pays little attention to the distribution of life chances, stating that "even when laws are changed to say different things about a targeted group, that group may still experience disproportionate poverty as well as a lack of access to healthcare, housing, and education" (pg. 9). Legal reforms do not prevent systemic violence like the disproportionate criminalization of the Trans population and immigration enforcement (Spade, 2015). Further, even legal systems that have official rules or policies of nondiscrimination are still a part of the larger system of power and "still operate in ways that disadvantage whole populations--- and this is not due solely, or even primarily, to individual bias" (Spade, 2015, p. 9). This means that analyses should be examining systems that administer life chances rather than individuals who may discriminate. Spade states that "through this lens we look more at impact than intent. We look more at what legal regimes do rather than what they say about what they do. We look at how vulnerability is distributed across populations, not just among individuals" (Spade, 2015, pp. 11-12). This lens helps to move away from the neoliberal ideals of individualizing the marginalized and those who discriminate against them to look at the systems that are created and work to maintain, systematic inequalities experienced by LGBTQ+ populations.

Micro Aggressive Discrimination

Apart from the previously mentioned complications of relying on a rights based approach to addressing discrimination against LGBTQ+ populations, consider when the discrimination experienced is more covert, perhaps even non-verbal. According to Nadal, Rivera and Corpus (2010), LGBTQ+ experiences of prejudice and discrimination have become more subtle and covert in recent years, meaning that the LGBTQ+ population is exposed to microaggressions, or unconscious forms of discrimination. Mircoaggressions can be directed at any marginalized group and are "brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group" (Sue, 2010). Sue (2010) describes racism as having become invisible, subtle, and more indirect which causes it to operate unconsciously and in unseen ways (pg. 9-10).

There are three forms of mircoaggressions, the first, microassaults are intentional and transmitted either verbally or non-verbally "through name-calling, avoidant behavior, or discriminatory actions towards the intended victim" (Nadal, et al., 2011, p. 235). The second, microinsults tend to more subtle and are often unconscious. They include verbal and non-verbal the use of communication "that conveys rudeness and insensitivity and demean a person's heritage or identity" (Nadal, et al., 2011, p. 235). Finally, the third type of microaggression is mircoinvalidations which "are also often unconscious and include communications that exclude, negate, or nullify the realities of individuals of oppressed groups" (Nadal, et al., 2011).

Although microagressions can be seemingly small, they are harmful and operate on a systemic level (Sue, 2010). Therefore, mircoagressions are enacted and upheld through systems and institutions, for example the exclusionary nature of forms all people have to fill out and much of the time they force people to check boxes that they may not fit into. For example, if the only options are male/female or husband/wife than those forms are exclusionary. Similarly, when an LGBTQ+ person, a Lesbian for example, is in a healthcare or social service setting and the staff asks questions about what her husband does for a living; she is experiencing heteronormative behavior, which is also microinvalidation. Mircoagressions affect both the standard of living and quality of life of marginalized groups such as LGBTQ+ and "they have the secondary effect of denying equal access and opportunity in education, employment, and health care" (Sue, 2010, p. 16).

CHAPTER 3: METHODOLOGY

Methodology

Theoretical Framework

This project investigates how LGBTQ+ people within Brantford /Brant County experience accessing healthcare and social services and whether or not they are treated equitably within those services. The project is anchored by principles of intersectional and anti-oppressive research. I am using an intersectional feminist lens combined with critical theory and a critical queer Trans politic to investigate and understand experiences in accessing healthcare and social services. These approaches are used to frame this research for two reasons: the importance of seeing the experiences through a number of lenses, and to understand how power works through dominant systems from a perspective that is outside of that structure. These theoretical lenses have not been used together before in a study examining LBGTQ+ experiences while accessing healthcare and social services that is community-based and participatory in nature. In addition, from a social justice perspective, it is a very effective way to approach the study. It is important to conceptualize access to health and social services in a way that allows us to look at belonging and community as strengths, and to see the rights-based approach as a barrier to achieving equity in access to healthcare and social services.

An intersectional feminist lens allows the research to be examined from the perspective of multiple marginalizations. It also provides examples of how an approach to analyzing one kind of oppression can be useful in understanding another. For example, hooks' (2009) work on racism in small town Kentucky, in *Belonging: A Culture of Place,*

provides a way to think about LGBTQ+ experiences of structural violence. For example, for LGBTQ+ people, the decision to be open or "come out" with an LGBTQ+ identity is one that entails risk as it can render them in a position of great loss and loneliness if they are not accepted by their families, friends, peers and communities. At the same time, the decision to hide their sexual orientation or gender identity can have the same implications, but within the individuals themselves. hooks (2009) writes about Post-Traumatic Stress Syndrome caused by racism, and while racism and homophobia are very different, they operate in similar ways. Therefore, this syndrome can also be applied to LGBTQ+ experiences of structural violence. Based on hooks' explanation of racism and experiences of post-traumatic stress syndrome, I argue that LGBTQ+ populations endure trauma through living in a heteronormative society in which they are cast as anything but the "norm". Obviously those with intersecting oppressions, such as people of colour who also identify as LGBTQ+ would face double the trauma risk. Whether it is fear of walking through heterosexual neighborhoods, fear of being attacked, of using gendered restrooms, of losing jobs or housing, or fear of disclosing one's sexual orientation or gender identity to medical or social service providers, it is a form of trauma. Whether it is feared or actually experienced, it is trauma that can cause Post-Traumatic Stress Syndrome.

When people cannot be safely open about who they are, they can experience a lack of belonging, acceptance or representation in the communities in which they live. If heteronormativity and LGBTQ+-phobia are fundamentally at the core of a lack of access to healthcare and social services, they are also as much about lack of space, community and belonging as they are about ignorance. If we approach the situation LGBTQ+

populations are facing in terms of experiencing a lack of equitable access to healthcare

and social services as stemming from structural violence that causes a lack of

connectedness, belonging and community, we can understand that it is more about a

system that has been created to maintain heteronormativity than it is about the individuals

seeking or providing the services, and we can get at the root of the problem.

Critical theory and the work of Foucault in particular, is an important aspect of

this research because it provides a way to understand the root of the problem. Foucault's

(1978) explanation of knowledge and power and the means through which they are

created and exercised through all points of any relation help us conceptualize the system

issues rather than blame individuals for creating marginalization. If power is imagined

outside of the typical ruler/ruled model, then it does not take the form of law but rather

works on multiple levels and in multiple directions (Foucault, 1978). Spade (2015) draws

and elaborates on Foucault's theory and uses a critical Trans politic to examine the

limitations of the law, theorize a rights-based approach as problematic, and cite power,

control and state violence as factors not only contributing to, but also creating and

maintaining, the institutions that enforce and uphold inequalities in the first place.

Spade (2015) argues that while Western society is defined by criminalization,

with tougher laws and protections under laws, the most marginalized people are the ones

being arrested at disproportionate rates (e.g. Trans people), and these are the same people

who are then expected to trust institutions such as police to provide services and to

protect them. Spade (2015) states that we "need a critical Trans politics that is about

practice and process rather than arrival at a singular point of liberation" (p. 2). A singular

point of liberation does not actually exist if the goal is real equality because the legal

framework cannot provide a solution when it is part of the structures that oppress people in the first place.

The proof of the failure in the rights movement to actually achieve equality is all around us. The literature shows that the LGBTQ+ population does not have equal access to healthcare and social services and that isolation and LGBTQ+-phobia are experienced regularly (Daley & MacDonnell, 2011; Bauer & Scheim , 2015; Mayer, et al., 2008). Those who have benefited the most from the Gay and Lesbian liberation movement are the most privileged of the population, particularly white wealthy men and more recently those who can fit neatly into homonormative ideals (Sears, 2005, Drucker 2015). The less privileged members of the LGBTQ+ community may continue to experience high rates of ongoing structural violence, and it is in keeping with this fact that I am conducting a research project on access to healthcare and social services so many years after human rights and protections under the law were achieved for many.

It is important to make clear distinctions between the desired normalization of the LGBTQ+ population and homonormativity. The normalization of Queer populations is about normalizing LGBTQ+ people by accepting them for who they are, regardless of their race, class, socioeconomic status, ability or gender identity or performance. Conversely, homonormativity is about accepting those who can meet certain rigid heteronormative ideals. For example, homonormative people are typically white, middle class, cisgender Gays and Lesbians who meet gender norms and are in long term monogamous relationships (Drucker, 2015; Duggan, 2002, Sears, 2005). Brown (2012) argues that attitudes about homosexuality have been liberalized and corporatized because of the preserved spending power of Gays and Lesbians. Therefore, tolerance of select

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members of the LGBTQ+ population is a neo-liberal decision based on economics rather than one of actual acceptance and equality.

Research Design

This research is community-based and guided by the principles of participatory action research (PAR), meaning that the study was informed through the direct involvement of the LGBTQ+ community and its allies in the research design and process (Rutman, Hubberstey, Barlow, & Brown, 2005). To investigate how the LGBTQ+ community members experience healthcare and social services access outside of large urban settings, it is important to work directly with those who have lived experience with accessing services. My position as a Queer activist in the Brantford/Brant County community helped make this possible. Because I am a member of the LGBTQ+ community, I was drawn to community-based participatory action research as my methodological approach, particularly because I believe it is important for a community to be producing its own knowledge about itself.

However, it is important for me to further recognize that my position within this community also has other implications for the research. I acknowledge that while the research was designed to be anti-oppressive, it is difficult for me to tell if it was or not. As a feminist and white woman, it is important for me to constantly consider my position, influence and role as a researcher. I am mindful that I am also a Queer woman who has resided within Brantford/Brant County for more than half of my life and am someone who does or has accessed healthcare and social services in this community. Thus, my position from within the margins clearly creates bias because this research matters to me

far beyond the MRP. Further, I may have been positioned within the Brantford/Brant County LGBTQ+ community, but I am also a white cisgender woman and an academic researcher. I came into this research project with a tremendous amount of power and privilege and I was continually mindful of and reflective on it (Pillow, 2003). My position as a feminist researcher informed my reflexivity around making sure not to exploit the LGBTQ+ community during the research, and in producing research that is guided by and useful to my community (Pillow, 2003).

My partnership with the organization The Bridge also made my methodological approach possible. There are a lot of great community members and allied organizations who were and are eager to do LGBTQ+ social justice work. The Bridge is a grass roots committee that aims to identify and address inequalities experienced by the LGBTQ+ community. For the purpose of gaining knowledge that key stakeholders (i.e. the LGBTQ+ community and The Bridge) feel is important and useful, I worked closely with LGBTQ+ community members and The Bridge to develop the research focus and the questions that were asked of participants. Further, because of the nature of PAR and its emphasis on the researcher being a part of the researched group or closely allied with it (Rutman, Hubberstey, Barlow, & Brown, 2005), and since I am a cisgender woman, I worked with a Trans-identified community-based research assistant. He is a Trans Activist who started the local Trans Peer Support Group in Brantford and was a crucial part of conducting this research, particularly with the Trans population.

I believe strongly in community based research and PAR and believe that these methodologies align nicely with my focus for this study. As stated, I believe that the local LGBTQ+ community holds the expertise in terms of knowledge development in the area

of LGBTQ+ access to health care and social services because these are the people actually experiencing the services or lack thereof.

Data Collection

This section outlines the data collection methods, participant inclusion criteria, recruitment strategies, informed consent, the role of the research assistant who engaged with the data collection process, the interview process, the focus group process and the ethical considerations.

Data collection method.

With input from the LGBTQ+ community and its allies, one method identified for data collection was the interview, which is the most commonly used method for qualitative research (Mason, 2002). It is also the method that most aligns with my ontological position that LGBTQ+ community members hold meaningful knowledge (Mason, 2002) in terms of access to healthcare and social services. With the help of community members and The Bridge, I created a semi-structured interview guide. In addition to the interviews, one focus group was also conducted with the Trans community in order to permit a greater level of involvement from that community due to demand for participation. The decision to conduct a Trans focus group was made because prior to starting the research project, a large number of Trans community members expressed an interest in participating and I wanted to provide an opportunity for more than one or two voices from the Trans community to be heard.

All interviews and the focus group were recorded on an electronic recording device and later transcribed by me. No one else, including the research assistant has worked with the recorded data.

Participant inclusion criteria.

In order to meet the inclusion criteria for this research project, for both the individual interviews and the focus group, participants had to be over the age of 18, identify as LGBTQ+, have accessed healthcare and/or social services within Brantford/Brant County and be willing to share their experiences of accessing healthcare and/or social services within Brantford/Brant County by participating in a confidential interview or focus group.

Recruitment strategies.

Participants were recruited using a few methods. The first was through placing poster in spaces where LGBTQ+ community members frequent, such as Grand River Community Health Centre, Sexual Assault Centre of Brant and LGBTQ+ peer lead groups, such as Gender Journey and LGBTQ+ Social. The posters were also emailed out through the Bridge's large LGBTQ+ email network and advertised on Brantford Pride and the Bridge Facebook pages. There were 2 different posters, one recruiting Lesbian, Gay and Bisexual participants for individual interviews and the other recruiting Trans participants for a focus group (Appendix 1 and 2). The poster indicated a bit of information about the project, the recruitment criteria and provided potential participants

with instructions to either call or email the number or email address provided if they wished to participate. I also contacted some of the LGBTQ+ peer lead groups and asked if the groups would be okay with me attending to talk about the research project, which I did. I also left Project Information sheets (Appendix 3) for potential participants.

As research participants came forward it became very evident that it would be difficult to get many participants, especially male or racialized LGBTQ+ participants. This is likely due to a common issue faced by most LGBTQ+ related organizing and/or events within Brantford/Brant County gatherings are predominantly White and mostly attended by Lesbians. Also, my position as a white, Lesbian researcher may have negatively impacted participant recruitment. Having all Caucasian and no cisgender gay male participants caused me a great deal of concern.

I decided to alter the research process by enacting targeted (snowball) sampling rather than random, which aligns more with anti-oppressive research (Potts & Brown, 2005). I did not feel that it was ethical to ask potential participants myself, as per my Research and Ethics approval. However, I decided to ask research participants if they knew any men or racialized people who met the research criteria and who might have been interested in participating. Through this method I was able to gain male participants. However, even though I, in addition to some of the research participants, corresponded with racialized people who wanted to participate, none of the potential participants felt comfortable doing so in the end.

Informed consent process.

During this research project, informed consent was achieved by having participants read, discuss and sign the informed consent form (Appendix 4 and 5). Before meeting with participants for interviews and the focus group, emails containing the project information (Appendix 3) and the informed consent form (Appendix 4 and 5) were sent to potential participants so that they could have time to read them over and consider whether or not they wanted to participate. Further, upon meeting participants were provided with two copies of the informed consent form and asked to sign both, keeping one copy and giving me the other. During this process I explained the main points of the form, particularly about confidentiality, anonymity and the use of pseudonyms. At this time participants could ask questions about the consent forms if they felt the need to.

Research assistant engagement in data collection.

For the purpose of this research project a research assistant was hired because I wanted the Trans community to feel like they could participate and I did not want my position as a cisgender woman to affect Trans participation level. As previously mentioned the research assistant is Trans and has ties to the local Trans community. He was required to take a Research and Ethics course and sign a Research Assistant Confidentiality Agreement (Appendix 6). We met twice before the focus group to go over the Interview Guide (Appendix 7) to make sure the questions were appropriate and to create an agenda (Appendix 8). He also promoted the research project on his own personal Facebook page and share information about it with people in various social

settings. The research assistant took the lead during the focus group and I jumped in as needed. Apart from co-facilitating the focus group, the research assistant has not had any further engagement with the data.

Interview process.

As noted above, with the help of community members and The Bridge, I created a semi-structured interview guide (Appendix 7). It is important to note that while there were specific questions in the interview guide, I relied much more heavily on the prompting questions and the interviews were typically much more conversation based than question based. Interviews were set up with participants who contacted me and met the research criteria. I corresponded with participants regarding the research until they felt comfortable meeting. However, in spite of many interactions, in some cases participants never wound up feeling comfortable or safe enough to participate in an interview. I conducted 6 individual interviews and one double (2 person) interview with community members who identify as Lesbian, Gay, and Bisexual.

I had previously lined up private interview space at the Sexual Assault Centre of Brant and Grand River Community Health Centre, but also acknowledged the fact that those spaces may not be comfortable or feel safe for all participants. It must be noted that there is not currently any LGBTQ+ space within Brantford/Brant County which made it difficult to offer safe and inclusive environments to potential research participates. The Sexual Assault Centre of Brant and Grand River Community Health Centre were chosen because of their affiliation with and support of LGBTQ+ organizing within Brantford/Brant County. Participants were given the option to meet at either of those

places, Laurier Graduate offices, or another space of their choosing. Participants were interviewed at all of these places, choosing whichever felt safer, was comfortable and convenient for them. For the 3 weeks of data collection I also kept my schedule wide open, including weekdays, weekends and days/evenings, so that participants could choose an interview time that fit within their schedules. One participant really wanted to have his voice heard but was unable to participate in a face to face interview and an accommodation was made to conduct an interview over Messenger.

Each interview was forty minutes to one and a half hours in length. Once data collection was completed, participants were given the option to review their transcripts and change, add or take out any information they wanted to. Most participants chose to review but some did not. Interview participants were asked to sign another consent form (Appendix 9) upon reviewing their transcripts.

Focus group process.

I chose to conduct a focus group with the Trans community because prior to the research project a lot of Trans individuals asked me when I was conducting research and expressed their desire to be a part of it. Given the short length and timeframe of this project, I knew that it would not be possible to interview all who were interested. Conducting a Trans focus group allowed me to include more members of the Trans population than would have been included otherwise. It is important to note that I was also open to conducting one on one interview with Trans individuals if they did not feel comfortable participating in a group setting. I corresponded with a Trans individual that that did not feel comfortable in the group. We worked together to plan to meet for an

interview but the participant cancelled due to feeling worried and scared to share their

story. In terms of participation 7 Trans or non-binary people signed up to participate and

4 actually showed up to the focus group.

I co-facilitated the focus group with a research assistant; who is a Trans identified

community member and also a former facilitator of the Gender Journey Peer support

group. It was held at Grand River Community Health Centre in the same room that

Gender Journey meetings are held in. This was an attempt at helping participants feel

safer and comfortable. The focus group was 3 hours in length and started with the group

creating ground rules (Appendix 10). We also created a word wall defining healthcare

and social services (Appendix 11). The Research Assistant lead the group the majority of

the time and the interview guide mentioned in the previous section was used (Appendix

4). Participants were also provided with food and drinks because the focus group ran

from 5 to 8 pm.

Ethical Considerations

This research project was approved by Wilfrid Laurier University Research and

Ethics Board in April 2016 (REB #4827). During the research many ethical standards

were put in place. The research was specific to Brantford/Brant County, which is a fairly

small community and thus poses some added risks to participants. All participants were

given pseudonyms to ensure confidentiality and anonymity. Interview participants were

also free to choose our interview locations, dates, and times. All participants were

provided with Project Information sheets (Appendix 3) and Informed Consent forms

(Appendix 4 and 5). It was also explained to participants that they could pass on any

question they did not feel comfortable answering and could stop the interview at any time. This was an important piece because I was asking participants to share personal and potentially tough stories about accessing services, which place people in very vulnerable positions.

As mentioned in previous sections I worked with a Research Assistant for the focus group, for me this was an ethical choice because I wanted to ensure that the Trans community was included and felt safer and I did not believe that I, as a cisgender woman could possibly do that. The focus group was held a community healthcare centre where many Trans groups take place. This was to ensure that Tran's participants felt comfortable and safer. All participants were provided with a detailed project outline and contact information for myself and my supervisor.

Data Analysis

The interviews and focus group were all transcribed verbatim, by me, using a dictation program called Dragon Naturally Speaking and then typing out each interview and the focus group. During this process the transcriptions were given letter names, for example, participant A and all names shared during the interviews and focus groups were changed to letters as well. In places where participants stated their partner's name they were changed to "my partner".

Coding.

The data was coded into themes first on paper, using colour coded tabs and then by using the qualitative software program 'NVivo'. The program aided in the process of

thematically coding the data collected, which are outlined in the results section of this paper. All data was examined by referencing the original research question and continuously investigating what counts as data in relation to the research question (Mason, 2002).

The data was examined literally, interpretively and reflexively. Meaning that the data has been read in its literal form and content, and then through an interpretive lens, followed by reflexively, during which time I explored my perspective and role as part of the data (Mason, 2002).

Using an intersectional lens I continuously read the data searching for axes of domination such as gender, race, sexuality, and experiences of disability – with the understanding that because of the interlocking nature of social relations oppression is experienced in a unified way (Lépinard, 2014). Furthermore, subjectivity is shaped by experiences of complex forms of oppression, which also shape a specific standpoint and political interests. These political interests have been negated or misrepresented by theories and/or policies and must be restored to the political agenda (Lépinard, 2014).

CHAPTER 4: FINDINGS

Findings

Participant Characteristics

In total 18 potential participants contacted me and were interested in participating. However, the final study consisted of 12 individuals who consented to participate in this study; 8 in individual interviews and 4 in a focus group. Those who did not participate either did not show up for their interviews or expressed not feeling comfortable enough to participate at the last minute.

To ensure anonymity, all participants were given pseudonyms, which were chosen from an online random name generator. Participants ranged in age from 23 to 64 years of age. All participants resided in and have accessed services within Brantford/Brant County. As noted in the previous section, despite my best efforts to make the research project inclusive and intersectional in terms of ethnicity, all participants were Caucasian. I interviewed 4 Lesbians, 2 Gays, 2 Bisexuals (one male and one female), a Trans man who identifies as Queer, as opposed to Bisexual, a Trans Lesbian, a Gender Queer person who does not identify with a specific sexual orientation and a Trans person who is just beginning to transition and identifies as 'yet to be determined'. This section provides a summary of the results collected from all 12 participants. Healthcare and social services were defined by participants. Healthcare was defined as including family doctors, specialists, nurse, dentists, hospital staff, community health centres, naturaopaths and other non-traditional medical services. Social services was defined as counsellors, peer

groups, churches, food banks, employment services, housing, crisis workers, and emergency services (i.e. police, ambulance, fire).

Analysis of the data revealed 2 major themes. The first, structural violence is perpetrated institutionally as evidenced by the following: 1) heteronormativity and assumptions of heterosexuality and/or gender which also operate through gender norms; 2) lack of knowledge; and 3) bias. The second major theme is resistance, which is by: 1) avoiding accessing healthcare and social services as a means to avoiding experiencing violence, 2) resisting heteronormativity and gendernormativity; and 3) belonging and safer services.

Structural Violence

Heteronormativity and assumptions of heterosexuality and/or gender.

The majority of participants in the study indicated that all spaces within Brantford/Brant County are not LGBTQ+ inclusive, meaning they had to temporarily create safe spaces for themselves through things like peer-lead groups and pride events. In relation to LGBTQ+ community, Meredith, a cisgender Bisexual female said, "if I wanted to access in relation to my sexuality, there was nothing and until we started working with the Bridge." The hospital and most doctors' offices, and social services were described as heterosexual spaces, i.e. not safe spaces. Many participants described what safe spaces are by defining what heterosexual spaces are not. For example, Blake, a cisgender Bisexual male who performs masculinity within the bounds of the gender binary stated, "When I first came to Brantford I couldn't find a doctor. I had to go to

emergency and I did six hour waits in line…" When asked if he had ever disclosed his bisexuality to hospital staff Blake stated:

> No, not at the hospital…because of experiences in life that if someone doesn't like your sexuality they can hurt you, so I know when to and when not to…I didn't see a safe space either…all I need is a little rainbow to know that I am safe. It could be in a lapel, it could be on the edge of a door; then I know I'm safe.

In relation to couples seeking counselling services Emma, a cisgender Lesbian who performs femininity well within the bounds of the gender binary stated:

> I generally don't have a lot of faith in being able to relate to counsellors or them having a lot of understanding of the LGBTQ+ community and I think sometimes it would be helpful, depending on what you're getting counselling for... there were no LGBTQ+ pamphlets or posters or anything of that nature…so there was nothing directed towards me…the counsellor gave us literature to read but it was definitely not literature on lesbian relationships… it was general literature…In Brantford I've actually never given any LGBTQ+ pamphlets or literature in my life.

When asked if she felt like those things would make a difference Emma answered:

> Yeah, those things would definitely make a difference. I remember watching the flag go up in Brantford the first time, which isn't a sticker but I remember thinking back to when I was in high school. I spent all of my time looking for rainbows and I remember going to Toronto and Hamilton…walking down the streets and seeing some businesses…they would just have a pride sticker

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somewhere around their entrance and it just made me feel acknowledged, like it was okay to be yourself while you were there, because you do monitor how you are acting depending on where you are if you are a member of the LGBTQ+. In Brantford the first time the pride flag went up I was crying because I was thinking back to how amazing that would have been in high school, to think the whole city, in essence, the Mayor, and there were about 120 people but like all those people are visible in Brantford, so that makes a huge difference for people.

The fear of not knowing how service providers are going to react to LGBTQ+ people disclosing their sexual orientation or gender identity is evident throughout these findings and is directly linked to heteronormative/gendernormative assumptions and space. For example, although Sabrina, a Trans Lesbian has had very good experiences with service providers since coming out, she also expressed, "when I first figured out about my true self I was so scared to talk to her because I didn't know how doctors would react to people who identify themselves as Trans."

Participants overwhelmingly discussed the assumptions service providers made about them as something that deeply affects both the care they receive and the amount of care they access. Assumed heterosexuality caused participants to regularly face the decision to out themselves or not. Meredith, a cisgender Bisexual woman who performs femininity well within the bounds of the gender binary explained:

…the default assumption is that you're straight, unless you tell them otherwise…that's making LGBTQ+ people invisible and forcing them to have to come out of the closet constantly instead of one of the first questions you may ask

your new healthcare clients is oh tell me a bit about yourself…what are your
pronouns… how do you identify and express your gender?...like you did for this
interview.

In relation to seeking medical services Tammy, a cisgender Lesbian who performs
femininity well within the bounds of the gender binary expressed:

There is also the assumption, the nurses have asked, the doctors have asked, 'is
this your sister? Is this your friend?' if they noticed one little bit of body
language, we don't look like sisters or friends...we have to continuously come out.

Tammy's partner Jenny, who is a cisgender Lesbian and does not perform
femininity within the bounds of the gender binary, added "well, it doesn't help when you
are in the middle of the hallway and in front of everybody having the conversation…it's
definitely an embarrassment!" Tammy stated:

To sit there and have to justify yourself is absolutely maddening. There is so
much anger there, yet you feel like you have to rein it in and not step on to many
toes or get anybody upset with you, or you feel like they will withhold care and
then the fear sets in.

Gregg, who is a Trans man that performs masculinity according to binary standards,
shared a similar story about having to out himself publically at the hospital:

You're in the hallway with a bunch of other people and this is where you really
have to give information. So now I have to say I'm on testosterone because it's a
drug. So in front of everybody, I'm not testosterone because I'm transitioning and

everybody's looking at you…all of the sudden the panic and anxiety rushes and you start to sweat.

Emma shared similar experiences:

When you go to emerg [ER] you're dealing with doctors and you have your partner there, like over the years they always treat the partner like it's your friend, which can be frustrating because then you have to continually be outing yourself and your already not feeling well and are in a fragile state… I know that it used to cause me a lot of anxiety when I was younger, obviously because I wasn't sure how people were going to react.

Although Sabrina has had very good experiences with her service providers since coming out as Trans she expressed "when I first figured out about my true self I was so scared to talk to her because I didn't know how doctors would react to people who identify themselves as Trans."

Crystal does not perform femininity according to binary standards and is not open with her family doctor about her sexuality. She stated that she is often mis-gendered but that it does not bother her because "it's something you just get used to." She experiences accessing care in a layered way in terms of marginalization, which she spoke a lot about. She has a physical disability and because of that she is often talked about or around rather than to. She believes that most service providers think that because she is physically disabled she is also cognitively impaired, which is not the case. Crystal used the example of nurses and doctors looking right past her to whoever she is with:

I had a friend that drove me to the hospital one time and they made my appointments with my friend and I'm sitting there saying 'hello I can hear you and I can speak'. I ended up having to change them because they didn't suit my schedule. It's the same thing but a different kind of thing when they find out that you're gay... And then you're gay and you're in a wheelchair and you're not white on top of everything else. A lot of people think that because I'm from Brantford I'm Native and they automatically treat you differently. I'm not Native but it shouldn't matter.

In reference to these experiences Crystal stated "you learn to live with it. I mean, you shouldn't have to but you do."

Recall that Emma and Tammy are both Lesbians and express their femininity socially acceptable ways, they each talked about doctors making assumptions around women's reproductive choices, stating every time you go to a doctor you have to 'out' yourself because one of the first things you are asked is what type of birth control you are on, and then you have to explain. Tammy recalled an experience with a doctor where when she disclosed her sexual orientation the doctor congratulated her for being a successful lesbian and in her words:

It was as if he had never seen a successful, functional, medically sound homosexual before…he seems genuinely shocked when I told him. He looked me up and down because the general reaction I get is 'but you're so feminine, or you're so girly. You're too pretty to be a lesbian'. I got the impression that I didn't fit the stereotype he was expecting.

Heteronormative assumptions may be amplified for bisexual people, especially for those who also perform femininity and masculinity in ways that uphold the gender binary. Meredith and Blake are Bisexuals who are currently in opposite gender relationships. Each of them talked about their relationships and the assumption of heterosexuality causing their bisexuality to be invisible. Meredith, who is in a monogamous relationship stated "I don't think I have ever told a doctor that I identify as bisexual." Meredith struggled with whether that is because her health has not intersected with her sexuality, or if she is experiencing internalized biphobia, or simply because she has never been asked about her sexuality by a doctor. On the other hand Blake, who is in an open relationship, is very open with his doctor but would not be with other medical services like the hospital. When Blake was asked if he would explain why that was his response was "because of experiences in life, if someone doesn't like your sexuality they can hurt you so I know when and when not to."

Some participants in this research do not perform gender according to norms and therefore experience varying assumptions based on their gender performance. For example, Jenny, who often wears men's clothing, and has very short hair expressed she is frequently assumed to be a man and when she is not she is pegged as a Lesbian because of her masculine appearance; while her partner Tammy, who wears dresses and lots of jewelry is always assumed to be heterosexual because of her feminine gender performance. Tammy expressed:

> Every single time they have mis-gendered her when looking at first glance and have either walked away or called out her name in confusion. I know that one time there were 3 men in the waiting room with us. The nurse looked around at

who had bracelets on and walked away so that doesn't leave a warm fuzzy feeling.

Gregg shared:

> I had to go to the hospital to get a stress test done and so you're in there in a gown and you can't bind, none of that... This is the thing - you always have to say the whole story all over again. You have to say this is my story, I'm transitioning, and these are my pronouns. Even after telling them they still mis-gendered me and they spoke as if I wasn't in the room they were speaking about me and not to me. It was an awful experience.

Without being explicitly asked, 8 of 12 participants expressed that they believed there was something wrong with them when they were younger and in some cases for many years to follow. For example, Crystal stated "I thought there was something wrong with me for many years…it's not everybody, even one person makes it hard to be yourself." Blake said:

> When I was in my twenties I was like, I like this and I like this but the majority of the people I hang out with like this…is there something wrong with me? It wasn't until I was 31 or 32 that I actually did some reading…and I remember thinking 'wow I'm bisexual' That explains it and it would've saved me so much hurt and pain and I don't mean just to myself, I mean to the whole world.

Lack of knowledge.

Participants were asked if they believed that service providers, in both healthcare and social services were knowledgeable about LGBTQ+ people and their needs. Four participants believed that their healthcare providers were supportive of LGBTQ+ people, and tried really hard. They each believed that their healthcare providers were not knowledgeable, but were willing to educate themselves as needed. Gregg stated:

> My doctor is a wonderful doctor. She's very supportive. She doesn't have a lot of
> education but she is willing to go the distance and she did a lot of research... She
> pulled up a bunch of materials about Hormone Replacement Therapy.

Interestingly, all participants who felt supported by their healthcare providers attended the same healthcare clinic and only believe that the physician they each see specifically is knowledgeable, either because of bad experiences with others or because of a general distrust and lack of confidence in healthcare providers. When asked about the knowledge level of healthcare providers Bradley who is a Gay cisgender man that performs masculinity well within binary standards stated at my specific health centre, yes", then speculated "old school doctors may not be supportive simply because sexual orientation was hidden for so many years prior to the current new generation of doctors, mean they may not have the overall knowledge." Further, many of the participants who believe their specific doctor is knowledgeable voiced that they would not ever go to the hospital in a situation where they needed to 'out' themselves because a general lack of knowledge in healthcare providers.

One theme that emerged was that 7 out of the 12 participants see doctors at clinics with multiple doctors. Three of them are able to always see the same doctor because they refuse to see anyone else and believe that the other doctors are not knowledgeable. Participants who are not able to see the same doctor each time they attend described that there is a lack of building personal relationships with doctors because of attending clinics with multiple doctors instead of having just one doctor. This causes a great deal of concern for participants. They worry about whom they will see, what they will have to tell them in relation to their sexual orientation and/or gender identity and how they will react. For example, Gregg shared:

> I have seen another doctor but it was not a comfortable experience because everybody's different in how they perceive who you are and I didn't get a great feeling from that. She was somewhat curt and wasn't helpful at all. That happened like a year and a half ago, so this next time I was offered to see somebody else I said no I'll just wait for my doctor.

Emma talked about LGBTQ+ people needing to constantly decide who to come out to or not stating:

> You don't just come out and then you're out. You have to constantly come out and you have to decide in each moment if it is safe, if they person you are coming out to will be accepting and you also don't want to embarrass them because they have made assumptions about you. It's a continuous process.

Meredith who was a patient at a clinic with multiple doctors expressed her concerns about it stating:

I never built a relationship with a doctor because I always saw someone different. To me, that is one of the problems with that kind of setup. In some ways it's more efficient and it helps them do their work and it helps move people through but people aren't connected to their doctors and you lose the fact that doctors can try and see issues over time because they know someone over time.

Eight of 12 participants that believed that their healthcare providers are not at all supportive or knowledgeable about LGBTQ+ healthcare needs at all. Emma spoke about the need to be able to advocate for your-self with healthcare providers stating:

…when I was younger and I would go to my doctor for a physical, she would ask if I had had intercourse and then she would tell me that I didn't need a Pap smear. I would basically have to ask to get one. She just didn't really understand and I felt like I had to explain to her, like I had to educate her on what the need for a pap smear was which is silly because you shouldn't have to explain to your healthcare professional how you have sex.

Three of the four cis-gender Lesbians who participated talked about forced pregnancy testing being an issue when they seek medical care, particularly on an emergency basis. All of them expressed that they have, on multiple occasions been ordered to have pregnancy tests, despite repeatedly explaining that there is no possible way they could be pregnant and that they have never had intercourse with men. Tammy explained "every single walk-in doctor I have been to since coming to Brant County, when I needed to get certain medical stuff done or required certain prescriptions…they

make me do a pregnancy test." Jenny had a hospital experience where she was forced to take a pregnancy test, she said to the nurses "do I have to take it if I've only ever been with women, there's no way possible for me to be pregnant" and the nurse told her that she believed her but that they needed her to take the test because "the doctor is kind of a jerk."

Poland, who is a cisgender Gay man that performs masculinity within binary standards sought help for an addiction and shared his experience:

> When I had my addiction issues, the biggest concern was that they felt that I was unhappy with who I was and it was always questions like 'are you suicidal, do you or don't you want to be here anymore, is it because of your sexual orientation that are not accepting of yourself?' I said no, 'I just have an addiction problem.' I just have an addictive personality so that's what it came down to. If it's in my grasp I'll do it and I will do it to the full extent that I can... I think he was looking for me to say; yeah it's because of my sexual orientation.

Karla, who does not identity with a particular sexual orientation and is non-binary, (meaning that they do not identify within the gender binary) also shared a story about being put in therapy as a youth:

> I came out as gay in high school. My mom put me in therapy and they just said 'oh no it's probably just his OCD and he's probably just obsessing over thoughts'. I was like oh no, I just want to sleep with men; I don't think that is much of a mental thought. He told my mother that I was probably, of course they tried saying it was a phase and that it was an obsession because I also have mental

health issues, they like to blame it on that.

Bias and judgment as a form of administrative structural violence.

One of the interesting things that came to light through this research was the ways that bias comes out. While some participant expressed being judged by service providers, others said that they experienced bias. For example, Gregg spoke about experiencing bias when he transitioned, stating:

> My previous doctor was okay but his nurse was not. It was a personal thing, there
> was a personal bias. She still did her job and she did it well but part of being
> supportive in the medical care is to go in and actually feeling those kinds of
> emotions, you know those Jekyll and Hyde types things and also she wasn't like
> that with before I transitioned... She never spoke derogatory or was mean or
> anything like that but you could still sense that there was ignorance because
> before we used to talk and laugh and I still tried to joke with her and stuff.

Some participant's spoke of very specific homophobic, biphobic or transphobic experiences of structural violence, however, most expressed that they experience it in subtle ways. Interestingly many participants stated that they would not disclose their sexual orientation or gender identity to their doctors if they had felt that their doctor was judgmental about other things, for example weight, which was an example that two participants provided. Meredith explained:

> …I felt really judged by my doctor about my body size and for me that instantly shuts me down. I'm like, forget this! And so there was no way I would have talked to her about anything more complex…My first experience is that you judge me on my body size and the way I look, like I can't even imagine what else you judge me on, so there's no way that bisexuality or anything else came up in those conversations or my access to healthcare.

Jodi who is just beginning to transition and identifies as "yet to be determined" has never visited the doctor as a woman, and talked about being judged by healthcare providers:

> … I have always have my nails done and she sort of flipped out, you know one of these real quickies and then out the door. The other, he noticed my hands and arms were shaved and he was professional but you could tell it was uncomfortable, just speed this up and get it over with… I went to the doctor as a guy, if I go back like this, how will they react, you know, so then what… I wouldn't feel comfortable going to my current doctors like this, as a woman. I should but I don't.

Poland stated "I think it's getting better. They're tolerating but I know that there are some people who are starting to accept." Poland is the only participant that said that doctors ask about his sexual orientation instead of assuming. He also expressed that he doesn't have issues with medical professionals stating:

> … that's normally one of the first things they ask. 'So what's your sexual orientation, how many partners do you have, do you practice safe sex, have you been tested?' And they don't frown either. They don't give a face… I would tell

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them where to go. You know what I mean; you do your job and don't judge, you get back what you put out so I just wouldn't tolerate it.

While Karla, a non-binary participant stated that they were afraid to go to their doctor and voiced concerns about having to sign everything as their biological gender. They talked about having a good experience with a local counselling centre:

They were more than okay with me. They actually called me by the name I went by and it was very comforting because everywhere I go I present myself with my chosen name and then when I have to sign something they say 'Oh that's not your name' and then I have to explain.

Karla also spoke of some bad experiences; one in particular was very troubling:

I was in the hospital for a suicide attempt... One of the reasons was that I wasn't comfortable in my body. I didn't like it and I still don't. I told them and they said 'well that's not a good reason'... It was kind of like I was more afraid of being in the hospital than being outside of it and that's not safe. While I was in there they had to constantly remind me that I am a guy, they kept reminding me that I am biologically male. If this is the way the medical profession is going to treat me then I am fucked.

Following the same theme Gregg stated, "I'm terrified, I need surgery and whoever we end up getting had my life in their hands" said in relation to a specialist he had seen in the past but has refused to work with him since his transition. Furthermore, Crystal is afraid to come out to her family doctor, stating:

I'm afraid to tell my family doctor... I don't know if it is the things he said or the

way he said them. When he asked me if I am single, married, divorced, or

widowed, in the way he said it to me, in the wat he looked at me, I knew if I said

anything then he would treat me differently so I didn't.

Crystal also recollected that her doctor has Christian posters hanging in his waiting room,

which she feels is inappropriate and may have been in part what caused her to feel

unsafe. When asked about how she could tell when someone was having a negative

reaction to her sexuality Crystal had an experience outside of Brantford that she spoke of:

The one girl, she clearly backed up and was afraid to touch me, like she was going

to catch the gay or something. It was obvious, completely obvious. Every time she

came in, like close to my bed, she put on gloves and a gown. Like seriously, what

you are going to catch.

Poland shared a story about an experience he had with the Brantford Police:

I encountered a lot of hatred from the Branford police. Years ago we went to the

Rodeo. It was my sister's birthday and I got a bunch of us all together and after

that we went to Admirals. We were hanging out and my friend is a social butterfly

and she was talking away and I went over and I talked in this man who just started

saying 'get outta here, fuck off' I said 'what your problem' and he just said 'fuck

off'. I said to my friends we have to hurry up and get outta here because this guy

is acting out and the guy said 'fuck you, you fucking faggot' The guy leaned

forward over his girlfriend, punched my friends and I said 'we've got to go', so

we ran out of Admirals and went to Harmony Square. We were sitting there

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eating and two officers showed up, a male and a female and said 'oh we are responding to a disturbance in Admirals, what's the situation?' I was trying to tell the officers 'the gentleman in there called me a faggot' and the male officer said 'well aren't you?'

Poland and his friends wanted to make a complaint about this officer. When he asked for the officer's name and badge number the officer threatened to arrest them for public intoxication. Poland and his friends called the police station to explain what happened, however the officer they sent to take the complaint was the same officer who had said the comment in the first place.

Tammy and Jenny shared that they have accessed a couple of social services within Brantford. Initially they described accessing counselling services as a very positive experience. They stated that their counsellor nice and accepting, however the counsellor did not follow up with them to spite them calling and leaving messages. This caused them to question whether or not the counsellor was actually accepting. They also shared an experience that was very difficult. They accessed the Foodbank, which they explained:

So the Christmas of this past year we ended up going to the Foodbank and getting one of the Christmas hampers. I mean the situation was awkward because there is a lot of pride involved and self-confidence things involved in accessing a social service like that. And then to walk in and be greet by these seemingly sweet, most conservative looking older women, who were also very nice and polite. When you access the service you have to provide names of everyone in your house and they ask for your driver's license. They asked if Jenny was actually Jenny. Obviously

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the gender marker says female and her name is very feminine and the woman

looked down and up and down and up again and said 'oh, is that really you?'

Jenny left…they are making judgments in their head about you. They are making

assumptions... You get the impression that they are either upset by you presence

or disgusted by your presence. You feel like second-class citizens. Not only are

you there accessing a service that maybe if you just worked harder, or you got a

better job or if you had a better work ethic or if you could just manage your bills

better you wouldn't be in that situation.

While some examples are more blatant, all participants expressed that most of the

time it is not what service providers say or do, but rather their body language that shows

their bias. When asked how participants can tell that service providers are not LGBTQ+

inclusive or accepting they all talked about different variations of body language. Many

said that when they disclose their sexual orientation a service provider who is not

accepting they can tell because they get visibly uncomfortable. For example, Emma and

Poland both stated that sometimes they will not make eye contact again or get fidgety.

Blake recalled a time when a specialist completely changed his demeanor with him:

I went to a specialist, I talked to him and he was free and casual and easy with me

and then the next time I came in I had a pride bracelet on and he shunned and

turned away from me. He would not shake my hand even and that was the

difference from the first meeting and the second.

Crystal said she has experienced nurses who "take a step back like they are going to catch

'the gay'." Gregg said that they sometimes "become cold and curt." Poland talked about

the importance of eye contact "you can't contract it through touch, like my eyes won't turn you into a gay."

Many participants stated that you can tell if there is no bias because when they disclose their sexual orientation there is no response; no look of shock; and no changes in their body language. For example, Emma stated "when I tell someone and they just say okay and move on to the next question then I know it's okay… it feels safe."

Lateral violence.

Some participants expressed perceived or actual experiences of lateral violence, while others, perhaps unknowingly, participated in it. For example, both Bisexual participants, Blake and Meredith, discussed the Lesbian, Gay and Trans community as being sources of oppression for them because of assumptions and lack of knowledge about Bisexuality. Their invisibility, because of their current opposite gender relationships and because of their gender performance, can also be read as heterosexual privilege, causing them and/or others to feel like their experiences are not as real as the Lesbian, Gay and Trans community. Both participants expressed that there is not really a place where Bisexual people fit within the LGBTQ+ community, within Brantford/ Brant County because there are no groups for Bisexual people and because of the LGBTQ+ community believing that Bisexuality is not real. For example, Blake stated:

I went out to meet and talk and the guy would be like 'you're not bisexual, you're gay' and I'd be like 'no, I'm bi… every-time and the females that I shared that

with; they were different. They were like that's cool but the guys were like

staking claim.

Meredith said:

> … I was really new to the community… and didn't know a lot of the dynamics
> that went on so I just sort of rolled with the various punches but I definitely know
> there were a few people in the community whose response to bisexuality would
> be 'that's not a thing.' …There is no Bi peer support group, which again I'm sort
> of sitting here thinking why haven't I just started one but again I think there's a
> way in which I'm very okay with being known in this community as being an
> activist and advocate for queer communities. I'm not sure, probably until more
> recently, where I felt more stable in my job that I could be like, out in terms of
> who I am. You know there's always that fear right, there's so many people in this
> community are not going to get it. They are not going to understand what
> bisexuality is. They're not going to accept it so being public in a way of leading a
> Bi peer support group; I don't think I've been there yet. I may get there. I feel
> closer to it, but I guess part of it is that if I wanted those social services I would
> have to create them. If I wanted a peer support group, it's not happening on its
> own.

While Meredith and Blake experience lateral violence because of their Bisexuality,

Poland may unknowingly perpetrate it. For example, in reference to other men getting

uncomfortable around him when he outs himself, he stated:

…we're not all the same and not every gay man wants a straight man. Like relax I

don't find you attractive to begin with so we're not all here to convert you and

that's why I find it hard when there are the ones, like the flamboyant ones. They

make it difficult for people like me and my partner, where we live our lives, like

I'm a gay male but I am Poland. Then there's ones that throw in your face and it's

like those are the ones that make it difficult for us when we're trying to pave this

way.

Resistance to Structural Violence

Avoiding accessing services as a form of resistance.

Many participants in this research project stated that they access services much

less than they would if they felt like services were accepting and knowledgeable of

LGBTQ+ needs. Participants also shared that in times when they do need to access care

and they experience violence they feel that they just have to take it, shove their feelings

down and just get through it, in order to get what they need from the service provider.

Crystal said that her experiences have shaped the way that she accesses healthcare and

social services because she is more careful now, stating "I know that you can't trust

everybody and you learn that as you grow up." Tammy stated:

I've avoided care for years. In some cases it's because of the type of medical

issues I have but the majority of it is that I don't feel comfortable. I don't know

how to explain this, I don't want to out myself for the millionth time and have

someone question me like really, 'will have you just tried being with the man?' I

can't imagine heterosexual women going into a doctor's office and them saying 'well really, when's the last time you slept with a woman, don't you think you should try it again?'

Jenny explained, "I don't want to go. I don't want to answer the questions. I don't want it out myself again. I don't want the looks. I don't want the kind of sidelong glances or the looks of disgust."

In reference to the bad experience at the Foodbank, Tammy stated:

> It's like oh yeah; I want to go do that again. How about we just go hungry! How about we just, you know, if money got really tight again, how about we just get a couple of loafs of bread and like cheese slices and we wouldn't have to go back there and we could just live off of that three meals a day. So then you're putting your health in jeopardy again, your nutrition, your mental health, your stability, your sanity.

Karla said that their bad experiences have hindered their access to care explaining:

> I don't even really want to go talk to a doctor, I'm afraid to talk to a doctor because there is very little I can actually do. I have to sign my biological sex on everything. Yeah I can legally change my name and change my dress or my apparel. I can easily change my voice. I can do that but I feel like there are limits to what I can do and when you are already treated poorly and hear the horror stories, it just makes you think, I'm not even going to bother.

Resistance to heteronormativity and gendernormativity.

Another way participants resisted was in their presentation and how they identify. For example, Karla explained:

> I'm non-binary, my pronouns are they, them, and their until a better one comes along that sounds more grammatically correct. My sexual orientation, I can't really put an exact label on it. Sexual orientation is a massive word and nowadays there is no real definite end of the spectrum. It's such a massive word now so I guess I prefer not to label my sexuality.

Further, Jodi uses both he and she pronouns and identifies as "yet to be determined". Virtually all participants are displaying that they resist heterosexuality by loving who the love and identifying outside of heterosexuality. Jenny and Crystal are both lesbians who do not conform to feminine norm, despite being constantly mis-gendered. When asked which pronouns she uses Crystal answered "I don't care... sometimes people call me he, sometimes people call me she. I just answer to whatever. It's never bothered me." Even though Jenny and Tammy stated that it is "embarrassing" and "horrible" to have to justify who they are, they continue to out themselves as a couple in situations where they know that their sexual orientation may be judged. Further, Jenny remains to present as very masculine despite continually experiencing violence for not conforming to rigid gender norms.

Ideal or safe experiences with service providers.

All participants who said that they felt supported by their service providers expressed that the service provider's space was outside of heteronormativity, for example

Gregg stated that his doctor's office "has posters up for all of the LGBTQ+ groups."
Bradley and Blake both stated that their doctor's office "had rainbows, posters or other
LGBTQ+ stuff" in offices or waiting rooms.

Participants who did not believe their doctors were supportive also stated that they
have never seen anything LGBTQ+ friendly in their offices. The importance of this stems
from participants responses when they were asked what would make them feel able to be
safely open about their sexual orientation and/or gender identity they all cited things like
rainbow stickers, posters, LGBTQ+ information, which would show them that it is a safe
space or that the providers are at least trying to be inclusive, for example Meredith said:

> I think it goes right back to, first having visual stuff within the actual office, like
> posters about LGBTQ+ sex and sexuality, rainbows, whatever it looks like but
> just as soon as you walk in the office to have a visual sense that people recognize
> that queer people exist. That would be the first step.

Emma stated "it would be helpful if they didn't assume you are straight, if they asked
how you identify…and if their forms were more inclusive to give people options rather
than making them pick boxes."

Further, participants stated that they would feel much more comfortable
disclosing their sexual orientation and/or gender identity if service providers did not
assume heterosexuality and instead asked how people identify. Meredith, who has never
disclosed to her doctor stated:

> If a doctor asked me directly 'how do you identify in terms of you sexual
> orientation and do you have any needs in relation to that?' I would easily be able

to say, oh I identify as bisexual and I don't think I have a lot of specific healthcare

needs but thanks for saying that because now I feel like if there is something I can

come back to you and talk to you about it.

CHAPTER 5: DISCUSSION

Discussion

It is important to note that this research is not about individualizing experiences or the knowledge level of individual service providers, but rather, examining the findings as symptomatic of the way that "power manifests in interconnected, contradictory sites, where regimes of knowledge and practice circulate and take hold (Spade, 2015, p. 4). The data is also being examined through an intersectional feminist lens which allows it to be understood through multiple intersecting oppressions including gender, race, class, sexuality and so on, as they relate to inequalities experienced by the Brantford/Brant County LGBTQ+ community. Throughout the finding section of this paper, participants' gender performance was noted because it is vital to understand, that while sexuality and gender are very different, it is not possible to investigate one without also taking the other into account. Both are power structures that categorize people and determine their life chances (Spade, 2015) and because gender is a category that is imposed on all people (Newman, 2012), it is important to understand how participants' in this research project perform gender and how their performance affects how they are treated and the care that they receive.

This discussion section of the paper is broken up into subsections which including heteronormativity and assumptions of heterosexuality and/or gender, gendered violence, homonormativity, lack of knowledge, bias and judgement as a form of structural violence, avoiding accessing services as a form of resistance to structural violence, resisting heteronormativity and gender normativity, heteronormative and inclusive space, rights and their limitations, and moving forward.

Accessing Healthcare and Social Services

During data collection participants of this research project placed much more emphasis on accessing healthcare than they did on social services. This could be because people simply access healthcare more than social services, or they may not feel comfortable disclosing whether or not they access social services. It could be because they generally have better experiences with social services or because they do not feel comfortable accessing them. Those who did access social services had varying experiences, meaning some good and some bad. Therefore, this is a potential area for further research.

Heteronormativity and Assumptions of Heterosexuality and/or Gender and Gendered Violence

Martin (2009) that gender and sexuality are both governed by heteronormativity, meaning that assumptions of heterosexuality and/or gender are dominant forces. Spade (2015) takes this idea further suggesting they are 'norms' that dictate how everyone should behave. These norms are enforced through power, which does not stem from any one person but instead is being exercised through all of points of any relationship (Foucault, 1978). Therefore, assumptions of heterosexuality and/or gender are enforced norms that place LGBTQ+ people in the position of having to choose whether or not to out themselves on a regular basis; thus, being confronted with potentially being ostracized, facing violence, and being treated poorly for simply being honest about who they are. Participants who perform gender within the bounds of the binary, discussed

being invisible and always perceived as heterosexual, while participants who do not perform gender according to binary standards were frequently mis-gendered and treated poorly. Moreover, virtually all participants who have disclosed their sexual orientation and/or gender identity to their healthcare or social service providers discussed assumptions of heterosexuality and/or gender, producing stress and anxiety. While those who have not disclosed their sexual orientation and/or gender identity rely on heteronormative assumptions and don't feel safe enough to correct them.

In some cases the assumptions made about participants was greatly affected by their gender performance. Recall Butler's (1990) work about gender being performative, meaning that humans are not born a girl or a boy or behaving feminine or masculine but rather, learn to become the gender which they have been assigned through learning to perform (Bulter, 1990). Throughout the findings it is clear that gender performance affects the treatment LGBTQ+ people receive. Take for example Jenny being mis-gendered when visiting the hospital and feeling embarrassed when she has to justify who she is in front of other patents and her example of her identity being questioned while accessing a service that required identification. Similarly, Karla's experience of medical staff constantly reminding them of their biological sex when they were seeking help for a suicide attempt because of not feeling comfortable and their body; is another example. Although these experiences are coming through individuals, they are enforcing dominant norms through policing gender (Pascoe, 2007; Spade, 2015).

Assumptions of heterosexuality and gender cause LGBTQ+ community members to have to decide how to approach each situation, figure out if it is safe to disclose or not, and learn to navigate getting the care that they need, despite the fact that none of this

would be necessary, as participants pointed out, if the dominant discourse were changed to simply ask rather than assume a person's sexual orientation and/or gender identity. Asking would eliminate the fear and anxiety of not knowing how service providers will respond and it would acknowledge and normalize the LGBTQ+ community.

It is important to acknowledge that there are differences in how accessing care is experienced, which are affected by gender and gender performance. For example, Lesbian participants who perform femininity well, within the bounds of the gender binary were always presumed to be heterosexual while Lesbians who are more masculine in appearance tend to be more likely coded as Lesbian and frequently as men. Mis-gendering people is structural violence. It is about policing gender and attempting to force people into rigid gender norms created by dominant forces (Pascoe, 2007). It is a way of maintaining the status quo and othering those who do not comply.

Further there are differences in the way that cisgender Gay men, Lesbians, Bisexuals, Trans, and Gender Non-conforming people seek and demand care. For example, in the research cisgender Gay men stated things like, "I just wouldn't put up with it" in a way that demands proper care. They also express that their healthcare providers know what they need, for example asking questions about sexual partners, protection, and HIV testing, which could be because of gender inequalities and because of the AIDS crisis and the amount of training doctors have had around it. Whereas Lesbians, Bisexual women, Trans and Gender Non-Conforming people had more of a tendency to be less demanding about the care they receive, saying things like "that's just how it is", "but you know, that's our community" or "you just deal with it." Furthermore, these participants expressed that their doctors did not know what they needed and instead insisted on

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providing forced pregnancy tests or attempted to force them into gender compliance. These examples speak to the gendered nature of the systems of power that dominate and to the normative socialization that girls and women are often subject to where they are actively encouraged to be demure, or peacekeepers, or not to question authority.

Homonormativity

Homonormativity refers to the normalization of a select group of LBTQ+ people (Duggan, 2002). Some research participants could be placed in this category because they are white, Gay or Lesbian, cisgender, have jobs and are in long term committed relationships. Based on the interviews, these participants experience less difficulty when accessing services, than the participants who are Bisexual, Trans, Gender Non-Conforming or those who experience disabilities. For example the white cisgender Gay men interviewed were both in long term relationships and had very little difficulty with healthcare providers, while Bisexuals were made invisible and Lesbians in long term committed relationships had significantly more difficulty accessing services but not nearly as much trouble as Trans and Gender-Non-conforming people. This is both because of gender as a system of power and because the homonormative participants meet the standards of what is acceptable within heteronormative society, while all others cannot possibly. Many of these participants face multiple marginalizations.

Lack of knowledge

Lack of knowledge of service providers is not about blaming individual service providers but about recognizing and confronting this lack of knowledge on a systematic level.

Wheeler & Dodd (2011) state that when assumptions are made about heterosexuality and/or gender binaries service seekers believe that disclosing their sexual orientation and/or gender identity will have a negative impact on the care they receive. Therefore, the dominant discourse of heterosexuality and gender compliance leads LGBTQ+ people to believe they will not receive positive care upon disclosing. This was evident in the findings of this project as well. Lesbian, Trans and Gender-Non conforming participants expressed this concern. For example; Gregg's comment about needing surgery and being scared because the doctor has his life in their hands. Likewise, his experience of having to disclose that he is Trans in front of other patients and his description of the feelings that took over him in that moment; (i.e. fear, panic and anxiety), are symptomatic of trauma and Post-Traumatic Stress Syndrome and the experiences that LGBTQ+ people frequently feel when they have to publically disclose their identities (hooks, 2009).

In addition, the ways that lack of knowledge came out in this research goes beyond having a lack of LGBTQ+ language skills to refusing to work with people, making partners leave the room, forcing people publicly out themselves, attempting to force gender compliance, and forcing pregnancy tests on Lesbians who have never had intercourse with men, which can also be construed as gendered violence. These components of lack of knowledge all fit within gender binaries and heterosexuality as

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dominating structures of power. This is not about what service providers individually

know about LGBTQ+ people, it's about systems that excludes LGBTQ+ and are

reinforced through social actors (Spade, 2015; Martin, 2009).

Bias and Judgement as a form of Administrative Structural Violence

Bias and judgment are often transmitted through social actors (Mule, et al., 2009)

which causes them to have the appearance of being individual bias and/or judgment,

while they are in fact symptomatic of violent systems of power that have been built to

categorize, divide and exclude certain members of the population (Spade, 2015), in this

case the LGBTQ+ population. For example, Poland's experience with the police brings a

lot of questions about protection laws. The officer's language, for example, although he

did not outright call Poland a "fag," he certainly implied it. Poland wanted to do

something about this and was essentially stopped by the police, who were the perpetrators

and who are supposed to protect him. As a white cis-gender male Poland is also the least

likely to experience police violence, yet he did. When the police are the administrators of

the violence that LGBTQ+ people are experiencing than accessing, or even trusting the

legal system to take care of them is a frightening thought (Spade, 2015). While Poland's

encounter with police violence was the only one voiced in this research project, it is

important to discuss because at first glance, Poland's encounter may look like an

individual or one off situation. However, if this experience is looked at outside an

individual context, it speaks to the structural power dynamics at play and the enforcement

of masculine gender norms, which are systematic and institutionally enforced (Spade,

2015, p. 9). It is also why a rights-based model does not work—if the laws are there to protect

rights, but the systems demonstrate that these aren't actionable, you get a loop of rights being

violated, but a lack of reporting the violations.

Avoiding Accessing Services as a form of Resistance to Administrative Structural Violence

Very little literature exists on LGBTQ+ populations outside of large urban

settings and particularly with regards to avoiding accessing healthcare and social services

(Harcourt, 2006; Bell& Valentine, 1995). However, the data that does exist suggests that

the LGBTQ+ population experience substantial health inequalities (Daley &

MacDonnell, 2011), which is in line with the findings of this particular research project.

Participants overwhelming stated that they avoid seeking medical care or accessing social

services because they do not want to face the violence of having to out themselves, justify

who they are, and deal with micro-aggressions. Recall that Gregg stated that he will not

go to the hospital, Tammy and Jenny spoke about going hungry rather than accessing the

foodbank and Jodi said that they have not gone to the doctors as a woman because they

do not feel comfortable. Karla, Crystal and Meredith all have never discussed either their

sexual orientation or gender identity with their family doctor. While some (4)

participants felt as though they had supportive healthcare providers, recall that they all

stated that they only felt their particular provider was safe. Each of them expressed never

disclosing their sexual orientation to any other healthcare provider, having bad

experiences when they did, or simply refusing to seek medical care outside of their

healthcare provider.

In many ways avoiding care is about self-preservation and resisting the potential or actual experience of violence. While this resistance to violence may pose further health risks it is also a way of not accepting or being a part of an exclusionary system. It is about taking control and not allowing the systems of power to violate those who do not take part in it and/or a way of inserting one's self into power structures by attempting to reclaim their own identities.

Resistance to Heteronormativity and Gendernormativity

All participants in this research project, whether Lesbian, Gay, Bisexual, Trans, Gender Non-conforming etc. resist heteronormativity and gendernormativity by simply being themselves, loving who they love, identifying how they feel and not complying with dominant norms, despite continually experiencing violence, as evidenced by this research. For participants, even the choice not to disclose sexual orientation and/or gender identity is an act of resistance. They may be resisting dominant labels, or resisting the potential or actual experience of violence.

Heteronormative Space and what Inclusive Space Looks Like

All participants discussed space and what "safe spaces," meaning LGBTQ+ inclusive spaces look like in comparison to heteronormative spaces. Brantford/Brant County is a fairly small community and there is no LGBTQ+ community centre or LGBTQ+ permanent space of any kind. Therefore, LGBTQ+ space must be temporarily created through peer-led groups and events (Gray, 2007; Marple & Latchmore, 2005;

Morris, 2015; Marple L. , 2005). As participants pointed out, unfortunately this means that most spaces they find themselves in are heteronormative, and simply being in these spaces and having to navigate them creates experiences of trauma (hooks, 2009). Participants also overwhelmingly stated that they typically do not see themselves represented in their service providers' offices, which affects their feelings of belonging and safety. The 4 participants that did express seeing themselves represented in their doctor's offices all attend the same healthcare clinic and expressed that they felt safe with their specific doctors; even though they do not feel that they are necessarily knowledgeable about LGBTQ+ needs. This implies that if service providers are not knowledgeable but are open to learning and creating visibly safer environments, perhaps a sense of normalcy and belong via posters or rainbows, which provide acknowledgement of the LGBTQ+ existence then participants feel safer. Furthermore, it suggests that LGBTQ+ inclusivity and safety when accessing services is more about making changes at a systemic level than an individual one because participants are essentially saying, service providers do not need to know everything but they do need to acknowledge LGBTQ+ existence and put a bit off effort into moving away from heteronormativity, gendernormativity and the spaces they occupy. Recall that heteronormativity and gendernormativity are structures of power that dominate, categorize and marginalize people. Further, homonormativity is also a structure of power. It divides, and categorizes the LGBTQ+ population by normalizing those who can met and/or are willing to conform to heteronormative ideals while further marginalizing those who cannot or are not willing to (e.g. LGBTQ+ people who are poor, youth, those experiencing disabilities, racialized people, Trans and gender non-conforming people) This categorizing and dividing of the LGBTQ+ population creates lateral violence. For example, Poland's comment about the

'flamboyant Gays' that make the rest look bad. Poland has an idea about how Gays

should look and act and this idea likely stems from the power structures that have

dictated how he should look and act. Further, Gay men who do not and cannot meet

expectations make every other member of the Gay population look bad.

When participants voiced what a safe LGBTQ+ environment looks like they were

expressing wanting to see themselves represented, which translates into wanting to be

considered "normal" and like they belong, rather than people who are shunned by service

providers who "take a step back from", "don't make eye contact", or be "cold and curt."

When participants stated that they can tell a space is safe if they disclose their sexual

orientation or gender identity and there is no response other than "okay." Recall that

Emma shared that when she was young she used to look for hours for rainbows because

that was a sign that in that space she could be herself while she was there. Emma was

looking for a sense of belonging, perhaps a place to find community. Blake said that all

he needs to know that he is in a safe space is a little rainbow. Additionally, Emma's story

about watching the flag go up at city hall making her feel visible within Brantford/Brant

County is a perfect example of the power that queering predominately heterosexual space

has. While these situations are individual experiences, they are also themes that emerged

from all participants. Each of them shared ideas about what safe spaces are and they are

spaces in which they see themselves. The importance of this is that this research must be

viewed through lenses that understand it is not individual experiences, but rather, power

stemming from "regimes of practice and knowledge that coalesce in conditions and

arrangements that affect everyone and that make certain populations highly

vulnerable…" (Spade, 2015, p. 3). In the case of this research it's LGBTQ+ people,

however, these regimes of power, through gender, sexuality, race, class etc. affect everyone because those who benefit from and fit within the 'norms' have to work really hard to maintain it.

Rights and their Limitations

Blatant experiences of LGBTQ+ phobia are the ones that people are more likely to have rights to protect them against, provided they can access them. Recall that people in Canada have the right to be free from discrimination and harassment on the basis of their sexual orientation and, therefore, the use of homophobic language is meant to be shut down. Further, human rights laws do not protect LGBTQ+ people in situations where homophobic language or physical violence is not explicitly used but rather, the violence is experienced through microaggressions. Recall that microaggressions are more subtle and often invisible forms of violence (Nadal, et al., 2011; Sue, 2010), which all participants in the study expressed experiencing. Even the assumption of heterosexuality and/or cisgender is a microaggression (Nadal, et al., 2011). Furthermore, human rights language is a band-aid rather than an actual solution to the problem. Laws are not proactive but reactive, which means that they do nothing to address the problem on a systematic level (Spade, 2015).

Although Transgender discrimination is not currently explicitly listed under any protection laws, Karla constantly being reminded of their biological sex, while being a patient in a state run medical facility constitutes harassment and discrimination (i.e. violence). However, Karla did not make a formal complaint. In fact none of the

participants in this study have ever made a formal complaint with regards to the violence they have experienced while accessing healthcare or social services. The one person who tried, Poland, experienced more violence by the police sending the officer to take the complaint that he was attempting to file it about. This is a blatant example of the use of power and control to perpetrate structural violence and is a perfect example of not only structural violence as a problem but also the need to move away from a rights-based approach to conceptualize a structural solution (Spade, 2015).

Project Limitations

Due to time and resource constraints, this research project was very short, with data collection only lasting for duration a duration of one month. This placed tight boundaries around the number of research participants, and also the amount of time there was to recruit participants. Budgetary restrictions also limited the number of Research Assistant's that could be hired. Although the project had a Trans Research Assistant, a racialized team member could possibly have helped potential participants who are racialized feel more comfortable with participating in the project. This could have had an impact on the whiteness of the project. It would have been very beneficial to gain some data and knowledge about how those with intersecting oppressions, such as racialized LGBTQ+ community members experience accessing services

While this project was initiated in Brantford/Brant County, an area for future research could be in other similar small communities to gain more data on how the non-metropolitan LGBTQ+ population experiences accessing healthcare and social services,

looking for potential similarities and discrepancies between them.

Recommendations

Having established that LGBTQ+ Brantford/Brant County community members experience structural violence while accessing healthcare and social services, which affect vital aspects of life including health, mental health and wellbeing, and sense of belong; it is imperative to think about ways to move forward. It is vital that the limits of a rights-based approach be recognized, if any real change is going to be made. Spade (2015) argues the need to break away from the narrow narrative that the current law reform framework tells about how power works. Systems of meaning and control that mal-distribute life chances such as racism, ableism, transphobia, xenophobia, and sexism, among others, operate in ways more complicated, diverse, and structural than the perpetrator/victim model allows (Spade, 2015). Moving away from the perpetrator/victim model allows room for the system to be questioned rather than the individual. In addition, the LGBTQ+ movement needs to be redeveloped, moving the work away from funding and leadership that consists of the most privileged of the LBTQ+ population (i.e. white capitalists and white middle/upper class Gays and Lesbians) (Spade, 2015), away from capitalist corruption and back to its roots (Sears, 2005). Spade (2005) states that "if we are to focus on "bottom-up" mobilization for transformative change rather than top-down empty declarations of equality, we need to build social movement infrastructure that can support mobilization" (pg.94). The importance of this rethinking and infrastructure building is about inclusion of the whole LGBTQ+ community, ensuring that no one is being left behind, and divides within the LGBTQ+ community are eliminated. It's about

creating a movement that makes real social change and brings all LGBTQ+ and other

oppressed groups in from the margins as community members who are a part of the

norm, and accepted for who they are, rather than tolerating those who can and/or choose

to meet homonormative standards.

CHAPTER 6: CONCLUSION

Conclusion

Overall this research has provided a greater understanding of how LGBTQ+ people within Brantford/Brant County experience accessing healthcare and social services. By gathering data about the experiences of 12 LGBTQ+ community members and examining how they experience accessing healthcare and social services through intersectional feminist, critical, and critical Trans politic lenses it is evident that all 12 participants experience high rates of structural violence. It is also clear that many experience multiple marginalizations because of intersecting oppressions, such as gender, as a structural power.

Heteronormativity, as a structure, forces LGBTQ+ people to have to live within a system that is not built for them, but instead pushes them to the margins and controls and constrains their life chances (Spade, 2015). Heterosexual and gender assumptions make LGBTQ+ populations navigate accessing healthcare and social services that structurally exclude them, while perpetrating further violence against them through social actors. Having to make the decision to seek healthcare or social services and risk experiencing violence or be sick and potentially go hungry is directly linked to controlling and constraining LGBTQ+ people's life chances. In addition, homonormativity creates a divide within the LGBTQ+ population by dictating what defines a 'normal' queer person and thus allowing the most privileged members of the population to come in from the margins, leaving the most marginalized, such as Trans people, racialized people, poor people, and street youth-behind (Drucker, 2015; Sears, 2005).

This research also makes clear that the experiences of structural violence affect LGBTQ+ community members' sense of belonging, connectedness and community, which are all vital parts of human life (Knopp, 2004; hooks, 2009; Easterbrook & Vignoles, 2013). The need to belong, feel connected and have community can be difficult for LGBTQ+ people if they do not see themselves represented in the spaces they enter. Evidence shows that being or feeling represented in spaces such as hospitals, doctors' offices or social service offices takes very little effort because many participates stated that they only needed to see a rainbow sticker, or poster that represented LGBTQ+ people in some way, to feel like the space is safer. This is about slightly queering space to share it with everyone. It does not mean that a space is safe, but rather, shows that an effort to be inclusive is being made.

Many participants expressed that they avoid accessing healthcare and social services until they absolutely need to. This obviously has the potential to put their health and well-being at risk, but it may not be placing any more harm on them than experiencing violence and post-traumatic stress from accessing services. Avoiding accessing these services is resisting structural violence and thus repelling the system that is in place to categorize and restrain and marginalize them. Avoiding care as a form of resistance is about dodging violence and control in favour of self-preservation.

Participants resist dominate norms by being who they are and not conforming. It is acts of resistance each time they choose to walk down the street holding hands with their partner(s), love who they wish, and dress how they feel, disclose or chose not disclose their sexual orientation and/or gender identity, or chose not to identify within categories at all.

While this research has revealed that structural violence is in fact experienced by LGBTQ+ people within Brantford/Brant County, it is experienced both overtly and covertly. Participants indicated sometimes experiencing overt forms of structural violence through blatant bias and judgement for example when service providers refuse to work with LBTQ+ people or attempt to force gender compliance on them. However, much more frequently structural violence is perpetrated covertly, for example the lack of knowledge service providers have about LGBTQ+ needs is structural aggression that reinforces dominant norms. The microaggresions participants in this research study faced may have been administered through individual service providers, but service providers are social actors reinforcing dominant norms. Furthermore, these covert forms of structural violence are not likely to be something an LGBTQ+ person could file a human rights complaint about because they fall under the radar of what constitutes a human rights violation (e.g. physical violence or being called derogatory names like "fag"). Moreover, when LGBTQ+ people do attempt to file formal complaints when overt violence is perpetrated against them, they are at risk of facing further structural violence from hegemonic powers that enact more barriers and prevent people from accessing their rights.

With LGBTQ+ community members experiencing structural violence while human rights laws are in place it is clear that legal reform has had limited success. Thus, it is time to rethink this approach and restructure the LGBTQ+ movement. Through the works of Sears (2005) and Spade (2015) it is possible to see an LGBTQ+ movement that supports mobilization outside of all of these repressive power structures such as gender, race, sexuality, class and so on. According to Sears (2005) a remobilization of the

LGBTQ+ movement that exists outside the capitalist market and not led by white upper or middle class Gay men is needed. Furthermore Spade (2015) states that it is necessary to transfer the movement away from a rights-based approach and towards creating real change from the ground up rather than the top down.

In closing, this research establishes that LGBTQ+ participants experience structural violence and often these experiences are covert. While they may not be physical in nature they are experiences of violence and they are equally harmful. Further, although structural violence is widespread change can still be made on a local level which can eventually create change at the structural level. It's about viewing liberation as a process, rather than something that can be achieved through rights. Change-making occurs through grassroots work, particularly when it is created outside of the capitalist market, apart from human rights discourse, and by the LGBTQ+ population. Achieving this outcome is about creating a movement that is truly inclusive of all LGBTQ+ people, and getting behind and supporting grassroots work to create real on the ground change.

Appendices

Appendix 1: Recruitment Poster for Interviews

Lesbian, Gay, Bisexual, Trans, and Queer (LGBTQ) Experiences while Access Healthcare & Social Services within Brantford/Brant County Research Project

(This research project has been approved by Wilfrid Laurier University's Research and Ethics Broad # (REB4827).)

M.A. student Christine Wildman, in the Social Justice and community Engagement Program at the Laurier Brantford Campus, is conducting a study to better understand the experiences of the LGBTQ community, when accessing Healthcare and Social Services.

If you are interested in sharing your experiences about accessing healthcare and social services and answer YES to the following three questions, please consider participating in this study. The information you provide will be used to inform healthcare and social service providers of the needs of the LGBTQ community.

✔ Do you identify as Lesbian, Gay, Bisexual or Two-Spirited?

✔ Do you access healthcare and social services within Brantford/Brant County?

✔ Would you be willing to discuss you experiences in a confidential, individual interview?

For more information, or to schedule and individual interview, please contact Christine Wildman at: christinewildman@live.ca or at 519-755-5908

All messages are confidential. Please leave a message with your first name and where and when you can be contacted.

LAURIER *Inspiring Lives.*

Faculty of Arts: Social Justice & Community Engagement

Appendix 2: Recruitment Poster for Focus Group

Lesbian, Gay, Bisexual, Trans, and Queer (LGBTQ) Experiences while Access Healthcare & Social Services within Brantford/Brant County Research Project

(This research project has been approved by Wilfrid Laurier University's Research and Ethics Broad # (REB4827).)

M.A. student Christine Wildman, in the Social Justice and community Engagement Program at the Laurier Brantford Campus, is conducting a study to better understand the experiences of the LGBTQ community, when accessing Healthcare and Social Services.

If you are interested in sharing your experiences about accessing healthcare and social services and answer YES to the following three questions, please consider participating in this study. The information you provide will be used to inform healthcare and social service providers of the needs of the LGBTQ community.

✓	Do you identify as Trans?
✓	Do you access healthcare and social services within Brantford/Brant County?
✓	Would you be willing to discuss you experiences in a confidential focus group?

For more information please contact Christine Wildman at: christinewildman@live.ca or at 519-755-5908.

All messages are confidential. Please leave a message with your first name and where and when you can be contacted.

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Appendix 3: Project information Sheet

Project Information:
Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ+) Experiences Accessing Healthcare and Social Services within Brantford/Brant County

(This research project has been approved by Wilfrid Laurier
University's Research and Ethics Broad # (REB4827).

Background to the Project

I (Christine Wildman) am a student a Wilfrid Laurier University's Brantford Campus in the Social Justice and Community Engagement Program. During my undergraduate program in Human Rights I conducted an LGBTQ Needs Assessment through Survey Research. The current project is phase two. Myself and my community based Research Assistant Sean Cullen will be further assessing the needs of the LGBTQ community though interviews and a focus group which will explore how the Brantford/Brant County LGBTQ population experiences accessing healthcare and social services.

In this project, we will:

- interview Lesbian, Gay, Bisexual and Two-spirited community members
- conduct a focus group with Trans identified individuals;
- produce documents, reports and other resources that express the experiences of the LGBTQ community.

Team Members:

This project is based out of Wilfrid Laurier University's Social Justice and Community Engagement Program. It will be led by Christine Wildman and supported by Sean Cullen, both of whom are LGBTQ identified community members.

The members of the team are:

- Christine Wildman (Wilfrid Laurier University MA Student)
- Sean Cullen (Community Based Research Assistant)

Your Involvement as a Project Participant

As a project participant, you will take part in either a one-on-one interview or be part of a group discussion. Overall we will be doing:

- One-on-one interviews with 4 different LGBTQ identified Brantford/Brant County Community Members
- One focus group, to include approximately six Trans Identified Brantford/Brant County Community Members.

The **questions** we will be asking of all our research project participants will (generally) be:

1.) Can you tell me a bit about yourself: how old you are, your pronoun, sexual orientation, gender identity, where you live, who lives with you, children, etc.?
2.) Can you tell me about a time when you have accessed healthcare in Brantford/Brant County?
3.) Can you tell me about a time when you have accessed social services in Brantford/Brant County?
4.) How have these experiences shaped how you access services?

Participation in the project is voluntary, and you may withdraw at any point.

We intend to publish articles and resource documents from the material.

Your identity will remain anonymous in all materials produced.

All of the interview and focus group materials will be kept confidential and will only be seen by the researchers until we agree with you what can be put in the public documents. We will not publish anything without your permission.

If you have questions about the project you may contact the following:

Christine Wildman
Social Justice & Community Engagement Program
Wilfrid Laurier University
E: christinewildman@live.ca
P: 519-755-5908

Appendix 4: Interview Informed Consent

Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) Experiences while Access Healthcare and Social Services within Brantford/Brant County Interviews

(This research project has been approved by Wilfrid Laurier
University's Research and Ethics Broad # (REB4827).

Purpose:

Christine Wildman, a student at Wilfrid Laurier University in the Social Justice and Community Engagement Program is conducting a study under the supervision of Dr. Jennifer Root. You are invited to participate. The purpose of the study is to examine the experiences of the LGBTQ community when accessing healthcare and social services. I will use this information to provide a LGBTQ Needs Assessment Report to the community at large and to publish some academic papers.

Procedures:

If you participate in this study, you will be interviewed by Christine Wildman. The discussion will be recorded on an electronic recording device. If you volunteer to participate in this interview, you will be asked some questions relating to your experience with accessing healthcare and social services with the Brantford/Brant County community. These questions will help us to better understand how Brantford/Brant County LGBTQ community members experience accessing healthcare and social services.

- The interview will be comprised of four basic questions, and some follow-up questions:
    - Can you tell me about yourself: how old you are, your preferred pronoun, sexual orientation, gender identity, where you live, who lives with you, children, etc.?
    - Can you tell me about a time when you have accessed healthcare in Brantford/Brant County?
    - Can you tell me about a time when you have accessed social services in Brantford/Brant County?
    - How have these experiences shaped how you access services?

Your participation is completely voluntary. You may withdraw from this study at any time without penalty. You may also choose not to answer any questions that you do not feel comfortable answering.

Benefits and Risks:

Your participation may benefit you and other LGBTQ community members by helping to improve access to and experiences accessing healthcare and social services. No risk greater than those experienced in ordinary conversation are anticipated. However, if something during the interview causes discomfort, you will have received a list of LGBTQ related resources where you can seek counselling.

Confidentiality:

Anonymous data from this study will be analyzed by Christine Wildman. No individual participant will be identified or linked to the results. The results of this study may be presented at academic conferences, in academic papers, community events or trainings, and in a publically available needs assessment report; however, your identity will not be disclosed. All information obtained in this study will be kept strictly confidential. All materials will be stored in a secure location in the researcher's home office in a locked cabinet. No one other than the researcher will have access to the materials.

Consent:

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this interview.

Participant's signature: _____

Printed name: _____

Date: _____

If you have any questions or concerns about this study, please contact Christine Wildman at christinewildman@live.ca or Research supervisor Dr. Jenn Root at jroot@wlu.ca.

Appendix 5: Focus Group Informed Consent

Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) Experiences while Access Healthcare and Social Services within Brantford/Brant County Focus Group

(This research project has been approved by Wilfrid Laurier
University's Research and Ethics Broad # (REB4827).

Purpose:

Christine Wildman, a student at Wilfrid Laurier University in the Social Justice and Community Engagement Program is conducting a study under the supervision of Dr. Jennifer Root. You are invited to participate. The purpose of the study is to examine the experiences of the LGBTQ community when accessing healthcare and social services. I will use this information to provide a LGBTQ Needs Assessment Report to the community at large and to publish some academic papers.

Procedures:

If you participate in this study, you will be in a group of approximately 4-6 self-identified Tran's people. There will be two facilitators who will ask questions and facilitate the discussion. The discussion will be recorded on an electronic recording device. If you volunteer to participate in this focus group, you will be asked some questions relating to your experience with accessing healthcare and social services with the Brantford/Brant County community. These questions will help us to better understand how Brantford/Brant County LGBTQ community members experience accessing healthcare and social services.

- The focus group will be comprised of four basic questions, and some follow-up questions:
    - Can you tell me about yourself: how old you are, your preferred pronoun, sexual orientation, gender identity, where you live, who lives with you, children, etc.?
    - Can you tell me about a time when you have accessed healthcare in Brantford/Brant County?
    - Can you tell me about a time when you have accessed social services in Brantford/Brant County?
    - How have these experiences shaped how you access services?

Your participation is completely voluntary. You may withdraw from this study at any time without penalty. You may also choose not to answer any questions that you do not feel comfortable answering.

Benefits and Risks:

Your participation may benefit you and other LGBTQ community members by helping to improve access to and experiences accessing healthcare and social services. No risk greater than those experienced in ordinary conversation are anticipated. However, if something during the group causes discomfort, you will have received a list of LGBTQ related resources where you can seek counseling.

Confidentiality:

Anonymous data from this study will be analyzed by Christine Wildman. No individual participant will be identified or linked to the results. The results of this study may be presented at academic conferences, in academic papers, community events or trainings, and in a publically available needs assessment report; however, your identity will not be disclosed. All information obtained in this study will be kept strictly confidential. All materials will be stored in a secure location in the researcher's home office in a locked cabinet. No one other than the researcher will have access to the materials.

Everyone in the group will be asked to respect the privacy of the other group members. All participants will be asked not to disclose anything said within the context of the discussion, but it is important to understand that other people in the group with you may not keep all information private and confidential.

Consent:

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this focus group.

Participant's signature: _____

Printed name: _____

Date: _____

☐ I agree to be quoted <u>under a pseudonym</u> in materials produced by the "LGBT Experiences of Community, Healthcare and Social Services in Brantford/Brant County" Research Project Team. All personally identifying information shall be removed or changed and contents of the quote will not reveal my identity.

☐ <u>I do not agree to be quoted.</u>

Signature: _____.

If you have any questions or concerns about this study, please contact Christine Wildman at christinewildman@live.ca or Research supervisor Dr. Jenn Root at jroot@wlu.ca.

Appendix 6: Research Assistant Confidentiality Agreement

This study, **Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) Experiences Accessing Healthcare and Social Services within Brantford/Brant County,** is being undertaken by Christine Wildman at Wilfrid Laurier University.

The study has two objectives:

1. To examine access to healthcare for LGBTQ+ populations within Brantford and Brant County.
2. To examine access to social services for LGBTQ+ populations within Brantford and Brant County.

Data from this study will be used to create a report that will be provided to local organizations, community members and will be published on The Bridge website.

I, Sean Cullen, agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. disks, tapes, transcripts) with anyone other than the Principal Investigator(s);
2. Keep all research information in any form or format secure while it is in my possession;
3. Return all research information in any form or format to the Principal Investigator(s) when I have completed the research tasks;
4. After consulting with the Principal Investigator(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Principal Investigator(s) (e.g. information sorted on computer hard drive).

Research Assistant:

| _____ | _____ | _____ |
| (print name) | (signature) | (date) |

Principal Investigator:

| _____ | _____ | _____ |
| (print name) | (signature) | (date) |

If you have any questions or concerns about this study, please contact:

Professor: Dr. Jennifer Root
 Email: jroot@wlu.ca

This study has been reviewed and approved by the Research Ethics Board at Wilfrid Laurier University. For questions regarding participants rights and ethical conduct of research, contact the University's Research Office at 519.884.0710 x3131.

Appendix 7: Interview/Focus Group Interview Guide

Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ+) Experiences Accessing Healthcare and Social Services within Brantford/Brant County

(This research project has been approved by Wilfrid Laurier
University's Research and Ethics Broad # (REB4827).

These questions will be used as prompts during the Focus Group and each interview with participants. This project is more discussion based and the following questions will be used to guide the process.

1. Introductions

   Confidentiality: no one knows you are being interviewed; recordings will be destroyed once the research is completed. You will be kept anonymous in any writing that comes out of the research.
   We will be recording the group conversation and then transcribing it later. You can pass on any question you do not feel comfortable answering.

2. Can you tell us a bit about yourself: age, your pronoun, sexual orientation, gender identity, where you live, who lives with you, children, etc.?

3. Accessing healthcare:

   Can you tell me about a time when you have accessed healthcare in Brantford/Brant County?
   Probing for:

   a. Do you have a regular doctor?
   b. Clinic with multiple doctors?
   c. Do you feel supported by your doctor?
   d. Do you feel that your doctor is knowledgeable about LGBT healthcare needs?
   e. Are you open with your doctor about your sexual orientation/gender identity?
   f. Why/why not?
   g. What experiences have shaped your decision to be out to you doctor or not?

      h. Can you tell me about a time when you felt supported by your healthcare provider or a time when you didn't?

      i. If you felt supported but made that experience feel positive?

4. Accessing social services:

Can you tell me about a time when you have accessed social services in Brantford/Brant County?

Probing for:

      a. Are you able to find safe counselling support?

      b. Do you feel safe/comfortable being open about your sexual orientation/gender identity with the service provider

      c. Do you feel that they are inclusive, friendly and knowledgeable about LGBT people?

      d. Can you tell me about a time when you accessed services and it was a bad experience and what made it bad?

      e. Can you tell me about when you accessed services and it was a good experience, and what made it positive?

5. How have these experiences shaped how you access services?

      a. Have you ever changed service providers because of an experience?

      b. Stopped going or gone less, more?

6. Anything else you want to share with me?

Appendix 8: Focus Group Agenda

Trans Focus Group Agenda

1. Introductions around the room

2. Introduction to the Project: what it's about.

3. Take a moment to review the consent form and get everyone to sign them.

4. Ground Rules: Set some group ground rules; have the group come up with them; things like don't talk over one another, anything said in the room stays there, acknowledge each person's sharing as their own experience which may differ from others.

5. Word Wall: defining healthcare/defining social services (have the group come up with words that describe what healthcare and social services are, could be places of providers.)

6. Questions to be discussed: (you can choose not to participate in answering any of the questions that you do not wish to answer.

    a. Can you all tell me a bit about yourselves, age, pronouns, sexual orientation, gender identity, where you live, i.e. Brantford or Brant County, who lives with you, children, roommate, partner, parents ect?
    b. Can you tell me about a time when you accessed healthcare in Brantford/Brant County?
    c. Can you tell me about a time when you accessed social services within Brantford/Brant County?
    d. How have these experiences shaped how you access services?
    e. Anything else anyone wants to share that they feel is important or relevant to the topic?

7. Closing circle: give each person an opportunity to say some closing thoughts.

8. Thank you's!

Appendix 9: Consent after Transcript Review

CONSENT FORM

Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) Experiences while Access Healthcare and Social Services within Brantford/Brant County
(This research project has been approved by Wilfrid Laurier
University's Research and Ethics Broad # (REB4827).

I, _____, have agreed to participate
   please print full name

voluntarily in this research project.

☐ *I have read, agree and approve the contents of my transcript to be an accurate depiction of our interview/focus group*.
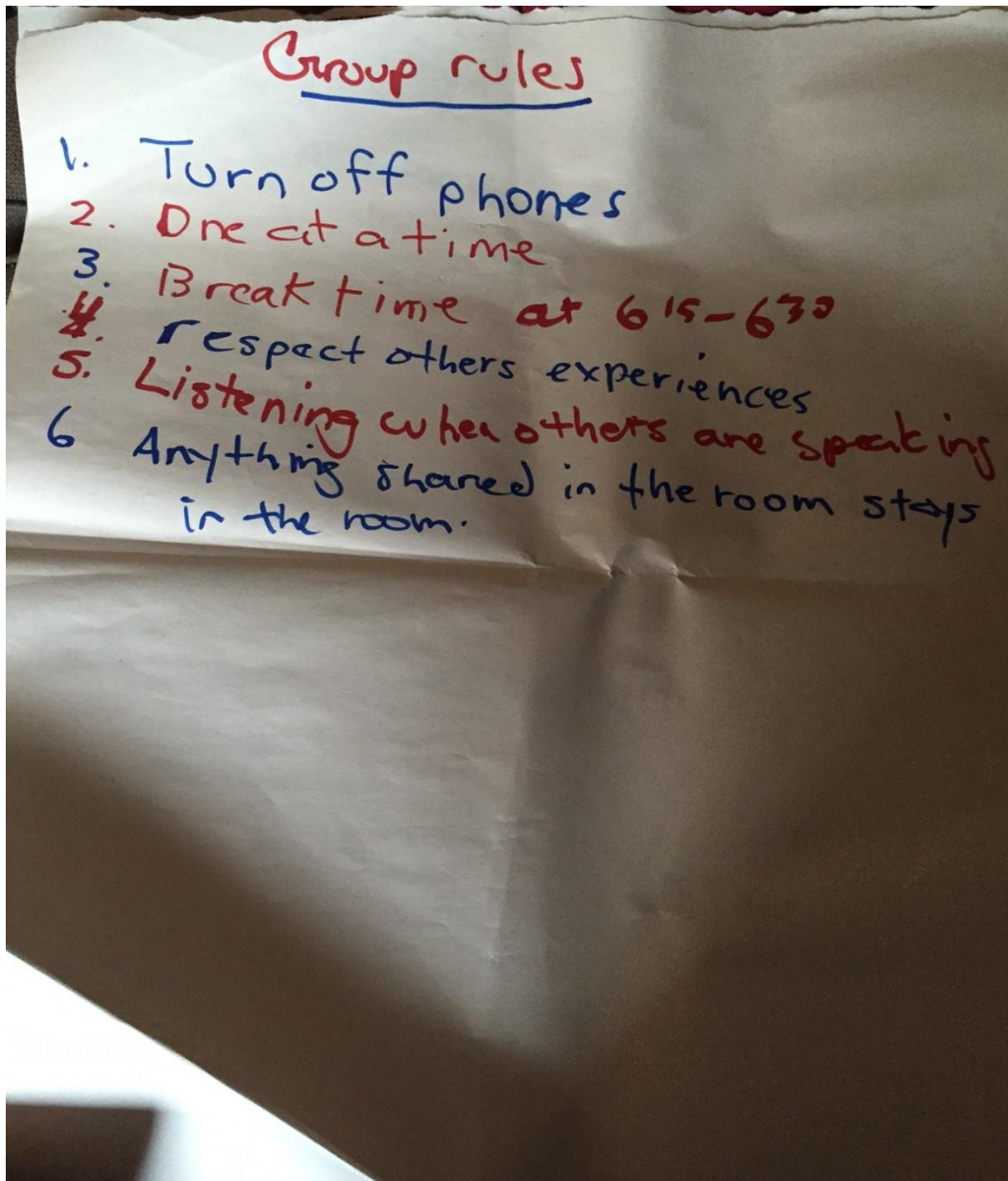
☐ *I agree to be quoted <u>under a pseudonym</u> in materials produced by the "LGBT Experiences of Community, Healthcare and Social Services in Brantford/Brant County" Research Project Team. All personally identifying information shall be removed or changed and contents of the quote will not reveal my identity.*
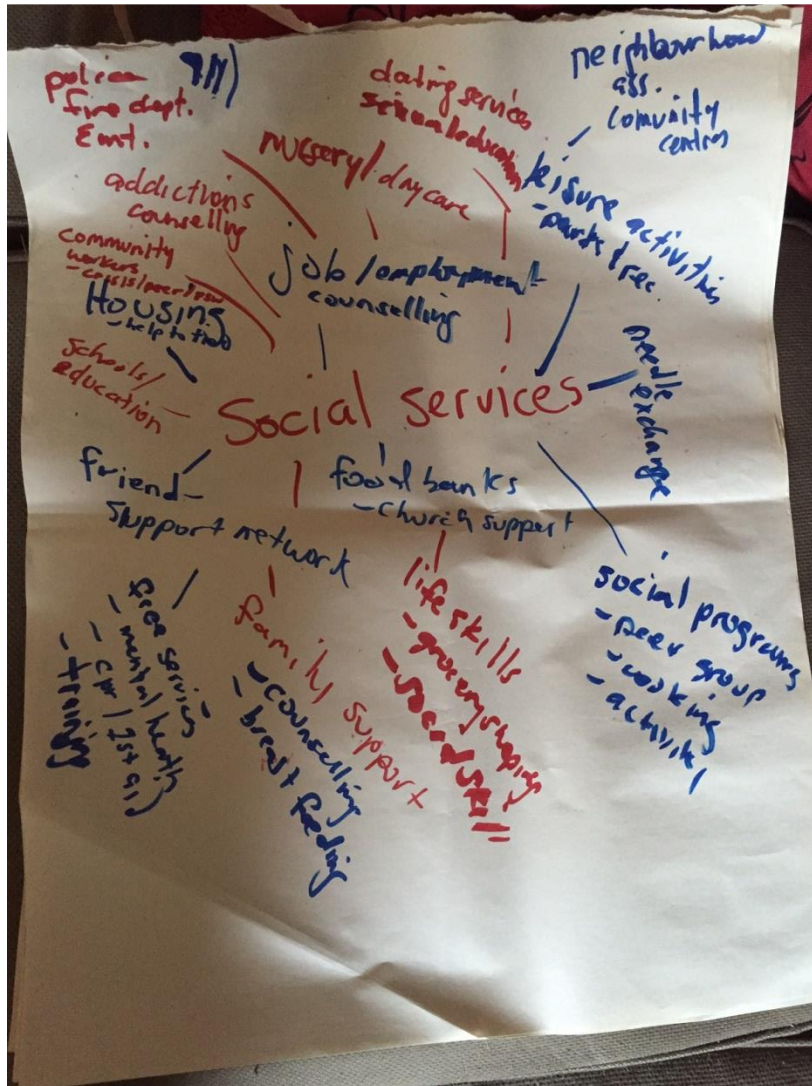
☐ *<u>I do not agree to be quoted.</u>*

Participant signature _____Date _____

Researcher's signature _____Date _____

Appendix 10: Focus Group Rules (as set by the group)

Group rules

1. Turn off phones
2. One at a time
3. Break time at 6¹⁵–6³⁰
4. respect others experiences
5. Listening when others are speaking
6. Anything shared in the room stays in the room.

Appendix 11: Focus Group Healthcare Word Wall

Appendix 12: Focus Group Social Services Word Wall

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