

Healthcare Service Utilization and Perceived Gaps: The Experience of French-Speaking 2S/LGBTQI+ People in Manitoba

Utilisation des services de santé et lacunes perçues : l'expérience des francophones 2S/LGBTQI+ au Manitoba



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Abstract

Ethnolinguistically diverse 2S/LGBTQI+ (two-spirit, lesbian, gay, bisexual, transgender, queer and intersex) populations have unique healthcare needs and experience health inequities compared to their cisgender or heterosexual peers. This community-based participatory study sought to describe the profile and healthcare needs and experiences of official language minority French-speaking 2S/LGBTQI+ adults in Manitoba. Participants ($N = 80$) reported that gender and sexual identity were often concealed from service providers; many respondents faced discrimination based on their ethnolinguistic and sexual identities. Service gaps are identified pertaining to mental and sexual health; locating 2S/LGBTQI+-friendly, patient-centred care in French is difficult. Policy and practice should address systemic inequity and discrimination experienced by this equity-seeking population.

Résumé

Les populations ethnolinguistiquement diversifiées et qui s'identifient à la communauté 2S/LGBTQI+ (bispirituels, lesbiennes, gais, bisexuels, transgenres, queers et intersexes) ont des besoins uniques en matière de soins de santé et vivent des inégalités par rapport à leurs pairs cisgenres ou hétérosexuels. Cette étude participative communautaire vise à décrire le profil ainsi que les besoins et les expériences en matière de soins de santé chez des adultes 2S/LGBTQI+ d'expression française en situation minoritaire au Manitoba. Les participants ($N = 80$) ont indiqué qu'ils dissimulaient souvent leur genre et leur identité sexuelle devant les fournisseurs de services; de nombreux répondants ayant été victimes de discrimination fondée sur l'identité ethnolinguistique et sexuelle. Les lacunes en matière de services ont trait à la santé mentale et à la santé sexuelle; il est difficile de trouver en français des soins axés sur le patient qui soient adaptés aux besoins des personnes 2S/LGBTQI+. Les politiques et les pratiques devraient s'attaquer aux iniquités et à la discrimination systémiques dont sont victimes ces personnes en quête d'équité.

Introduction

The 2S/LGBTQI+ (two-spirit, lesbian, gay, bisexual, transgender, queer and intersex) populations persistently experience poorer mental and physical health than the general population as illustrated by a higher incidence of chronic conditions such as asthma, obesity, cardiac disease, arthritis, cancer (Casey 2019; Dai and Hao 2019; Hsieh and Ruther 2016) and psychological distress (Edkins et al. 2018; Gilmour 2019; Pakula et al. 2016; Parent et al. 2019). Systemic inequity experienced within healthcare settings may contribute to this reality (Konnoth 2020). Considering that homosexuality was only depathologized in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1973 (APA 2013) and in the International Classification of Diseases (ICD) in 1990 (WHO 2019), the international medical and psychiatric community's stigmatization of 2S/LGBTQI+ people has only recently begun to be remediated (Drescher 2015). However, a recent study of Manitoban 2SGBQ+ (two-spirit, gay, bisexual and queer) men concluded that discrimination continues

to be a barrier to healthcare service use for this population: many experienced discrimination firsthand from healthcare professionals and did not have access to a general practitioner, and only a quarter of those who did felt they could speak openly about their sexual orientation to providers (McLeod et al. 2021).

The COVID-19 pandemic exacerbated the pre-existing discrimination and chronic minority stress (Meyer 1995, 2003) already experienced by 2S/LGBTQI+ populations worldwide (Brennan et al. 2020; Egale 2020; Goldbach et al. 2021; McLeod et al. 2021; Salerno et al. 2020), particularly for dually minoritized 2S/LGBTQI+ individuals belonging to diverse ethnicities (Goldbach et al. 2021; Prada et al. 2023; Whittington et al. 2020). Strikingly, 2S/LGBTQI+ people in Canada face numerous barriers to service access, especially mediated through stigma and discrimination, including services related to housing (Lyons et al. 2021), mental health (Ferlatte et al. 2019) and the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) prevention and treatment (McLeod et al. 2021). Barriers include stigma (especially stigma experienced when an individual has numerous intersecting minoritized identities), financial insecurity and perceived discrimination on behalf of the service (including healthcare) providers. Considering the Manitoban landscape more specifically, 2S/LGBTQI+ people in rural Manitoba report experiencing discrimination, stigmatization and lack of provider awareness and sensitization to 2S/LGBTQI+ identities and experiences as barriers to their healthcare access (Henriquez and Ahmad 2021). Indeed, perceived invisibility brought on by systemic barriers to service utilization among 2S/LGBTQI+ people in Canada – as in Manitoba – is directly linked to them performing poorly on indicators of psychological and physiological health, and this can be especially pronounced in rural or remote areas (Henriquez and Ahmad 2021; Souleymanov et al. 2023). While experienced by many 2S/LGBTQI+ people, barriers can be especially salient and deleterious for transgender and gender non-binary people (Rutherford et al. 2021).

In parallel, the impact of language barriers on healthcare access and quality of care for official-language minority (OLM) populations in Canada – such as francophones outside Quebec – are well-documented (Bowen 2015; Ohtani et al. 2015; Schwei et al. 2016). Such barriers lead to increased wait times, greater distances to travel and, at times, bullying by service providers, discouraging patients from even asking for services in French (de Moissac and Bowen 2017). Often, they result in unmet healthcare needs (Alimezelli et al. 2013; Bahi and Mulatris 2018; Benoit et al. 2012; de Moissac and Bowen 2017), leading to poorer health outcomes for these populations (Bouchard et al. 2018; Chartier et al. 2012). As such, healthcare providers are becoming increasingly cognizant of the value of language access services in providing appropriate patient-centred, culturally congruent care, especially among vulnerable populations (Schwei et al. 2016). Since 1989, the active offer of services in French, defined as “[t]he set of measures taken by designated public bodies to ensure that French language services are evident, readily available, easily accessible, and publicized, and that the quality of these services is comparable to that of services offered in English”

(Francophone Affairs Secretariat n.d.), has been encouraged to remediate this issue. However, systemic and structural barriers persist, including nationwide shortages of bilingual healthcare professionals serving OLM communities (de Moissac et al. 2015; de Moissac and Bowen 2017; Drolet et al. 2014), reducing access to care in the official language of the minority in Manitoba and across Canada.

Hence, both 2S/LGBTQI+ and OLM identities have been shown to independently hinder patient health, their care and treatment outcomes. When these minority identities intersect, they exacerbate inequities that such populations face (Pachankis and Goldfried 2013; Ramirez and Galupo 2019). Such populations are generally not well-served by healthcare systems as “[c]lients may enter services having felt unable to locate their experiences within a seemingly mutually exclusive relationship between mainstream sexual minority and [their minority community’s] social narratives” (Choi and Israel 2016: 351). Cultural and social connection through holistic care is essential, allowing 2S/LGBTQI+ patients to integrate all parts of their identity in a narrative that coheres with their goals and values (Choi and Israel 2016).

While a thrust has recently been observed in Canada to investigate racialized 2S/LGBTQI+ subpopulations (Hart et al. 2021; Husbands et al. 2022; Lee-Foon et al. 2020), such research remains under-represented compared with that investigating 2S/LGBTQI+ populations more broadly. For instance, Bowleg’s (2012) critique of public health research seldom considering multiple intersecting identities – including gender, sexuality and ethnic diversity – when investigating 2S/LGBTQI+ and other minoritized populations calls for its meaningful inclusion in all future public health inquiry. Indeed, most research conducted on ethnically diverse 2S/LGBTQI+ populations pertains to visible minority populations in the US (for example: Choi and Israel 2016; Cyrus 2017; Page et al. 2022); few report on Canadian (Gates-Gasse and Lassonde 2015) or OLM populations (Sherbourne Health, Rainbow Health Ontario and Government of Ontario 2020). According to the 2021 national census data, one in 300 Canadians aged 15 and older are transgender or non-binary; over half of the non-binary people live in one of Canada’s six largest urban centres (Statistics Canada 2022). As for French-speaking OLM populations in the province of interest (Manitoba), over 36,000 Manitobans reported French as a first official language (2.7%) and over 110,000 identified as bilingual (8.3%) (Auclair et al. 2023). Hence, a quantitative needs analysis – a first in western Canada – was conducted among the OLM (French-speakers) 2S/LGBTQI+ (inclusive of all people who do not identify as cisgender or heterosexual) population in Manitoba (hereafter named “Community”), to explore their socio-demographic profile, health and social needs and experiences. A first publication stemming from these data described this population’s socio-demographic profile and needs (Prada et al. 2023). In our paper, we discuss access to healthcare and experiences of discrimination. The data will inform healthcare providers, policy makers, researchers and other community stakeholders on this vulnerable population’s experience with healthcare.

Methods

This community-based participatory study was initiated by the community partner – Collectif LGBTQ* du Manitoba (<https://collectiflgbtq.ca/>) – a grassroots organization advocating for French-speaking 2S/LGBTQI+ Manitobans that sought funding, enlisted researchers and was closely involved throughout this project. While a primarily quantitative approach was employed, participants were also invited to qualify through certain responses. Inclusion criteria were being at least 18 years of age (age of majority in this province), residing in Manitoba and self-identifying as French-speaking and 2S/LGBTQI+. The survey was available in French only; average proficiency in this language was required to participate. Of note, inclusion criteria for language proficiency in French was used rather than mother tongue, as many members within the francophone community of interest do not have French as a mother tongue (such as immigrants) but are more fluent in this language than in the official language of the majority (English). Ethics approval was obtained from the research ethics board of Université de Saint-Boniface, Winnipeg, MB (ETH 2020 04 Juin 2020). Informed consent was obtained from all participants prior to survey completion.

Data collection occurred over three weeks in June 2020, during the first wave of the COVID-19 pandemic. Recruitment strategies included convenience and snowball sampling, namely, through e-mails sent via local francophone 2S/LGBTQI+ and community partner networks; promotion on social media (both organic and paid); and press releases sent to media province-wide, both in French and English.

The 38-question survey, co-constructed by the research team and Community members and inspired by a similar study in Ontario (Gates-Gasse and Lassonde 2015), comprised four sections: (1) socio-demographic and ethnolinguistic profile; (2) social support and health-care needs; (3) perceptions of discrimination and marginalization; and (4) priorities for the future (Prada et al. 2021). The questions were mostly multiple-choice, although participants could select the “other” option to be able to specify further. Open questions were also asked. For questions pertaining to challenges, service use and barriers to use, lists were provided to participants who were invited to choose all options applicable to them. The barriers in the questionnaire were inspired by other research done on 2S/LGBTQI+ populations and linguistic minorities (of which some of the authors have extensive experience), as well as in consultation with Collectif LGBTQ* du Manitoba. The study tool was pilot-tested among four Community members for clarity of questions, as well as ease and time of survey completion, then made available in print (Prada et al. 2023) and online through the Canadian-based data host LimeSurvey.

All statistical analyses were performed using SPSS version 24.0 for Windows (SPSS, Inc., Chicago, IL). The data were described as proportions and were further analyzed according to age groups (18–34, 35–54 and 55 years or over), as needs and service utilization differ with age. Furthermore, historical events may also have had some impact on the experience of discrimination and access to services (Prada et al. 2023). Chi-squared or Fisher’s exact tests were computed to identify statistically significant differences between age groups ($p < 0.05$).

Results

Socio-demographic and ethnolinguistic profile

A total of 80 respondents participated; approximately half were aged between 18 and 34 years, a third were between 35 and 54 years and 19% were 55 years or older (Table 1, available online at www.longwoods.com/content/27239). Nearly half identified as women and a third as men. The highest proportion of respondents identified as gay, lesbian or bisexual. Most lived in an urban setting, alone or with their partner or spouse. Most were single or in a same-sex common-law relationship or marriage and reported post-secondary education and full-time employment. One in five were considered low-income (personal annual income < \$20,000). Most respondents reported having no known functional limitations, although the most frequently reported limitation was psychological.

For their ethnolinguistic profile, three-quarters of the respondents identified as White. Two-thirds identified as bilingual (French and English), and three-quarters indicated French as their maternal language still spoken at home. Self-reported proficiency in both French and English for oral, writing and comprehension was generally advanced.

Healthcare service utilization and perceived gaps

Healthcare service utilization trends, per age group, are presented in Table 2 (available online at www.longwoods.com/content/27239). Healthcare services most used by respondents included those provided by family physicians or nurse practitioners, walk-in clinics, private healthcare services, hospitals and other clinics or healthcare centres; more than half of the respondents received services from the designated francophone healthcare centre. Few consulted these services only in French, save at this designated health centre. Furthermore, 69.2% had consulted psychological services, and 29.2% had consulted sexual health services, most often in English. Few reported using addictions-related services (9.2%), assisted procreation or adoption services (9.2%) or services for people living with HIV or AIDS (4.6%). Some statistically significant differences emerged between age groups: the 35- to 44-year-old age group was most likely to have consulted assisted procreation or adoption services as well as services for people living with HIV/AIDS, while no 18- to 34-year-old participants reported having used either of these services. Furthermore, although not statistically significant, participants 55 years of age and older were most likely to have accessed services in French than all other groups, save for hospital services.

Among service users, high satisfaction levels were generally reported for private healthcare services and services provided by family physicians or nurse practitioners. Respondents generally felt less satisfied with services received from walk-in clinics, hospitals, clinics or healthcare centres and mental health supports. One participant qualified these findings:

I used some of these services only once, and then stopped. In some cases, it's because the service wasn't offered in French, or because I felt that my sexual orientation was not taken into account or misunderstood. (Participant #49, 55–64 years of age)

A considerable number of participants reported experiencing difficulties locating community information and health-related 2S/LGBTQI+-friendly services in French, finding a family physician or locating other healthcare services. In terms of services received in French, many indicated that it was difficult or very difficult for them to locate and access services in French and that the active offer of services in that language was only sometimes or rarely practised:

There is a general lack of service access for francophones, and when it's focused on an even smaller [2S/LGBTQI+] community, we can feel even more targeted/stigmatized. (Participant #13, 35–44 years of age)

Often, as a gay man, the situation can become quite complex as the types of services geared to our community and that understand us without judgement are only offered in English. (Participant #49, 55–64 years of age)

Participants perceived gaps in services pertaining to both their sexual or gender identities and their ethnolinguistic identities. Their most reported unmet needs are social activities and psychological, physical and sexual healthcare services. Approximately half of the respondents indicated an unmet need for French-language, 2S/LGBTQI+-friendly services pertaining to senior lodging, adoption, assisted fertility, surrogacy or midwifery and long-term care. Between 30 and 40% of the participants also expressed a need for such services relating to substance use and addictions (including drugs, alcohol and gambling) and assistance in finding lodging. Some statistically significant differences emerge between age groups. For example, respondents 55 years of age and older more frequently reported needs for services relating to senior lodging, home meals and healthcare services.

Barriers to service utilization

Barriers to healthcare service utilization, per age group, are presented in Table 3 (available online at www.longwoods.com/content/27239). Participants were invited to select from a list of possible obstacles to service utilization in their preferred language, even when in need. Among the six most-reported barriers, five pertained to the language of service. Many chose to utilize services in English rather than in French because it was easier to do so in English; although not statistically significant, this was reported most often by younger participants. Others were unaware that such services existed, found that the service provider's proficiency in French was inadequate or felt that their own proficiency in French was inadequate. Almost one in four respondents reported that such services were unavailable in French.

Sexual or gender identity-related barriers to service access are largely related to anticipated discrimination from service providers. Some also reported fear of getting “outed” or identified as 2S/LGBTQI+ or services not being sufficiently geared to the person's sexual or gender identity-related needs as corroborated by one participant:

I sometimes choose to not obtain certain services in French out of concern for lack of discretion from the service provider and their associates. (Participant #153, 35–44 years of age)

Other barriers to service utilization included inaccessibility of services because of distance and limited transportation options.

Discrimination and identity concealment

Perceptions of discrimination and identity concealment trends, per age group, are presented in Table 4 (available online at www.longwoods.com/content/27239). Many respondents reported experiencing discrimination based on their sexual orientation or their use of French. Some also reported discrimination regarding their linguistic identity, mental health concerns or age.

Although most respondents indicated always or often feeling respected by service providers regarding their sexual orientation or gender identity, half of the participants indicated rarely or never disclosing their sexual orientation or gender identity to service providers compared with 18.5% indicating always or often doing so. The most frequently reported motivations for concealing participants' sexual orientation or gender identity included the following: the opportunity did not present itself or the context of the interaction did not lead to this topic; their sexual orientation or gender identity had no bearing on their access to services; or this information did not concern service providers. More than a third of the participants also reported discomfort discussing this topic or concern that the service provider may have been uncomfortable discussing this with them.

Discussion

This study – the first of its kind in western Canada – provides insight into the unique experiences and needs of OLM French-speaking 2S/LGBTQI+ adults pertaining to healthcare access and utilization. The data were collected during the first wave of the COVID-19 pandemic.

The most reported barrier to healthcare service use, even when in need, pertained to limited access to, or absence of, services in French. The dearth of active offer and consequent difficulty locating and accessing services in French reported by most participants are corroborated by previous literature showing that OLM individuals often feel disadvantaged compared with the anglophone majority (Ngwakongnwi et al. 2012). Furthermore, although many OLM francophones across Canada have advanced fluency in English, some may have little or no fluency in languages other than French, including young children, the elderly and the newcomers from Quebec or French-speaking countries. Furthermore, fluency in a second language (English) may be jeopardized when in a position of vulnerability, such as when in pain, under the influence of medication or in psychological distress (de Moissac and Bowen 2017). Finally, accessing services in French can also be motivated by other factors, such

as a desire to improve or maintain linguistic competency (Office of the Commissioner of Official Languages 2023) or to create or reinforce ties with members of the French-speaking community. As such, given the dearth of 2S/LGBTQI+-friendly French-language services highlighted by current data, participants were less likely to experience patient-centred care. Language barriers should be addressed to ensure quality of care and patient safety to level the inequity that OLM populations continue to face in healthcare settings (Savard et al. 2021; Seeleman et al. 2015; Zhao et al. 2021).

Furthermore, anticipated and experienced discrimination relating to both their OLM and sexual or gender identities were reported by many respondents. Although most indicated feeling respected by service providers, over half of them reported regularly or always concealing their sexual or gender identity or not using certain services for fear of discrimination. A recent study among Manitoban 2SGBQ+ men echoes this finding: there, only a quarter of respondents felt that they could speak openly about their sexual orientation with their healthcare provider, and over 65% indicated having experienced discrimination in healthcare settings within the previous two years (McLeod et al. 2021). While little research has been conducted among transgender and gender non-binary people in Manitoba, results from the Trans PULSE Canada survey conducted throughout the COVID-19 pandemic likewise revealed the numerous obstacles to healthcare experienced by transgender and gender non-binary people in Canada, and that these barriers may have been heightened through this global health crisis (Tami et al. 2022). Alarming, it is those transgender and gender non-binary people in Canada – vulnerable given their poor mental health – who may be most prone to primary healthcare avoidance, compared to their cisgender 2S/LGBQ+ (two-spirit, lesbian, gay, bisexual and queer) peers (Rutherford et al. 2021). As the French-speaking community in Manitoba is perceived by many as small and tight-knit, fear of being “outed” as an 2S/LGBTQI+ person may be particularly salient for members of the Community. Considering that identity concealment impedes appropriate treatment (Casey 2019; Foy et al. 2019; Hsieh and Ruther 2016), this finding highlights the importance of healthcare professionals proactively addressing these topics with patients. The responsibility lies on the provider, not the patient, to broach such sensitive topics (McLeod et al. 2021). Clinicians must also be proactively cognizant of their internalized biases or prejudice, which may hinder treatment (Wynn and West-Olatunji 2009).

Many participants underscored their unmet need for psychological support services. It is troubling that mental health supports were most often accessed in English as mental healthcare that is congruent with patients’ cultural and linguistic needs is essential to treatment efficacy (Chartier et al. 2012; Choi and Israel 2016; Vu et al. 2011). Present findings suggest that 2S/LGBTQI+ people are more inclined to seek professional psychological support than non-2S/LGBTQI+ peers (Pachankis and Goldfried 2013). Previous reports have emphasized the clinical efficacy of targeted strategies for ethnically diverse 2S/LGBTQI+ populations, including mindfulness (Li et al. 2019), family intervention, group therapy and cognitive behavioural therapy (Igartua and Montoro 2015). Proactively addressing issues, such as

stigma, internalized homophobia or heteronormativity (Brewster et al. 2013), and focusing on the holistic integration of a 2S/LGBTQI+ patient's ethnic, historical and cultural identities (Choi and Israel 2016) are also vital.

Furthermore, while respondents underscored their unmet need for 2S/LGBTQI+ sexual health services in French, few used services for people living with HIV/AIDS. These findings are of concern as 2S/LGBTQI+ populations have unique sexual health needs, and approximately six Canadians contract HIV daily – namely, men who have sex with men (Public Health Agency of Canada 2020). With a 52% increase in HIV transmission between 2018 and 2021 in Manitoba (Manitoba HIV Program 2022), comprehensive, multi-layered preventative services promoting 2S/LGBTQI+ sexual health continue to be vital (Manitoba HIV Program 2022; McLeod et al. 2021) and should take into account the unique linguistic needs of this Community.

Findings predominantly reflect the experiences and needs of individuals self-reporting select sexual and gender identities (namely gay, lesbian or bisexual). Also, participants were mostly younger, White, born in Canada and from urban areas, and few reported living with a disability. Such homogeneity is not consistent with recent Canadian statistics on 2S/LGBTQI+ populations (Statistics Canada 2022). Compared to Manitoba's broader francophone population (French as its mother tongue), a significantly higher prevalence of participants reported low income and living alone. In contrast, a considerably lower proportion reported being elders or residing in rural areas (Auclair et al. 2023). This suggests that their profile and needs may, in fact, be distinct from their larger OLM communities. Furthermore, despite heterogeneous recruitment strategies, some sub-populations remain under-represented, such as visible minorities and Indigenous Peoples. Although not the focus of this article, given the low proportion of non-White respondents, analysis of findings pertaining to Métis and Black participants appear to suggest that their plight is worse than that of White respondents, as reported elsewhere (Goldbach et al. 2021; Whittington et al. 2020). Also, the fact that more than half of the respondents reported no disability is unexpected as the literature reports higher incidence of illness and disability among 2S/LGBTQI+ populations compared to the larger population (Casey 2019; Egale 2020; Martin-Storey et al. 2019; Statistics Canada n.d.). Future targeted studies ought to intentionally include such equity-seeking populations (El-Hage and Lee 2016). The data from the 2021 national census – the first to include more holistic and accurate questions on gender and sexual identity – will be helpful to future study (Statistics Canada 2020, 2022).

Implications for policy and practice

Members of this Community face compounded healthcare inequities given their intersecting OLM ethnolinguistic and 2S/LGBTQI+ minority identities. As such, a community-led, community-informed approach targeting policy and professional practice to proactively ensure equity, diversity and inclusion (EDI) competency while caring for ethnolinguistically diverse 2S/LGBTQI+ people is vital (Prada et al. 2021, 2023). Such efforts must also be

cognizant of the larger prejudicial systems that equity-seeking groups occupy, and empower the client to address these larger issues (macro) while also addressing individual morbidity (micro) (Buchanan and Wiklund 2020). As some 2S/LGBTQI+ people feel healthcare professionals misunderstand their experiences and needs and others are hypervigilant to experiences of stigmatization in healthcare settings (Foy et al. 2019), increasing awareness and providing professional development for service providers on the specific needs and experiences of 2S/LGBTQI+ OLM populations is crucial (Prada et al. 2023). Furthermore, regular evaluation and adaptation of healthcare policies to address systemic inequity and discrimination, especially those faced by dually minoritized populations, should be conducted. Healthcare professionals must also endeavour to reinforce the provider–patient alliance (McLeod et al. 2021) by proactively initiating conversations on sexual and gender identity with all patients and actively offering services in French. Understanding that cultural and social connections are essential to forging positive social identities, any clinical strategy that brings the patient to feel they must mute one of their identities to receive treatment will fail to provide adequate, patient-centred care (Choi and Israel 2016). These issues must be addressed at systemic, policy and individual provider levels. Otherwise, the obstacles hindering service utilization by members of this Community will continue to reinforce the stigmatization and inequity they face.

Strengths and Limitations

This study is the first to report on OLM 2S/LGBTQI+ populations in western Canada. Considering this Community represents a small minority within an even smaller minority, the sample size ($N = 80$) is adequate; heterogeneous recruitment efforts allowed the research team to overcome recruiting obstacles inherent to the COVID-19 pandemic. Furthermore, its community-based paradigm through the close involvement of Community members at every step of this study further enhances its validity, as it was executed by and for this Community.

Limits include the relatively homogeneous sample, which is inconsistent with the recent statistics on 2S/LGBTQI+ people in Canada (Statistics Canada 2022); results may only be generalizable to analogous populations. However, as this study was founded in community-based participatory research principles (Gélineau et al. 2012; Godrie 2017), we sought a basic understanding of the specific context in which our sample lived; thus, the findings allow us (community partners in collaboration with researchers) to enact change. As data were collected during the COVID-19 pandemic, related stressors may have confounded results. Furthermore, given the descriptive nature of the data collected, causal relationships cannot be inferred.

Conclusion

The intersecting identities of OLM French-speaking 2S/LGBTQI+ Manitobans impact their access to and experiences with healthcare services. The data highlight limited active

offer of 2S/LGBTQI+-friendly services in French and twofold discrimination based on gender or sexual and ethnolinguistic identities. Given the current insufficiency of healthcare provision to this population, particularly with respect to mental and sexual health, policies and practices must be adapted to the linguistic and 2S/LGBTQI+ needs to ensure accessible, culturally competent and 2S/LGBTQI+-affirming treatment and prevention service provision and, in doing so, reduce systemic and structural inequities faced by this Canadian population.

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