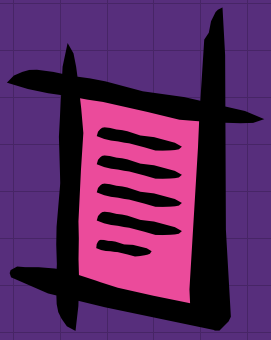

PTP
PINK
PAPER

2SLGBTQIA+ HEALTH DISPARITIES IN CANADA

2026

PINK TRIANGLE PRESS

Contents

Land Acknowledgment

Pink Triangle Press acknowledges that we work from the unceded territory of many nations, including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples. Today, these lands remain home to a diverse array of First Nations, Inuit, and Métis peoples. We also acknowledge that the city of Toronto, in which we are based, exists through Treaty 13 with the Mississaugas of the Credit, and subsequent treaties.

Further, we respect and affirm the inherent and Treaty Rights of all Indigenous Peoples across this land. We have and will continue to honour the commitments to self-determination and sovereignty we have made to Indigenous Nations and Peoples.

Lastly, Pink Triangle Press acknowledges the historical and ongoing oppression of lands, cultures, and the original Peoples of Turtle Island, also known as Canada. We encourage others to learn the histories of this land and its original Peoples, and to consider how our connections to these territories can best contribute to projects supporting Indigenous self-determination.

About Pink Triangle Press

Pink Triangle Press (PTP) is one of the longest publishing 2SLGBTQIA+ media groups in the world. Our primary aim is to inspire our communities to pursue a future where everyone is free to celebrate who they are. PTP was founded on the understanding that storytelling and sharing experiences is a powerful tool for liberation. It is our belief that media created by, for, and about 2SLGBTQIA+ communities is crucial to their ability to thrive. We seek to amplify the work of activists, creators, thinkers, and change makers. PTP is proud of its impact working with diverse communities to foster change. Building on our long history of promoting freedom and equality, we continue to bring communities together to create a better world for 2SLGBTQIA+ people.

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Women and Gender Equality Canada
Femmes et Égalité des genres Canada

Introduction

1

1.0 Introduction

First, do no harm.

Universal healthcare is central to what defines Canada. Most Canadians believe that everyone deserves access to healthcare based on our needs—regardless of who we are, where we live, or how much money we have.

Pink Triangle Press decided to focus on health for our 2025 Pink Paper, to find out if the promise of healthcare delivers for 2SLGBTQIA+ Canadians. The findings are sobering: The research reveals that universal access does not exist for queer people in this country. Queer Canadians are significantly less healthy, and have much reduced access to healthcare, than other Canadians. These disparities are stark—and even starker as we look at different identities and demographics within our communities.

2SLGBTQIA+ people experience anxiety and depression on average about 50% more than non-queer people. When broken down by our various identities, the research finds that health outcomes are much worse for some of us. Trans, intersex, asexual, questioning, and pansexual people fare especially poorly.

The report reveals other important differences between intersectionalities. Quality of life is poorer for rural, Black, and Two-Spirit respondents, and poorest for lower income and less educated queers. Meanwhile, cancer rates are more than doubled in gay and asexual respondents.

Our community healthcare experience is similarly alarming. Forty percent of us report habitual discrimination for our sexuality from healthcare professionals, more than four times the rate of non-queer respondents. And we report denial of care, often experienced as healthcare providers being unequipped to competently address our health concerns, and unable to provide alternatives. A dead end.

For too many of us, the healthcare experience is broken.

The good news in this report is that gay men, by some but not all measures, are doing well. Their health outcomes are approaching those of straight, cisgender people when it comes to several areas, including rates of anxiety and depression.

There are many factors at play here, but our unique history of community health care is certainly a factor. AIDS organizations were some of the first institutions created by our

communities. The crisis in those founding moments was acute due to the almost universal ostracism and fear of our community – we were truly on our own. But the upside was the birth of health organizations built by and for us, on our own terms.

Today, trans, non-binary, and gender diverse people face the heaviest burden of a swelling backlash. At the same time, queer healthcare has moved beyond the grassroots, and is often managed by mainstream institutions with mandates beyond our communities – this represents progress, but also a challenge. These mainstream institutions may have good intentions when it comes to diversity, but our findings show they are not delivering for 2SLGBTQIA+ Canadians.

The Pink Paper on health is a wake-up call. Our people are suffering and our healthcare system is failing one of its foundational principles: "First, do no harm."

I'd like to acknowledge the incredible work of the teams that produced and made possible this groundbreaking report. Thanks to authors and researchers Nadia Bouhamdani and Dominique Bouhamdani, editor and researcher Alex Custodio, graphics designers Xiaotiang Wan and Kevin Andrews, proofreader Kaya Skovdatter, translators at Rainbow Translations, Environics Research, research manager Zoltan Nemeth, project manager Gina Hara, and our Managing Director Jennifer McGuire. Thanks to Women and Gender Equality Canada for their financial support.

David Walberg,
CEO and Executive Director,
Pink Triangle Press

1.1 Executive Summary

Canada lacks standardized and inclusive health information on 2SLGBTQIA+ individuals. What little data we do have is aggregated, which makes it difficult for medical professionals and policymakers to address the specific needs of diverse identities within this umbrella. The 2025 Pink Paper on Health is one of the first national studies to fill this gap, offering a data-driven, equity-oriented, and identity-affirming framework for healthcare reform.

This report presents the findings of the first national, bilingual, comparative study on 2SLGBTQIA+ health and healthcare experiences in Canada. Drawing on data from a cross-sectional survey of over 2,100 respondents, half of whom identify under the 2SLGBTQIA+ label, this report reveals systemic disparities across four main areas: health outcomes, service accessibility, care quality, and lived experiences of stigma and discrimination in Canadian healthcare systems.

Results from the 2025 Pink Paper on Health demonstrate that the Canadian healthcare system provides inequitable care for 2SLGBTQIA+ communities. Across the board, the 2SLGBTQIA+ individuals we surveyed experience inferior health outcomes and lower quality of life compared to their non-2SLGBTQIA+ counterparts. These hardships are deepened by repeated struggles to access care as well as by feelings of dissatisfaction with the health services they do receive. 2SLGBTQIA+ respondents reported stigma, discrimination, and negative encounters in Canadian healthcare settings. These experiences were especially pervasive after they disclosed their sexual orientation or gender identity to providers who lacked either the knowledge, clinical skill, or experience to offer affirming care.

Overall, this study's findings show that limited access to inclusive, knowledgeable, and responsive healthcare services contributes to worsening physical and mental health outcomes for 2SLGBTQIA+ individuals. Encounters with a healthcare system that too often feels unwelcoming or harmful leads many 2SLGBTQIA+ individuals to avoid disclosing important medical information to practitioners or to postpone seeking care altogether. Limited access to affirming care in Canada therefore directly leads to a cycle of unmet needs and declining well-being.

2SLGBTQIA+ individuals experience a lower quality of care than their cisgender and heterosexual counterparts for several reasons, but the data highlights three major factors: **1)** inadequate healthcare provider training focused on 2SLGBTQIA+ health; **2)** a lack of inclusive communication; and **3)** the absence of culturally safe care. The results notably point to healthcare providers' education as a crucial site of intervention for improving 2SLGBTQIA+ health outcomes and satisfaction.

Key Findings:

1

Persistent Health Disparities

- 40% of 2SLGBTQIA+ individuals reported a diagnosed **mental health condition**, twice the rate of non-2SLGBTQIA+ participants (20%).
- **Depression severity** was highest among pansexual (47%) and asexual (45%) individuals, more than double that of non-2SLGBTQIA+ respondents (22%).
- **Anxiety severity** was highest among pansexual respondents (50%), over twice what non-2SLGBTQIA+ respondents (24%) experience. Queer (45%), asexual (47%), and Two-Spirit (45%) respondents also report disproportionately high rates of anxiety.
- **Cancer prevalence** was alarmingly high among asexual (15%) and gay (11%) individuals, more than double the rate of non-2SLGBTQIA+ participants (5%).

2

Reduced Quality of Life

- Across physical, psychological, environmental, and social domains, 2SLGBTQIA+ respondents consistently reported lower **Quality of Life (QoL)** scores than their non-2SLGBTQIA+ counterparts. These disparities were not experienced in isolation. Our intersectional analysis revealed that social determinants of health, such as **income**, **education**, and **geography**, shape and amplify negative outcomes.

3

Inadequate Access to and Satisfaction with Care

- The services 2SLGBTQIA+ individuals identify as being the most important (e.g. **mental health care** and **gender-affirming treatments**) are reported as the least accessible and least satisfying.
- Satisfaction with **mental health services** was below 30% among 2SLGBTQIA+ respondents overall and even lower among asexual (12%), queer (11%), genderfluid (3%), and Two-Spirit (3%) individuals.

4

Systemic Discrimination

- Up to 77% of Two-Spirit respondents reported experiencing **discrimination in healthcare settings**. Many described having to hide their identity, explain basic aspects of their existence to providers, or lie about their gender or sexual orientation to avoid being dismissed, misgendered, denied care, or treated with hostility.
- Experiences of discrimination were more prevalent among racialized and rural respondents, underlining the compounded effects of intersectional marginalization and the unevenness of care across geographic regions.

5

Structural Barriers and Mistrust

- Inconsistent service delivery (especially in rural and remote areas) makes many individuals less likely to seek care when they need it.
- 56% of 2SLGBTQIA+ individuals turn to online platforms for health information compared to 40% of their cisgender and heterosexual counterparts. These higher rates are due to related factors of lack of access to care and widespread mistrust in the system.

Key stakeholders from across Canada—including clinicians, community leaders, and health system professionals—highlighted pervasive issues that contribute to asymmetrical qualities of care. These include misgendering, a lack of provider knowledge about 2SLGBTQIA+ needs, provider burnout, and limited representation of 2SLGBTQIA+ individuals within healthcare settings. Stakeholders emphasized the importance of community-led care models, education reform, and systemic accountability mechanisms designed to improve health equity.

Recommendations for actionable change

To address these challenges, the 2025 Pink Paper on Health offers insight into several recommendations for actionable change:

1.

Integrate 2SLGBTQIA+ health into healthcare education

Academic institutions, educators, and policymakers should actively partner with 2SLGBTQIA+ communities to ensure health curricula audits and reforms address the issues that matter to 2SLGBTQIA+ people living in Canada. Embedding inclusive, evidence-based training that centres gender diversity, trauma-informed care, and anti-oppressive practices across all levels of education and professional development will lead to more equitable care.

2.

Expand inclusive mental health services at federal, provincial, and institutional levels

Increased access to culturally competent, publicly funded mental health care, including gender-affirming services supports everyone across Canada. However, mandatory training in 2SLGBTQIA+ competency and trauma-informed approaches will ensure 2SLGBTQIA+ individuals benefit equally from these services.

3.

Standardize inclusive sex and gender data collection

Respectful, standardized practices for collecting sex and gender identity data should be implemented at the federal level to support early identification of disparities and inform equitable care and policy.

4.

Develop inclusive cancer screening and chronic disease prevention programs

Policymakers, healthcare providers, and community groups should co-create cancer screening and chronic disease prevention programs tailored to 2SLGBTQIA+ populations, addressing unique barriers like discrimination and care avoidance.

5.

Conduct a national environmental scan of available 2SLGBTQIA+ healthcare services

Researchers and academic partners should lead a Canada-wide scan to map services, identify gaps, and highlight regional strengths. These findings will support more strategic planning and resource allocation that addresses existing gaps.

6.

Improve access to health services in rural and remote communities

Federal and provincial efforts to strengthen 2SLGBTQIA+ care in underserved areas through incentives, virtual care models, and community-led clinics will help prevent care quality from being dependent on geography. Policymakers should consult with service providers and individual communities to improve access in impactful ways.

7.

Make institutions safer by centring 2SLGBTQIA+ voices

Prioritizing lived experience and the leadership of 2SLGBTQIA+ individuals helps institutions, researchers, and health leaders authentically represent real perspectives in Canada. Hiring roles like peer navigators and equity officers can reduce self-advocacy burdens and foster trust in care systems.

The 2025 Pink Paper on Health offers an unprecedented national overview of 2SLGBTQIA+ health and healthcare experiences in Canada, representing one of the most detailed studies to date. The evidence it presents shows how Canada's healthcare system currently fails to meet the needs of 2SLGBTQIA+ communities, particularly in rural and racialized contexts. Respondents described profound experiences of exclusion, stigma, and mistrust, all of which undermine care and contribute to a cycle of unmet health needs. This report therefore offers data designed to give policymakers, educators, and healthcare providers a clear direction to begin closing these gaps. Ensuring equitable and affirming care for 2SLGBTQIA+ people is not only a matter of health justice—it is an evidence-based imperative.

1.2 A Note on Language

Throughout this document, we refer to individuals and groups who identify as descendants of pre-colonial civilizations in Canada as **Indigenous**. While there is no universally accepted definition for this diverse group, we employ this terminology with the understanding that individuals and communities have the autonomy to define themselves (Allan & Smylie, 2015).

The 2025 Pink Paper on Health adopts the **inclusive acronym 2SLGBTQIA+** to represent a heterogeneous population with diverse sex and gender identities and a spectrum of sexual orientations. This acronym is dynamic and ever evolving. An earlier term, LGBT, stands for **lesbian**, **gay**, **bisexual**, and **transgender**. The addition of **Two-Spirit (2S)** recognizes an umbrella term describing a gender or sexual identity outside of western binaries used by Indigenous North American cultures (OUTSaskatoon, 2020; Robinson, 2017). It serves as a unifying term across diverse Indigenous nations, who have long recognized and respected non-binary gender roles while still respecting unique cultural, spiritual, and linguistic understandings of gender and sexuality within communities. **Queer** and **questioning (Q)** were added to encompass a broader range of identities and experiences, while **intersex (I)**, and **asexual** and **aromantic (A)** further extended the acronym's inclusivity. Finally, the plus sign (+) assures the inclusion of all other identities not covered by previous initials.

We acknowledge that no single term can adequately convey the full range of identities under the 2SLGBTQIA+ umbrella. When we use the acronym, we are addressing multiple intersecting communities rather than a singular one. It is crucial to honour how individuals choose to identify themselves, irrespective of the terminology employed in this report. Consequently, when quoting interviews and qualitative statements, we preserve each participant's preferred vocabulary. A glossary of terms is available in **Appendix A**.

1.3 Objectives

There remains a notable lack of comprehensive, intersectional data on the health of 2SLGBTQIA+ individuals, which prevents medical practitioners, researchers, and policymakers from accurately identifying and addressing diverse health needs (Comeau et al., 2023; Stranges et al., 2023). While several community organizations and research groups have made critical contributions to this field, much work remains to address important gaps—particularly the lack of standardized, national-level demographic data collection on sex, gender, and sexual orientation, which remains uncommon in Canada's healthcare system (Gahagan & Subirana-Malaret, 2018; Stranges et al., 2023).

What little data we do have is asymmetrical and does not accurately represent **all** identities under the 2SLGBTQIA+ umbrella. For example, the concerns of **Two-Spirit**, **intersex**, and

asexual people are often invisible across many aspects of healthcare. While some health needs are shared between 2SLGBTQIA+ populations, the communities are not monolithic. Because healthcare systems and research practices have yet to fully adopt a responsive, intersectional approach, they have not addressed persistent health inequities among 2SLGBTQIA+ individuals.

To that end, **the primary goal of the 2025 Pink Paper on Health is to bring awareness to the persistent health disparities faced by 2SLGBTQIA+ communities in Canada**, with a particular focus on intragroup differences across gender and sexual orientation. **As the first bilingual, national, and intersectional study of its kind**, this report offers a foundational framework for understanding the health needs and lived experiences of 2SLGBTQIA+ individuals. Because identifying health disparities across groups requires a reference, we use data simultaneously collected from cisgender and heterosexual individuals as a baseline for this research. This information allows us to quantify the magnitude of disparities, contextualize inequities, and pinpoint where systemic gaps are most pressing. Without such a reference group, it would be difficult to meaningfully demonstrate inequities in health outcomes.

We have collected cross-sectional data from 2SLGBTQIA+ and non-2SLGBTQIA+ individuals across Canada, in both English and French, to assess self-reported **1)** health status, **2)** access to healthcare, **3)** experiences of discrimination in healthcare settings, and **4)** community-identified health priorities. Ultimately, this document is intended to serve as a trusted resource for future research, media reporting, and health advocacy. We aim to inform and support efforts in academic, policy, and community settings.

1.4 Background

Social Determinants of Health and Health Inequities

Health is shaped by a complex interplay of biological, behavioural, social, environmental, and systemic factors, collectively known as determinants of health "(Government of Canada - Social determinants of health and health inequalities, 2024)". These determinants of health include:

- biological factors, such as genetics and sex;
- personal behaviours, such as diet, physical activity, and substance use;
- social environments, such as support networks provided by family, friends, and communities;
- physical surroundings, such as place of residence;
- and healthcare service availability and quality of medical care (Eckstrand et al., 2016; PHAC, 2018).

Social determinants of health are specific socioeconomic factors within the broader context of determinants of health. These include one's position in society based on income, education, employment, ethnicity, **sex**, **gender, and sexual orientation**, among other factors (Government of Canada - Social determinants of health and health inequalities, 2024). Because social determinants of health significantly influence a broad spectrum of health, functional, and quality-of-life outcomes, variations in these determinants across population groups contribute to **health inequalities**. These are the measurable differences in health status or outcomes between groups. When these differences arise from systemic disadvantages, discrimination, or marginalization, they become **health inequities**.

Health inequities are **avoidable** differences in health status or in the distribution of health resources between different groups, rooted in social injustice (PHAC, 2018). Health inequities emphasize the moral and ethical dimensions of health disparities. They highlight the need for corrective action because limited healthcare access and quality of care results in heightened risk of disease, lower life expectancy, and overall reduced quality of life. Discrimination, racism, and historical trauma are social determinants that lead to health inequities for many groups, namely Indigenous Peoples, Black people, people of colour, and members of the 2SLGBTQIA+ community.

Social determinants of health are interconnected. One factor will often influence or amplify the effects of others. For example, **cisheteronormativity**—the assumption that cisgender, heterosexual identities and relationships are the default—is compounded by other forms of discrimination, such as ageism, ableism, and racism. When we approach the subject through an intersectional lens, we see that each factor increases individuals' vulnerability to poor health outcomes (Bauer, 2014; Eckstrand et al., 2016; Hsieh & Ruther, 2016; Veenstra, 2011).

Studies show that stigma and discrimination against 2SLGBTQIA+ people makes it harder for them to advance into higher-paying jobs (National Academies of Sciences et al., 2020). This can lead to lower income, which in turn restricts access to nutritious food, stable housing, and healthcare services (Flaubert et al., 2021; Rolfe et al., 2020). Unstable or low-wage employment also limits access to health insurance and paid sick leave, thereby restricting access to preventative care and treatment. Taken together, these factors mean individuals will often have to work while sick, worsening their own health and increasing community transmission in the process. Similarly, food insecurity contributes to chronic conditions, such as obesity and diabetes, which are harder to manage without stable employment or access to care.

This interconnectedness makes it extremely challenging to isolate one specific factor as the root cause of health inequalities and inequities. It also underscores the necessity for comprehensive approaches to healthcare reform that address multiple determinants simultaneously to foster a more equitable health environment for all.

Sex, Gender, and Sexual Orientation in the Context of Health

Sex, gender, and sexual orientation profoundly influence the leading causes of death and morbidity worldwide. Yet these variables—especially gender and sexual orientation—are rarely recorded in clinical settings or healthcare research (Comeau et al., 2023; Gadsden et al., 2024; Geller et al., 2018; Hallam et al., 2023; Heidari et al., 2016; Mauvais-Jarvis et al., 2020; Rebekah et al., 2021; Subramaniapillai et al., 2024). This knowledge gap is significant because data collected in research settings informs clinical guidelines and health policy. When studies fail to include these variables, their findings reinforce preventable disparities and compromise the quality of care for marginalized populations.

Although some Canadian institutions have recently issued guidelines to promote the inclusion of sex, gender, and minority groups in research design, their real-world impact has been limited (CIHR, 2022; HealthCanada, 2023; Johnson et al., 2009; Merone et al., 2022; Peters et al., 2021). Once again, several factors contribute to this challenge, including the fact that most studies take young, cisgender heterosexual men as default research subjects, as well as a legacy of endosexnormativity, cisnormativity, heteronormativity, and misogyny. These tendencies are further compounded by researchers' misunderstanding of the definitions of sex and gender (Lowik et al., 2024). As a result, providers lack the evidence, training, and policy frameworks needed to address the distinct health needs of 2SLGBTQIA+ communities. In this section, we provide clear definitions of sex, gender, and sexual orientation in the context of health to reduce confusion.

Sex, gender, and sexual orientation are fluid, related, and complex concepts that significantly impact an individual's health and health-related outcomes (i.e. determinants of health) (Comeau et al., 2023). As mentioned, people often conflate sex and gender, despite significant efforts toward precision, accuracy, consistency, inclusivity, and clarity in health care (Sumerau, 2020). When researchers and educators adopt colonial, racist, and heterosexist definitions of sex and gender, they often erase intersex, Two-Spirit, trans, and gender diverse people from health care settings (Lowik et al., 2024).

Sex modifies physiology and disease via genetic, epigenetic, and hormonal regulation (Mauvais-Jarvis et al., 2020). In other words, sex refers to the biological and physical characteristics attached to the categories of intersex, female, and male (Shannon et al., 2019). **Intersex** is an umbrella term used to describe people who are born with reproductive anatomy, primary or secondary sex characteristics, hormones, or chromosomes that differ from the characteristics that have been associated with female or male biology. Conversely, the term **endosex** refers to those whose characteristics fall within the ranges of what the medical system considers female or male.

Sex-dependent differences can influence a person's susceptibility to particular diseases, their response to treatments, and their overall health. For example, hormones like estrogen and testosterone affect cardiovascular health, bone density, and mental health among other health aspects (Eckstrand et al., 2016). Conditions such as cervical and prostate cancer are

also sex dependent. When assessing patients, healthcare professionals need to understand which aspects of gender and which aspects of sex impact symptomatology and risk factors. This includes ensuring that patients receive appropriate screening. While cervical cancer screening is usually recommended for women, it is actually people with cervixes who require cervical cancer screening, regardless of gender.

Gender refers to someone's identity and expression in relation to culturally formed categories. As a result, gender is a **societal and cultural construct** that affects how people perceive themselves and how they are perceived by others (Manandhar et al., 2018). **Cisnormativity** is a dominant colonial ideology that assumes sex and gender always align in a predictable way, without considering historical and cultural aspects of gender. The belief that trans and non-binary people are a recent novelty is unfounded and based in a lack of understanding that gender fluidity has long existed, especially in pre-colonial societies. Restrictive and historical binary gender norms have a documented negative effect on the health and wellbeing of gender-diverse individuals as well as on cis people (Comeau et al., 2023). Gender inequality leads to increased health risk through discriminatory values, norms, beliefs, and practices. Because of the interrelatedness of social determinants of health, this inequality also increases susceptibilities to disease, disability, and injuries, as well as biases in health research and systems (Shannon et al., 2019).

Sexual orientation is a pattern of emotional, sexual, and/or romantic attraction. It can be distinct from **sexual or romantic behaviour**, which refers to the specific acts or partners with whom one engages (StatCan, 2024). While orientation captures who a person is drawn to over time, behaviour describes what a person does. These dimensions do not always align. For example, someone may identify as gay but have partners of multiple genders. Assuming clinical risk based on orientation alone can therefore lead to inappropriate care or microaggressions. Culturally competent guidelines recommend asking about behaviour directly to ensure accurate risk assessment, appropriate screening, and respectful, individualized care.

Canadian Advocacy Work

Advocacy groups across Canada have made significant strides in advancing 2SLGBTQIA+ health through research, community programs, and policy initiatives. For example, **Egale Canada** has been instrumental in conducting research on healthcare access for LBQ women, trans, and nonbinary individuals, as well as LGBTQI seniors. Their efforts have led to the development of inclusive school and workplace training programs, reaching over 4,200 individuals in 2023 alone (Our Impact: Egale Canada, 2024). Organizations like **It Gets Better Canada**, the **Canadian Centre for Gender and Sexual Diversity** (CCGSD), and **LGBT YouthLine** have also launched the #YouthVoicesWillPrevail campaign to amplify the voices of queer and trans youth amidst rising anti-2SLGBTQIA+ violence (It gets better Canada: YouthVoicesWillPrevail, 2023). This initiative seeks to counteract hate

and provide a platform for youth expression and advocacy. **Trans PULSE Canada** has also played a pivotal role in advancing 2SLGBTQIA+ health in Canada. Their community-driven research has highlighted critical health disparities, such as high rates of unmet healthcare needs and barriers to access gender-affirming care (Scheim et al., 2021). In 2023, the federal government committed to improving 2SLGBTQIA+ mental health by investing $2.8 million into community-based programs, such as **Community Based Research Center**'s "Investigaytors," which aimed to enhance mental health literacy and support among 2SLGBTQIA+ communities (Government of Canada invests $2.8 million to support 2SLGBTQI+ mental health, 2023).

Collectively, these efforts demonstrate an increasing awareness of the health needs of 2SLGBTQIA+ individuals and a commitment to building inclusive, supportive environments across Canada. However **significant knowledge gaps persist, particularly in relation to equitable access to care. The resurgence of anti-2SLGBTQIA+ violence poses a growing concern for the safety, dignity, and health outcomes of these communities as well.**

1.5 Methodology

Pink Triangle Press engaged Environics Research to conduct research for this 2025 Pink Paper on Health. The study was conducted in two phases. The first involved developing and administering a **pan-Canadian survey**. In the second, Environics Research conducted **structured interviews with key stakeholders** to derive deeper insights into the survey findings.

The 15-minute survey was developed in English and French and included questions regarding:

- **health status**
- **healthcare accessibility**
- **experiences of stigma and discrimination**
- **health priorities**

The survey included both quantitative and qualitative items (i.e. open-ended questions) for a more in-depth understanding of the existing health disparities in the Canadian healthcare system. Data was collected between March 19 and April 7, 2025.

Sixteen structured stakeholder interviews took place between March 27 and May 7, 2025. These were conducted with individuals specializing in 2SLGBTQIA+ health. Interviewees included healthcare leaders, healthcare professionals, medical students, researchers, and Indigenous stakeholders. These individuals are based in Ontario, Quebec, Saskatchewan, Alberta, Manitoba, Nova Scotia, Newfoundland and Labrador, and British Columbia.

For detailed methodology, please refer to **Appendix B**.

Participants' Sociodemographic Characteristics

In total, 2,110 respondents answered the survey, the majority of whom were from Ontario (40%), followed by provinces in western Canada (30% MB, SK, AB, and BC) and Quebec (24%). Participants from Atlantic provinces represented 6% of the total cohort (Figure 1).

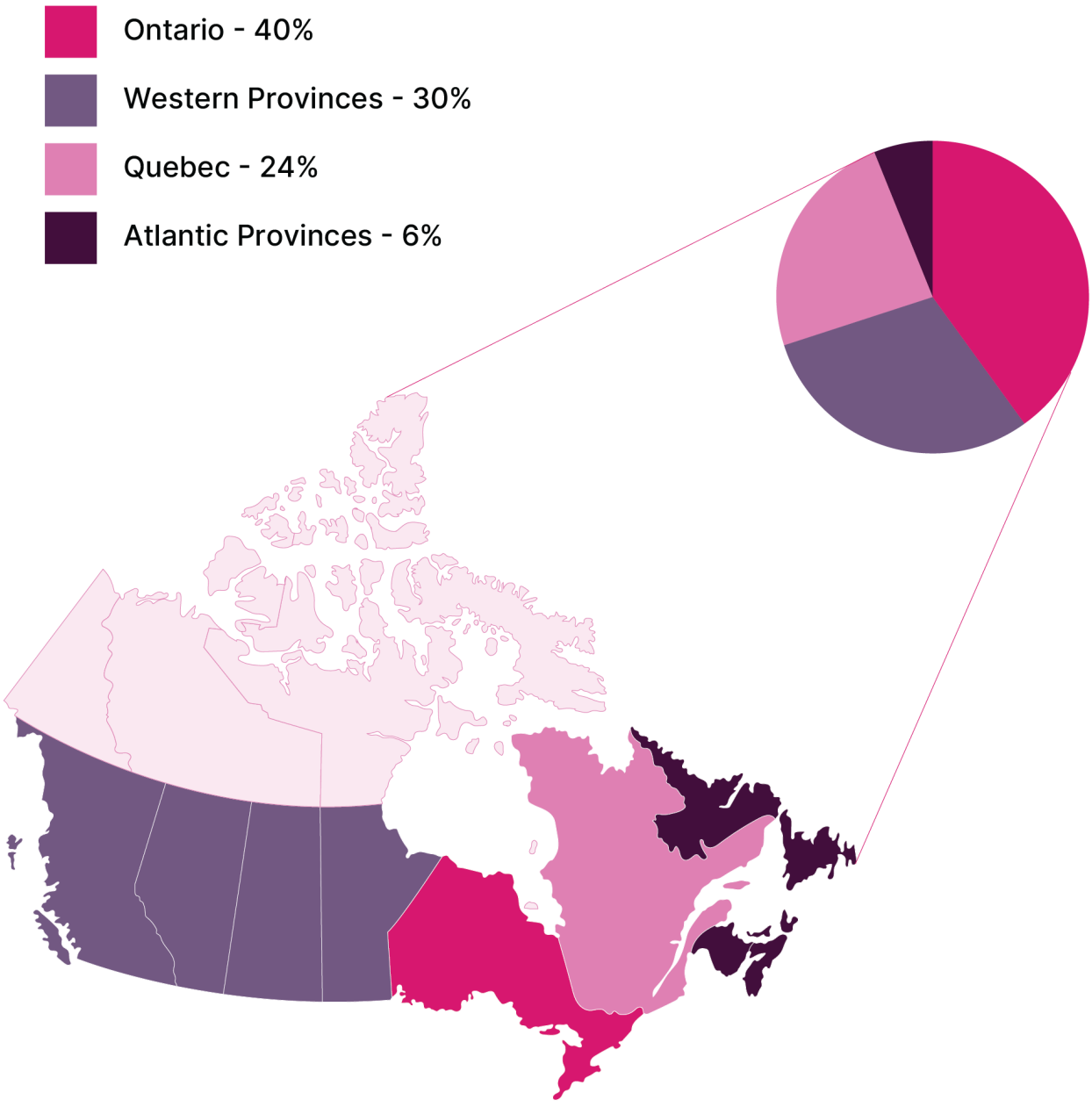


Figure 1: Geographic distribution of study participants.

Of the 2,110 respondents, 1,527 provided additional information about their sex, identifying as either male (48%, n=727) or female (51%, n=778). Fifty percent (n=1,062) of participants self-identified as 2SLGBTQIA+ while the other half represented non-2SLGBTQIA+ members (n=1,048). Within the 2SLGBTQIA+ group, 8% (n=85) of participants identified as **intersex**. The most frequently reported **gender identities** were **cis man** (38%) and **cis woman** (37%). 8% of respondents identified as **non-binary**, 4% as **trans men**, and 3% as **trans women** (Table 1). 2SLGBTQIA+ respondents most frequently self-reported being **bisexual** (34%), **gay** (29%), and **lesbian** (12%), followed by **pansexual** (9%), **heterosexual** (8%), **queer** (8%), and **asexual** (6%). T**wo-Spirit** was respectively reported as a gender identity and sexual orientation by 3% and 2% of 2SLGBTQIA+ members.

Table 1: Gender identities and sexual orientations reported by 2SLGBTQIA+ and non-2SLGBTQIA+.

Gender Identity, n(%)	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Cis Man	38%	50%
Cis Woman	37%	50%
Non-Binary	8%	-
Trans Man	4%	-
Trans Woman	3%	-
Two-Spirit	3%	-
Agender	3%	-
Genderfluid	3%	-
Bigender	3%	-
Genderqueer	3%	-
Questioning	3%	-
Prefer to Self-Describe	2%	-

Sexual Orientation, n(%)	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Bisexual	34%	-
Gay	29%	-
Lesbian	12%	-
Pansexual	9%	-
Heterosexual (straight)	8%	100%
Queer	8%	-
Asexual	6%	-
Demisexual	3%	-
Questioning	3%	-
Aromantic	2%	-
Two-Spirit	2%	-
Polysexual	1%	-
Prefer to Self-Describe	4%	-

Please note that columns do not sum to 100% because answer choices for sexual orientation and gender identity were not mutually exclusive (i.e., some individuals identify with multiple categories).

For a more detailed description of surveyed participants, please refer to **Appendix B**.

Clinical History

2

To effectively evaluate existing health disparities, the 2025 Pink Paper on Health collected **primary health concern** data from all respondents. Both the 2SLGBTQIA+ and non-2SLGBTQIA+ populations were also asked to disclose previous medical diagnoses. This approach was chosen to assure a comparative analysis of health status across populations with the aim of informing equitable health policy and system-level interventions. By identifying key differences in reported conditions and concerns, this work provides critical baseline evidence to guide inclusive healthcare planning and address unmet needs within 2SLGBTQIA+ communities.

2.1 Main Health Concerns and Self-Reported Medical Conditions

2SLGBTQIA+ communities report disproportionately higher rates of concern across most health-related domains compared to non-2SLGBTQIA+ individuals.

The most frequently cited health concerns among 2SLGBTQIA+ respondents are:

1. Competent healthcare professionals (43%);
2. Respectful healthcare (32%);
3. Feeling safe and understood in healthcare settings (36%);
4. Affordable healthcare or medications (42%).

These rates were consistently significantly higher than those reported by non-2SLGBTQIA+ respondents, suggesting systemic barriers to safe, inclusive, and affordable care. In addition, 2SLGBTQIA+ participants were more than twice as likely to identify **sexual health (20%)** and **gender-affirming care (8%)** as main health concerns, further highlighting unmet needs unique to these communities **(Figure 2)**.

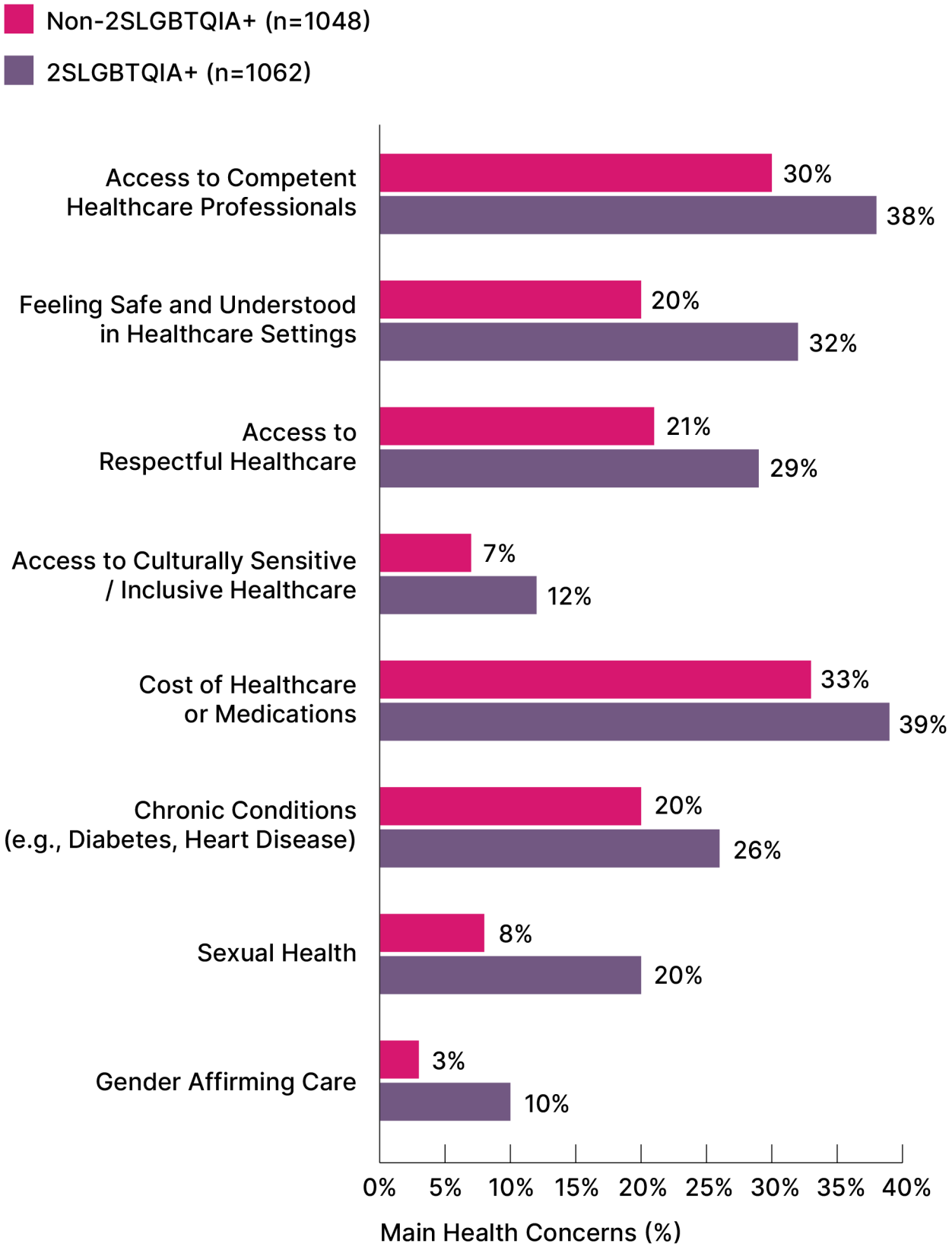


Figure 2: Most reported health concerns.

2SLGBTQIA+ respondents reported elevated rates of chronic disease and cancer compared to non-2SLGBTQIA+ individuals.

Data reveals substantial disparities in **clinical history** and **reported health conditions** between 2SLGBTQIA+ individuals and their non-2SLGBTQIA+ counterparts. Members of 2SLGBTQIA+ communities reported significantly higher rates of **digestive diseases (17%)** compared to non-2SLGBTQIA+ respondents **(11%)**. Particularly high rates were reported by those identifying as **pansexual (28%)**, **queer (24%)**, **and Two-Spirit (27%)** (Figure 3).

These results are surprising given the limited evidence linking 2SLGBTQIA+ identity to higher rates of digestive diseases. These findings highlight a need to investigate underlying factors such as chronic stress, healthcare barriers, and comorbidities.

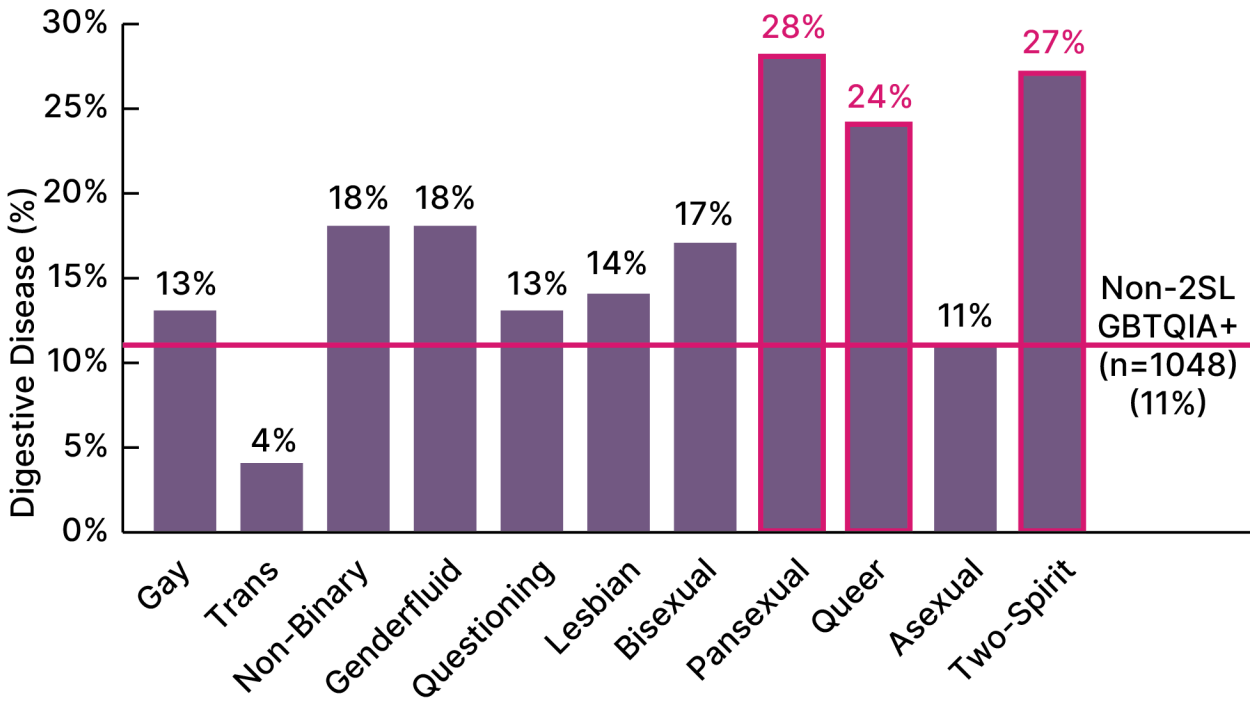


Figure 3: Reported diagnoses of digestive diseases (%).

The prevalence of **asthma and obesity** followed similar patterns with **pansexual** individuals reporting the worst levels in both categories (**22%** and **20%**, respectively) (Figures 4,5).

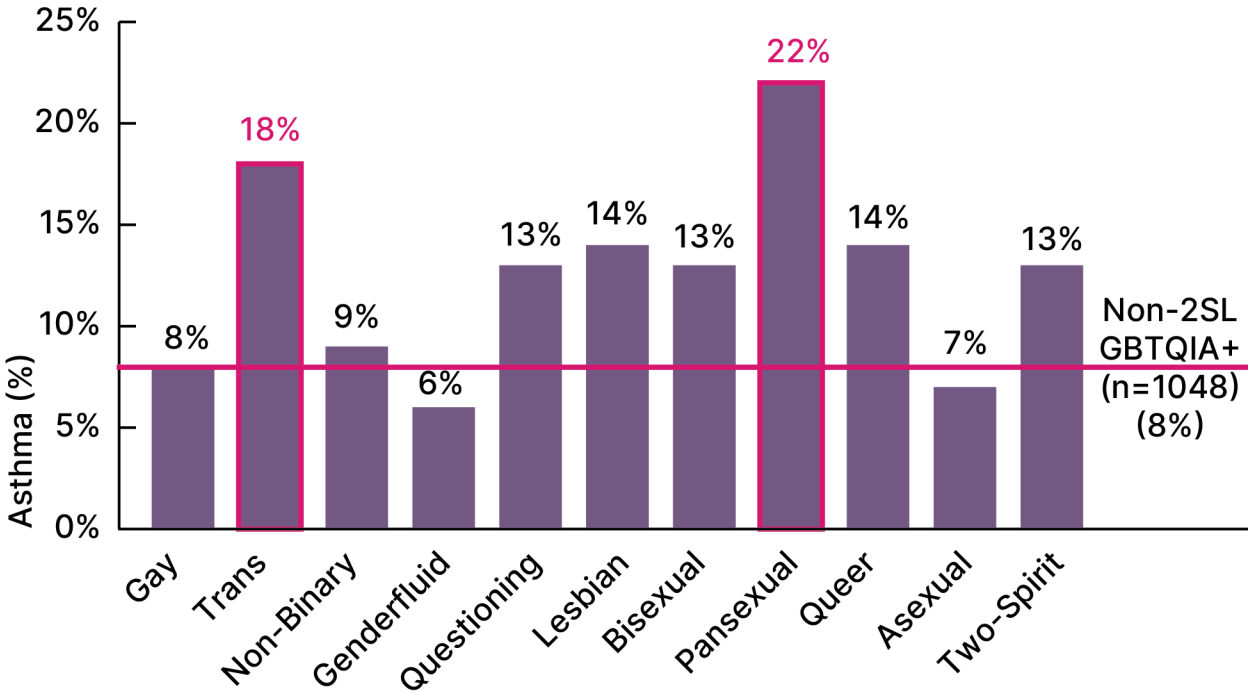


Figure 4: Reported asthma diagnosis (%).

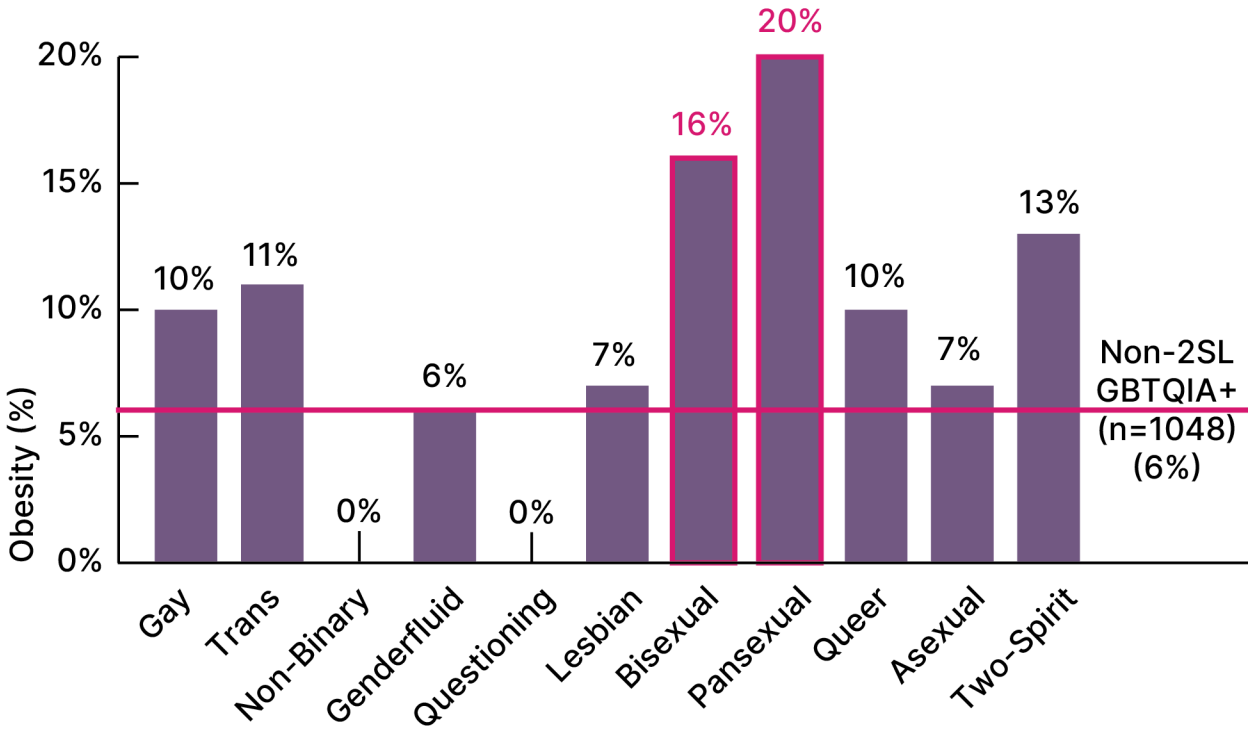


Figure 5: Reported obesity (%).

Chronic pain was also disproportionately common within 2SLGBTQIA+ communities. Alarmingly, the rates reported by **queer (28%)** and **Two-Spirit (27%)** respondents are more than **five times higher** than those of the non-2SLGBTQIA+ population **(5%)**, underscoring a critical, overlooked health disparity (Figure 6).

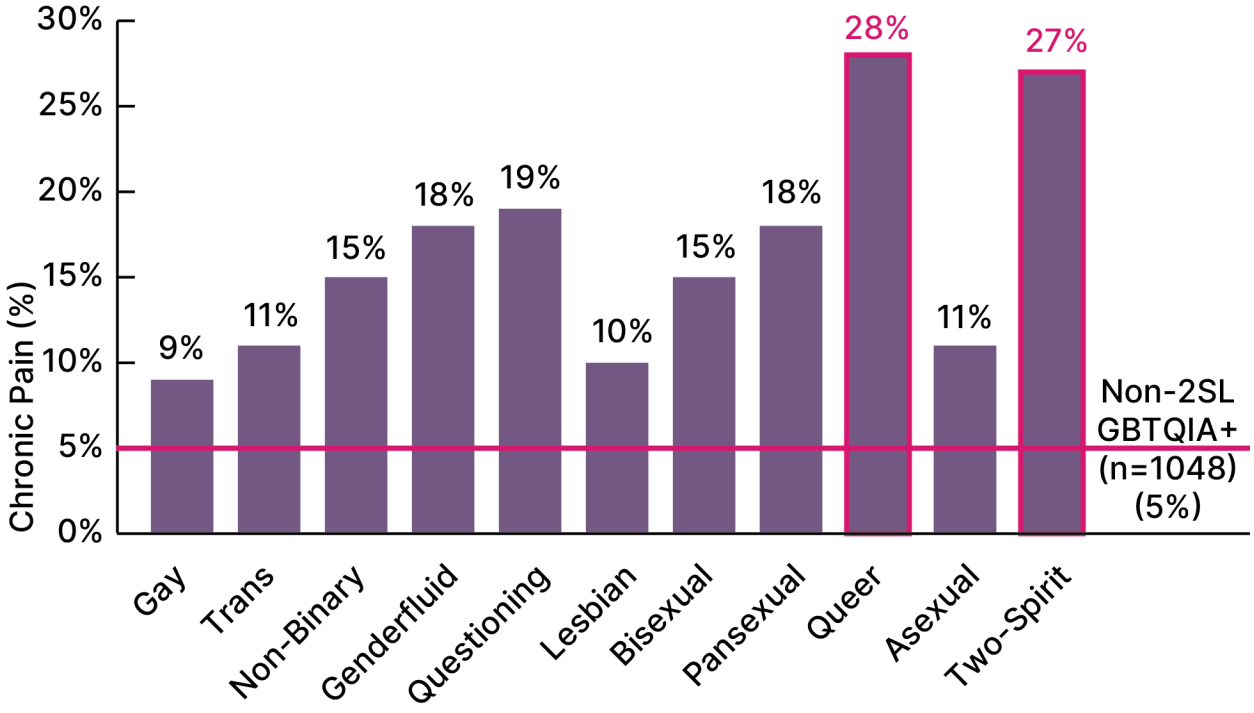


Figure 6: Reported chronic pain (%).

Although overall **cancer prevalence** among 2SLGBTQIA+ individuals **(6%)** was only slightly higher compared to non-2SLGBTQIA+ respondents **(5%)**, an aggregate view masks significant disparities within specific subgroups. **Asexual** and **gay** respondents reported alarmingly elevated rates of cancer diagnoses of **15%** and **11%**, respectively (Figure 7).

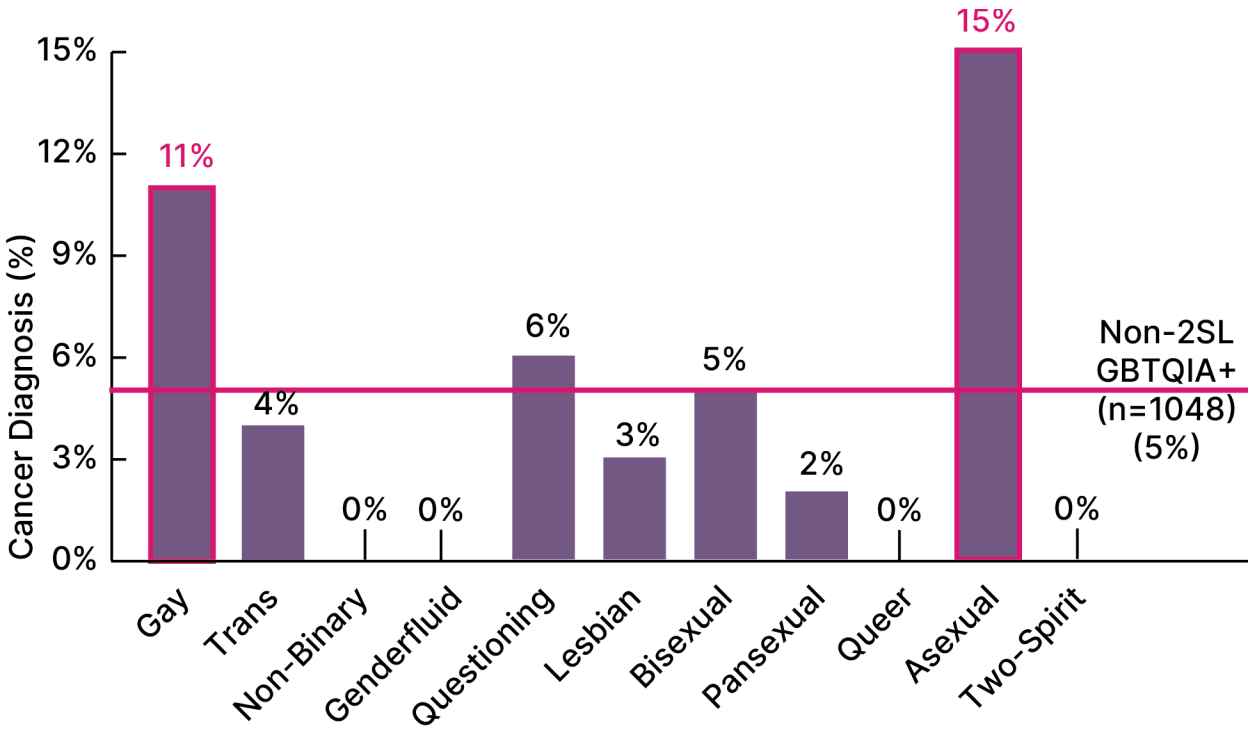


Figure 7: Reported cancer diagnoses (%).

Taken together, these findings illustrate the alarming ways in which aggregate data fails 2SLGBTQIA+ people. That is to say, approaching data in the aggregate obscures serious health concerns that affect specific communities. For example, the elevated cancer rates among gay and asexual individuals may reflect delayed or avoided cancer screening, or it may point to a lack of information regarding the importance of regular screening, even for individuals who are not sexually active. Importantly, existing literature indicates that **trans**, **non-binary**, and **intersex individuals** are more likely to delay or avoid cancer screening due to past experiences of stigma, misgendering, or a lack of culturally competent care (Charron et al., 2022; Comeau et al., 2023; Gayhart, 2025; Kcomt et al., 2020; Ragosta et al., 2023). All these barriers contribute to underdiagnosis and late-stage detection. The patterns in the data highlight the urgent need for every province to **implement inclusive, targeted cancer screening strategies that address the unique barriers and informational gaps faced by communities within the 2SLGBTQIA+ umbrella.**

2.2 Mental Health

2SLGBTQIA+ individuals are far more likely to cite mental health as a main concern (51%) than non-2SLGBTQIA+ peers (31%).

Mental health is a growing concern for Canadians and a known health disparity for members of 2SLGBTQIA+ communities (Comeau et al., 2023; Georgiades, 2021). Correspondingly, the most prevalent health concern identified by the 2SLGTBQIA+ respondents was **mental health** (Figure 8).

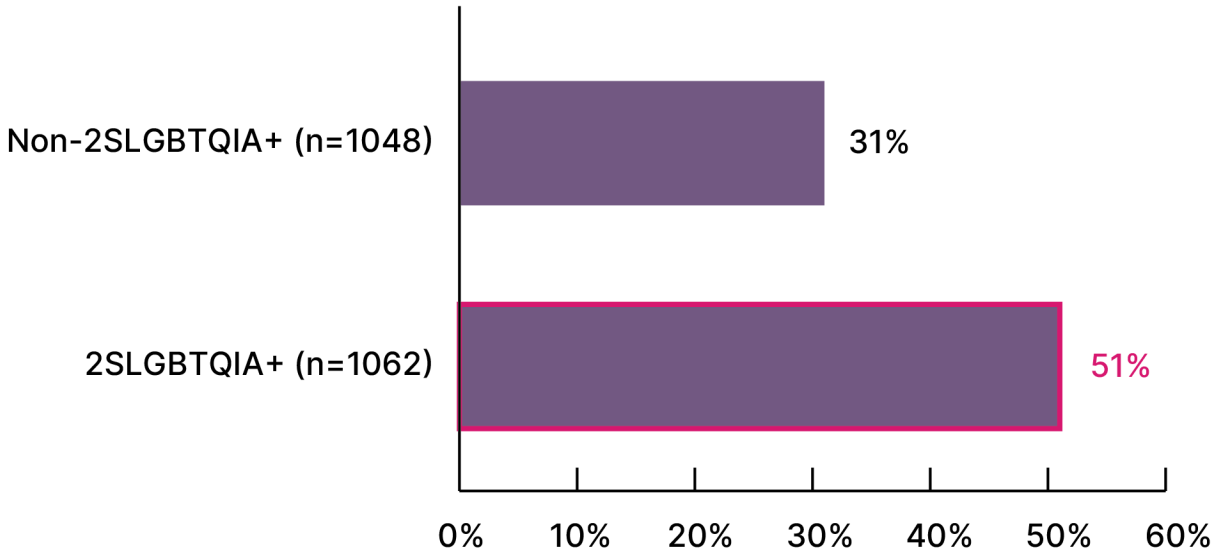


Figure 8: Mental health is the leading health concern among 2SLGBTQIA+ communities.

When questioned about their clinical history with mental health, nearly **40% of 2SLGBTQIA+ respondents** reported having been diagnosed with **at least one** mental health disorder, **twice the rate reported by non-2SLGBTQIA+ individuals (20%)**. Elevated diagnosis rates were observed across all identities within the 2SLGBTQIA+ umbrella, with particularly high prevalence among those identifying as **pansexual (52%)**, **queer (52%)**, **lesbian (50%)**, and **bisexual (47%)** (Figure 9).

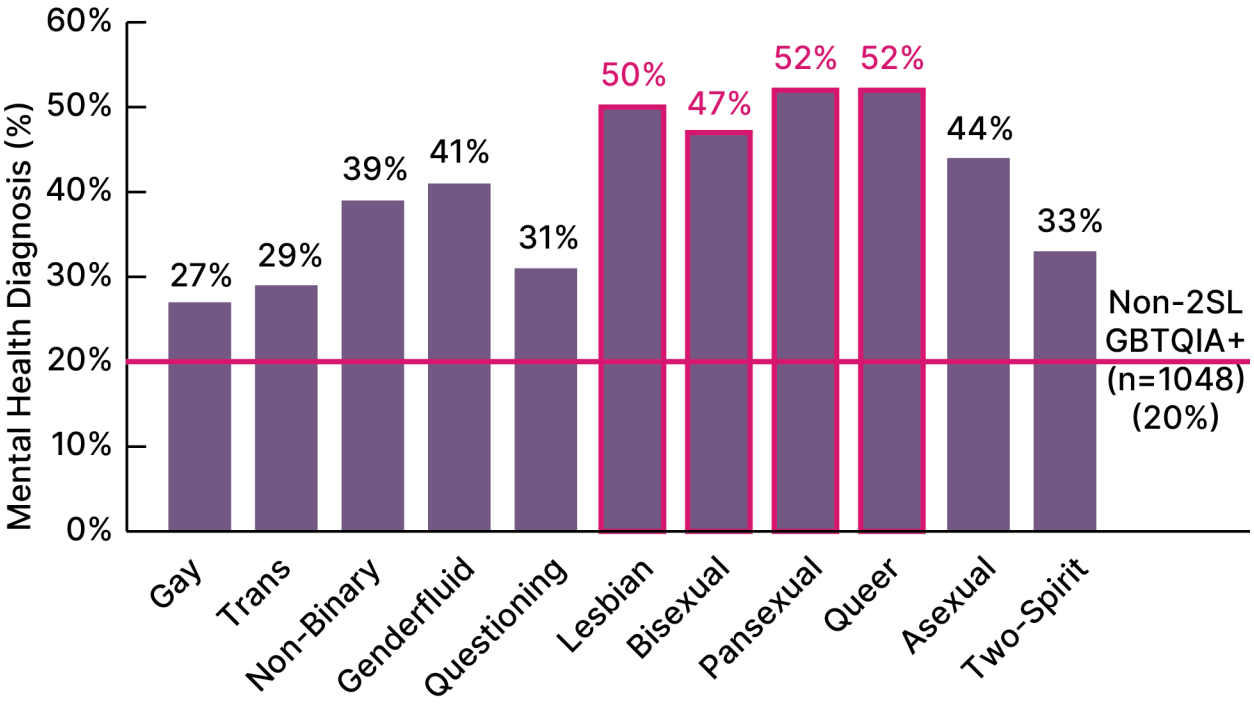


Figure 9: Prevalence of mental health diagnoses in 2SLGBTQIA+ communities.

Although mental health disorders affect everyone, these findings underscore the disproportionate mental health burden experienced by 2SLGBTQIA+ communities. It is also important to note that mental health conditions may even be underreported within 2SLGBTQIA+ communities. Systemic barriers, including limited access to affirming care, experiences of stigma and discrimination, and a lack of culturally competent providers can discourage individuals from seeking diagnosis or treatment. **Addressing these disparities through timely, inclusive, and identity-affirming mental health services will improve outcomes for 2SLGBTQIA+ individuals and advance the overall equity and responsiveness of Canada's mental healthcare systems. These access-related challenges are further explored in Section 3.0: Healthcare Access.**

Depression and anxiety severity highest among pansexual (47% and 50%, respectively) and asexual (45% and 47%, respectively) individuals, more than double rates in non-2SLGBTQIA+ respondents (22% and 25%, respectively).

Anxiety and depression represent the most common mental health disorders globally and in Canada, making them key indicators of psychological well-being at the population level. To provide detailed evaluations of mental health disparities, this study applied **validated clinical assessment tools** to compare the severity of anxiety and depression between 2SLGBTQIA+ and non-2SLGBTQIA+ populations. This approach enables a clearer understanding of the mental health impacts of systemic inequities.

Findings reveal elevated depression severity among 2SLGBTQIA+ respondents overall (32% vs. 22% among non-2SLGBTQIA+ respondents), but subgroup analyses show even starker disparities. Certain communities—such as **pansexual (47%) and asexual (45%)** individuals—reported nearly double the non-2SLGBTQIA+ rate. With the exception of gay participants, whose scores matched non-2SLGBTQIA+ respondents, all groups reported disproportionately high levels of depression, with pansexual and asexual individuals experiencing the most severe scores (Figure 10).

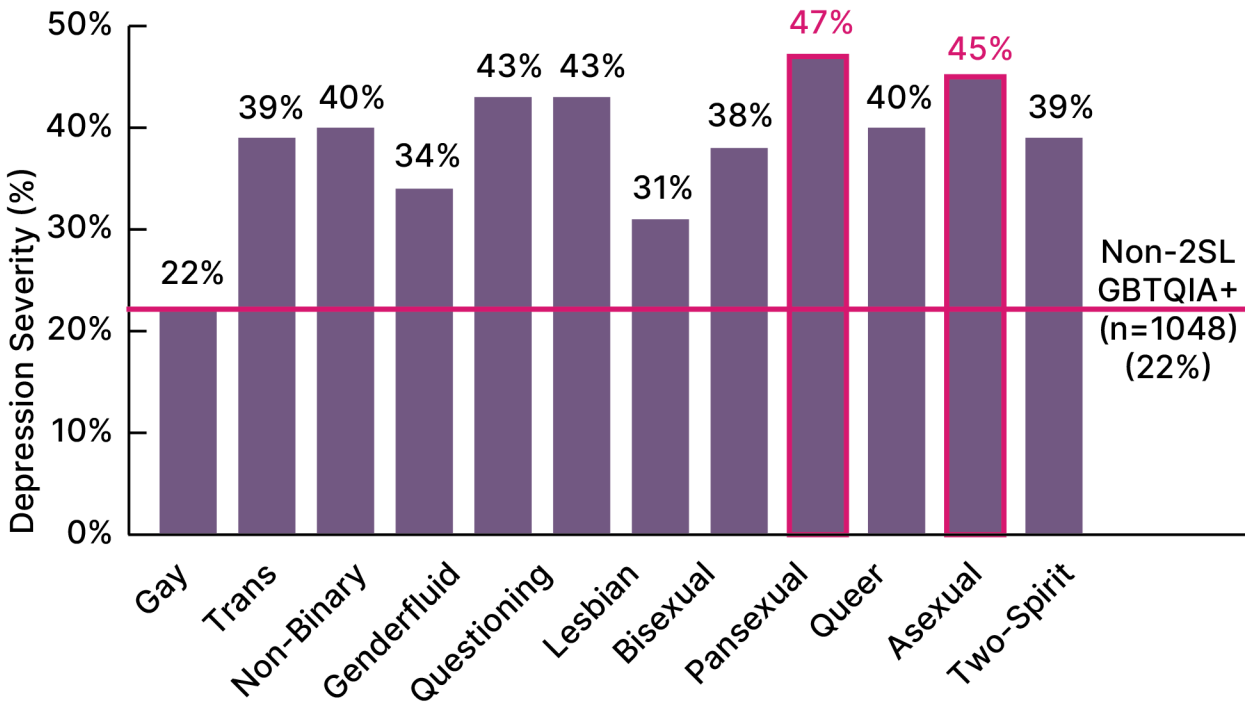


Figure 10: Depression severity in 2SLGBTQIA+ communities.

Data on anxiety severity reveals similar results. Most 2SLGBTQIA+ communities reported significantly higher anxiety scores than their non-2SLGBTQIA+ counterparts (25%) (Figure 11). Once again, **gay respondents** did **not** present higher levels of anxiety severity compared to non-2SLGBTQIA+ individuals. In fact, they showed identical prevalence. Individuals with the highest recorded anxiety severity were those identifying as **pansexual (50%)**, **questioning (47%)**, **asexual (47%)**, **trans (45%)**, **queer (45%)**, and **Two-Spirit (45%)**.

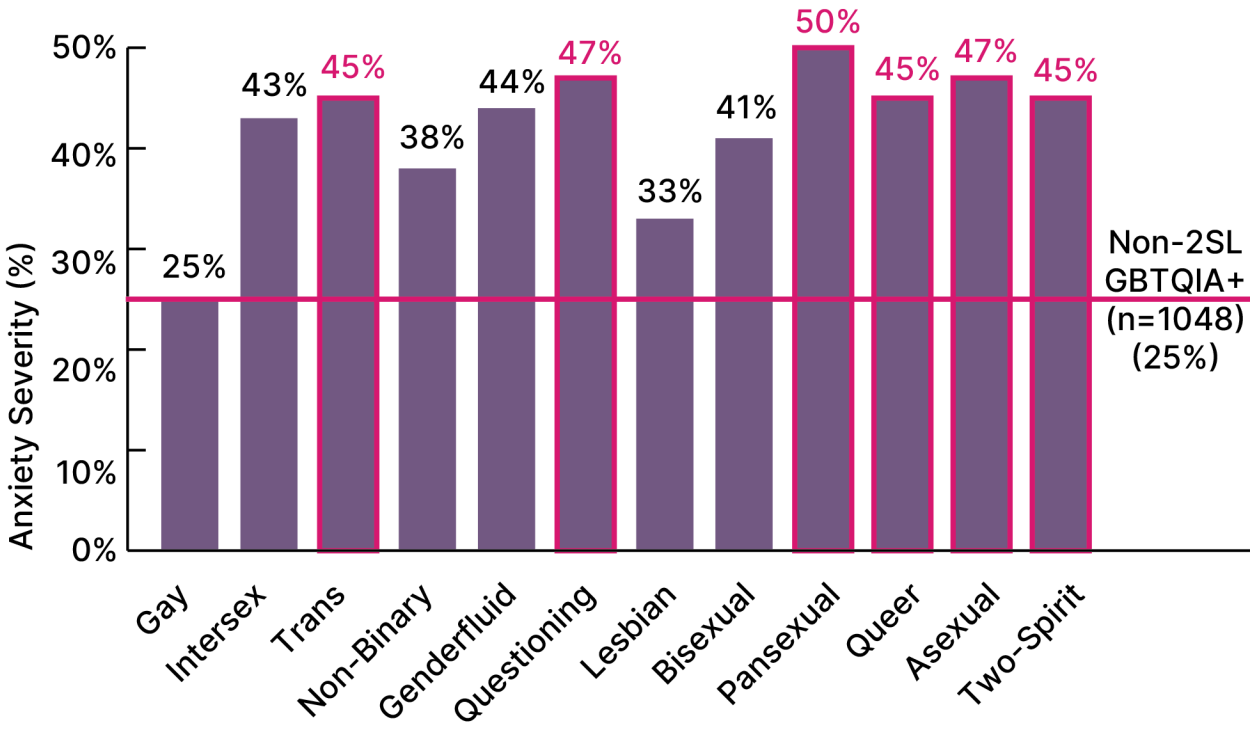


Figure 11: Anxiety severity in 2SLGBTQIA+ communities.

These findings highlight critical mental health disparities across 2SLGBTQIA+ communities. The severity of depression and anxiety among **pansexual, asexual, trans, questioning, queer, and Two-Spirit individuals** points to a deeply entrenched pattern of psychological distress. This data illustrates the compounding effects of cisheteronormativity.

Stakeholder interviews also echo these quantitative patterns. The qualitative data reinforces the persistent burden of mental health challenges, including **depression**, **anxiety**, **trauma**, and **neurodivergence** within 2SLGBTQIA+ populations. Interviewees highlighted that these issues are especially pronounced among **trans**, **non-binary**, and **Two-Spirit individuals**, all of which are linked to cumulative experiences of social exclusion, stigma, and discrimination. The disparities revealed by the quantitative and qualitative data underscore the need for inclusive, identity-specific interventions and **nuanced research into the unique stressors faced by different people with diverse 2SLGBTQIA+ identities.**

Intersectional disparities amplify depression and anxiety among 2SLGBTQIA+ populations, highlighting the need for more nuanced research and interventions.

Mental health outcomes within 2SLGBTQIA+ communities vary widely and are shaped by intersecting factors such as income, education, race, geography, and employment. To capture these differences, we analyzed the results through an intersectional lens.

Among 2SLGBTQIA+ individuals, respondents earning **less than $40,000 annually** reported the highest average depression severity **(38%)**, compared to **27%** among those earning **$100,000 or more** (Figure 12). Similarly, **education level** showed a clear gradient: respondents with only a **high school education** had depression scores reaching **37%**, compared to **28%** of those with a **university degree or higher**. **Geographic differences** were also evident. Those living in small communities reported an average depression severity of **37%**, while those in large urban centres reported a lower score of **30%** (Figure 12).

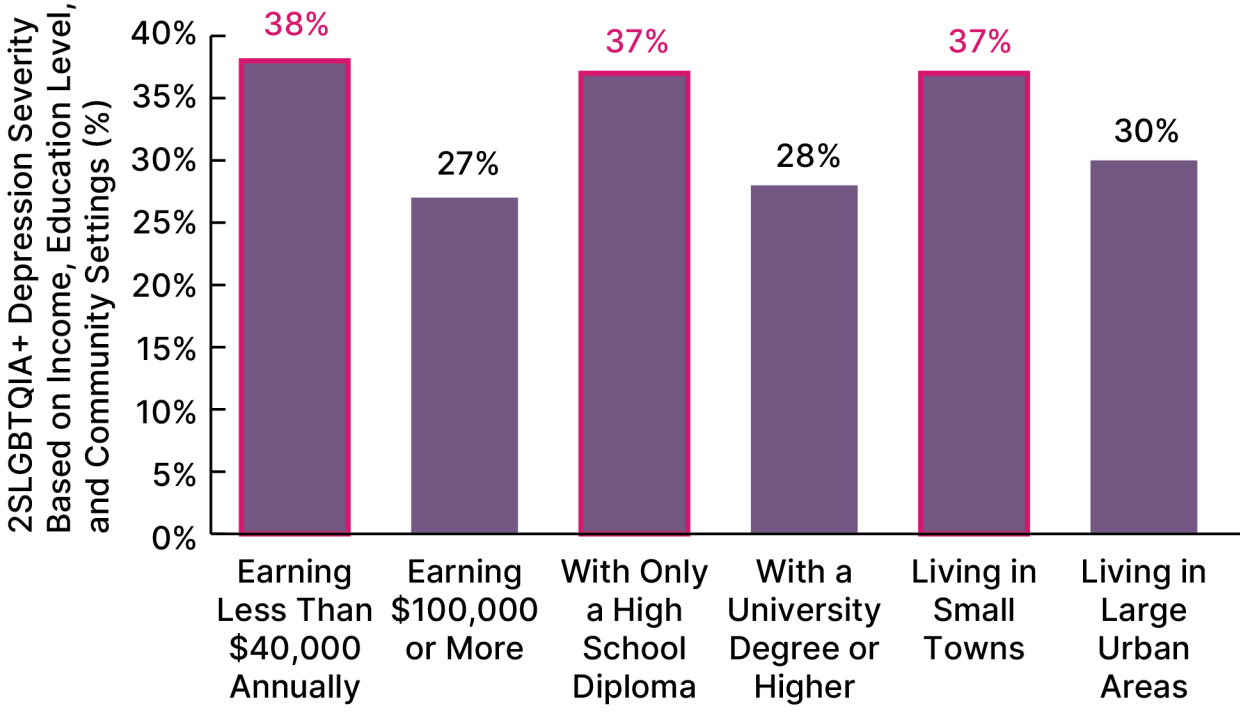


Figure 12: 2SLGBTQIA+ respondents' depression severity scores based on income, education level, and community settings.

Anxiety scores followed a similar pattern. Those in the lowest income bracket reported an average anxiety severity of **39%**, decreasing to **30%** among respondents in the highest income group (Figure 13). Respondents with a high school education reported anxiety scores of **40%**, compared to **31%** among those with a university education or higher. In terms of geography, those living in small communities had an average anxiety score of **40%**, while those in large urban areas reported lower levels at **33%** (Figure 13).

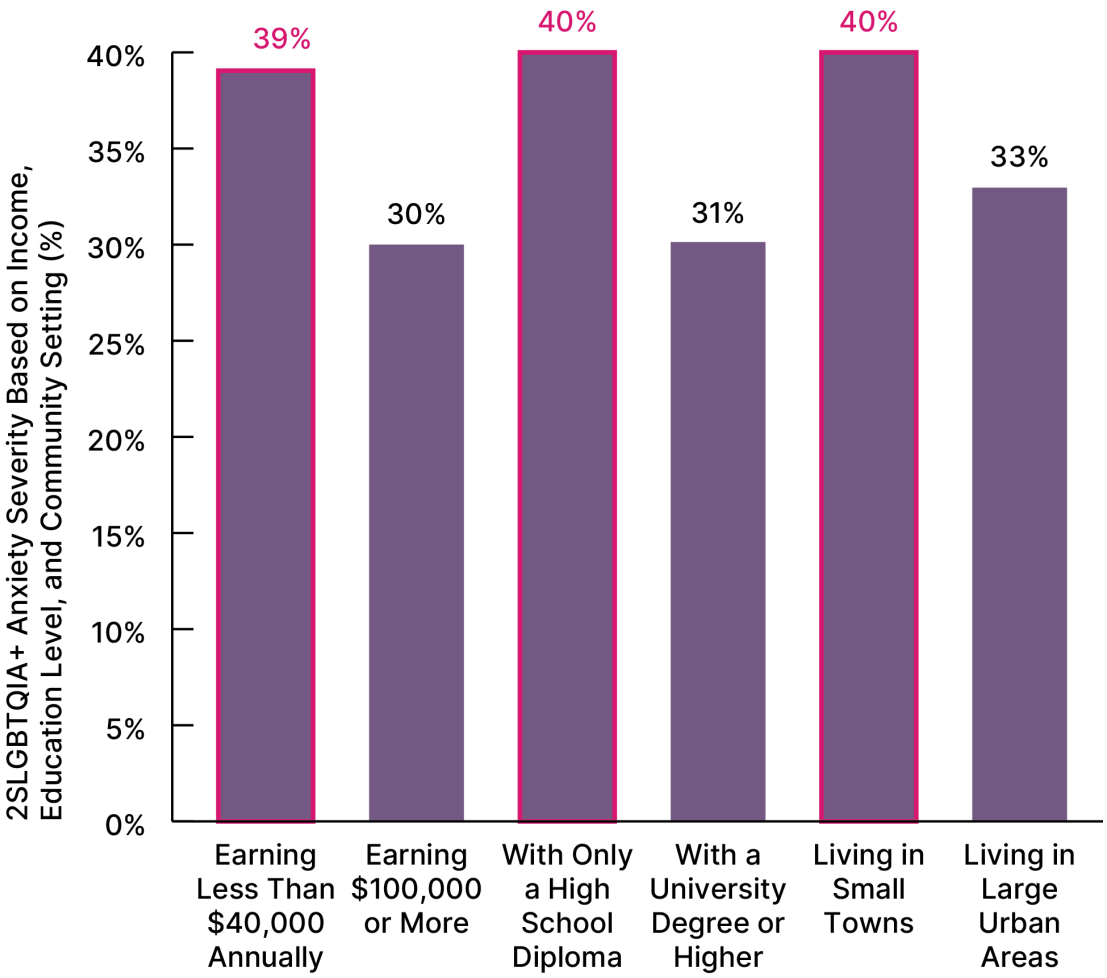


Figure 13: 2SLGBTQIA+ respondents' anxiety severity scores based on income, education level, and community settings.

These findings reinforce what we already know: social and economic factors such as income, education, and geography influence health outcomes. But this research also underscores how profoundly these factors affect 2SLGBTQIA+ individuals, who already face disproportionate levels of mental health challenges. **Having lower income, completing less schooling, and living in a small or rural setting compounds the mental health burdens experienced by 2SLGBTQIA+ communities.**

There is a well-documented shortage of mental healthcare professionals across Canada. For 2SLGBTQIA+ individuals, this shortage is exacerbated by a lack of culturally competent providers (Comeau et al., 2023; Schreiber et al., 2021). Many mental health professionals are not adequately trained to understand or support the unique needs of 2SLGBTQIA+ populations, especially trans and non-binary individuals. This knowledge gap can lead to care that is ineffective and, at times, even harmful. Lack of competency contributes to feelings of distrust and even re-traumatization in clinical settings. These challenges are further compounded by long wait times for mental health referrals and the limited availability of publicly funded or insured services. For many 2SLGBTQIA+ individuals, **especially those who have lower incomes or who live in rural areas**, accessing affirming mental health care becomes nearly impossible due to cost barriers and service gaps. **As a result, those most in need of support are often left without safe or accessible care, deepening health inequities and reinforcing cycles of marginalization.**

2.3 Quality of Life

Health-related **Quality of Life** (QoL) instruments measure different aspects of a person's perceived quality of life and are important tools in healthcare evaluation (WHO, 1993). More specifically, QoL evaluates the perception of an individual's position relative to the cultural and value systems in which they live as well as their goals, expectations, standards, and concerns. Quality of Life can be subdivided into four domains:

- physical health (e.g. energy levels);
- psychological health (e.g. mental health);
- social relationships (e.g. sex-life);
- and the environment (e.g. having enough money) (WHO, 1998).

Across the board, 2SLGBTQIA+ Populations report lower Quality of Life scores, with the widest gap in psychological well-being (61% vs. 69% for non-2SLGBTQIA+).

Analysis of self-reported Quality of Life (QoL) scores reveals notable disparities between 2SLGBTQIA+ and non-2SLGBTQIA+ individuals across all measured domains (Figure 14). As with previous sections, results show lower **physical health** scores among 2SLGBTQIA+ individuals **(64%)** compared to non-2SLGBTQIA+ participants **(69%)**. **Psychological well-being** showed the greatest disparity, with 2SLGBTQIA+ respondents **(61%)** scoring 8 percentage points below their non-2SLGBTQIA+ counterparts **(69%)**. **Environmental quality of life** was also lower for 2SLGBTQIA+ individuals **(65%)** than among non-2SLGBTQIA+ respondents **(69%)**. **Social relationships** showed scores of **62%** for 2SLGBTQIA+ individuals compared to **67%** for the non-2SLGBTQIA+ group (Figure 14).

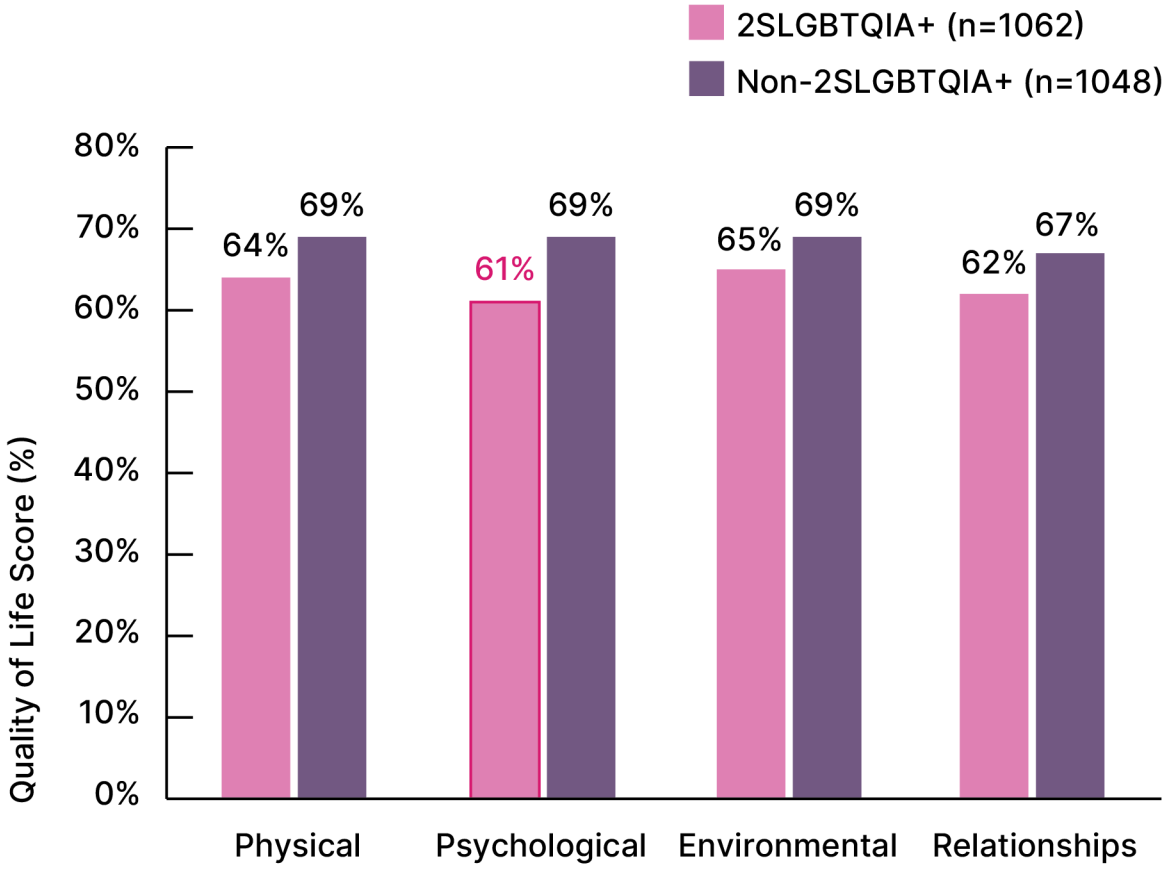


Figure 14: Scores for the four domains of Quality of Life (%) in 2SLGBTQIA+ communities vs. non-2SLGBTQIA+ individuals.

Key stakeholders highlight chronic stress and social isolation as major barriers to improved Quality of Life.

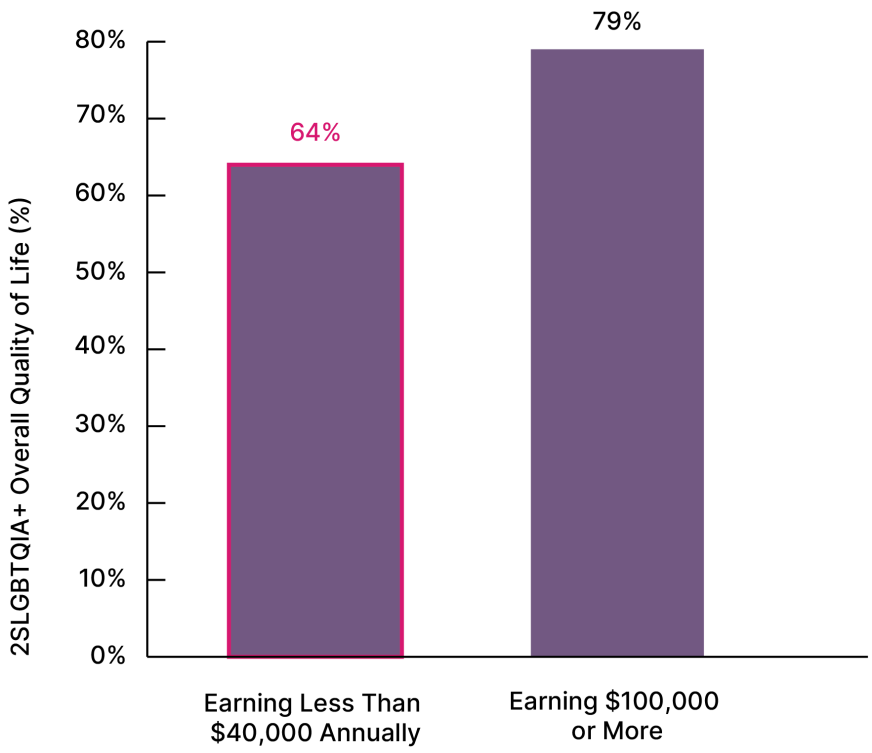
Chronic stress and social isolation emerged as recurring themes in stakeholder interviews. Interviewees describe both barriers as major factors that negatively impact QoL among 2SLGBTQIA+ individuals. **These concerns were particularly acute for older adults and people living with HIV**, who often face heightened social exclusion, a lack of familial support, and precarious housing situations.

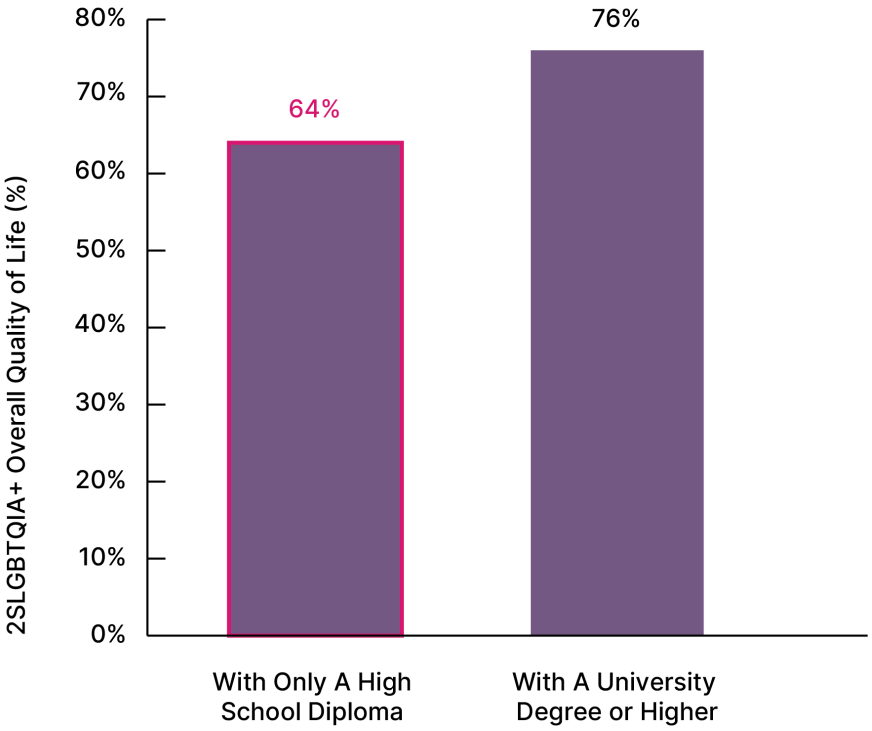
> ***In our inpatient unit, we become their pseudo family because there isn't family around them to take care of them. And so the real challenge as we discharge people: where do we discharge them to? Because there typically isn't a safe place to land, and, as people age and become more frail, it is actually quite a dire situation.***
>
> *– Hospital CEO (Ontario)*

Quality of Life varies across intersecting social and economic factors, and this variance is amplified by cisheteronormativity.

Intersectionality offers a critical framework for understanding the layered nature of discrimination. Individuals who are both 2SLGBTQIA+ and part of racialized communities, or who live in rural or remote areas, often face systemic barriers that extend beyond those experienced by their white or urban counterparts. These overlapping social determinants of health can significantly magnify the risk of poor health outcomes. Without explicitly examining these intersecting identities, there is a risk of reinforcing existing inequities. The 2025 Pink Paper on Health therefore integrates an intersectional perspective to inform inclusive, responsive, and effective healthcare policy and service delivery.

Survey results revealed the compounding effects of social and economic factors. Among 2SLGBTQIA+ respondents, **income and education** were the strongest predictors of perceived quality of life. Individuals earning **less than $40,000** annually reported a QoL score of **64%** compared to **79%** for those earning **$100,000** or more (Figure 15). Similarly, 2SLGBTQIA+ individuals with only a high school diploma reported a QoL score of **64%**, significantly less than those with a university degree or higher **(76%)** (Figure 16).





Figures 15, 16: Overall quality of life measured for 2SLGBTQIA+ individuals with different income and education levels, respectively (%).

Quality of Life also declined with **community size**. Individuals living in large urban areas reported a QoL score of **72%**, compared to **68%** in small towns (Figure 17).

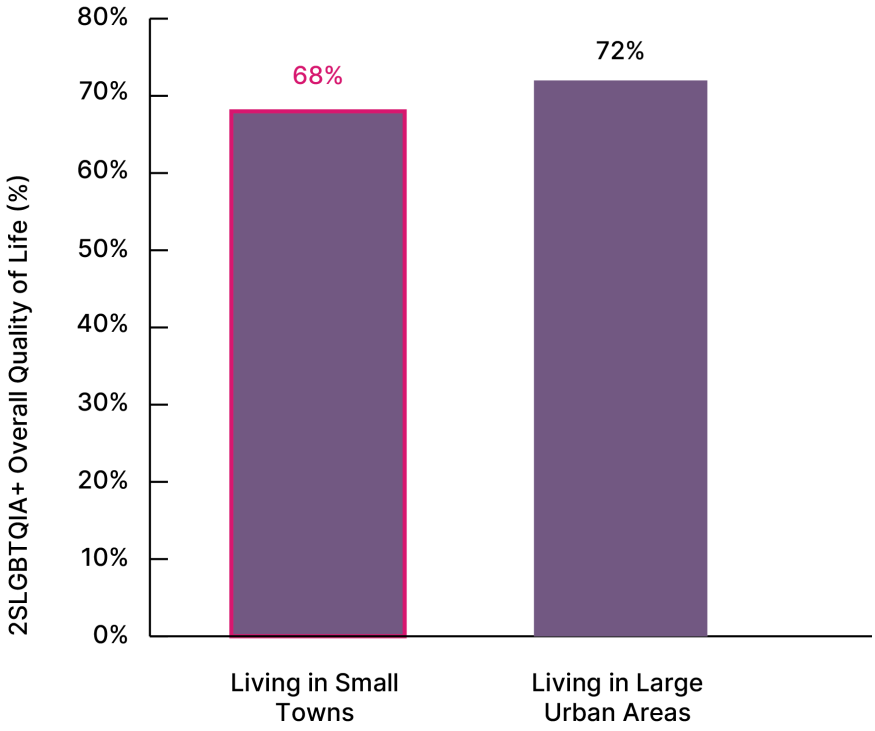


Figure 17: Overall Quality of Life measured for 2SLGBTQIA+ individuals living in small or large community settings (%).

These results highlight significant and consistent disparities in health-related Quality of Life across all measured domains. Importantly, this data also demonstrates that Quality of Life among 2SLGBTQIA+ individuals is not experienced uniformly. Those with lower incomes, less formal education, and limited access to stable employment consistently reported lower quality of life scores. These patterns reflect the compounding effects that social and structural determinants of health have on access to care and the ability to live with safety, dignity, and support.

Taken together, these findings underscore a need to improve the psychological well-being and overall QoL of 2SLGBTQIA+ populations. This goes beyond inclusive language and requires targeted reforms within healthcare and related systems. **Entry points for change include integrating 2SLGBTQIA+ health content into provider training, expanding access to culturally competent mental health services in rural areas, and ensuring health data collection captures gender identity accurately.** These concrete steps can help mitigate the impacts of poverty, education gaps, geographic isolation, and systemic discrimination, moving the healthcare system closer to equitable outcomes.

2.4 Summary of Key Findings

- Self-reported clinical history and health concerns highlight **persistent and significant disparities affecting 2SLGBTQIA+ communities** in Canada. These disparities are further shaped by **geographic location and income**.
- Health disparities are **experienced asymmetrically by different identities within the 2SLGBTQIA+ umbrella.**
- Mental health professionals are **not adequately trained to understand or support the unique needs of 2SLGBTQIA+ populations**, particularly trans and non-binary people. This knowledge gap leads to further harm.
- Reported **Quality of Life** differs significantly between 2SLGBTQIA+ individuals and their non-2SLGBTQIA+ counterparts across all measured domains. These differences are further shaped by **intersecting factors**, such as **income**, **education**, and **geographic location**.

Addressing these disparities requires several interrelated strategies. These include:

- Implementing identity-inclusive data collection across national and provincial health systems, paying particular attention to underrepresented groups such as intersex, asexual, and Two-Spirit individuals.
- Expanding access to culturally competent healthcare by integrating 2SLGBTQIA+ health content into medical and nursing school curricula, supporting continuing education for current providers, and increasing funding for community-based clinics offering specialized affirming services.
- Integrating 2SLGBTQIA+ health considerations into chronic disease prevention and cancer screening frameworks by developing inclusive guidelines, by training providers on identity-specific risks, and by establishing clear accessible referral pathways to specialized care.

Healthcare Access

Understanding the perceived importance of specific health services across diverse identities was a critical component of this study. Given the unique and often unmet healthcare needs within 2SLGBTQIA+ communities, we identified which services individuals prioritize in relation to their health and well-being. By comparing responses from 2SLGBTQIA+ and non-2SLGBTQIA+ individuals, we aimed to uncover gaps in existing service provision and to highlight the urgent need for inclusive, accessible, and identity-affirming care. This approach also enables a more nuanced understanding of intra-group differences. Through this research, we acknowledge that health priorities vary significantly within the broader 2SLGBTQIA+ population based on intersecting experiences of gender identity, sexual orientation, and systemic marginalization.

For the following sections, participants were asked how strongly they agreed or disagreed with certain statements, using a 5-point scale. Answers were grouped as favourable (+1), neutral (0), or unfavourable (–1). These were added together for each group and converted into percentages, allowing comparisons across identities. Because unfavourable responses are included, some groups may show negative percentages, meaning there was more disagreement than agreement.

3.1 Healthcare Priorities

Mental health access was rated as important to more 2SLGBTQIA+ respondents (69%) than non-2SLGBTQIA+ (52%), with highest priority among queer (90%), pansexual (87%), and trans (83%) individuals.

When asked to rate the importance of specific healthcare services, more than half of 2SLGBTQIA+ and non-2SLGBTQIA+ respondents said **access to mental health professionals** was important. However, more careful analysis reveals this service was reported as being significantly more important to 2SLGBTQIA+ individuals **(69%)** than non-2SLGBTQIA+ people **(52%)**.

More specifically, **queer (90%)**, **pansexual (87%)**, **and trans (83%)** respondents reported this service to be critical. Interestingly, the importance of accessing mental health services was nearly identical between **gay (53%)** and non-2SLGBTQIA+ respondents **(52%)**, unlike all other 2SLGBTQIA+ groups who viewed such access as significantly more important.

Sexual health services were rated as important by more than twice as many 2SLGBTQIA+ respondents (45%) compared to non-2SLGBTQIA+ (21%), with highest priority among genderfluid (73%), intersex (64%), and trans (60%) individuals.

Sexual health services were reported as more than twice as important to 2SLGBTQIA+ **(45%)** respondents than non-2SLGBTQIA+ participants **(21%)**. These services were identified as most important by **genderfluid (73%)**, **intersex (64%)**, and **trans (60%)** respondents. In contrast, such services were markedly less important for those who identify as **asexual (13%)**. **Reproductive health** was important for 2SLGBTQIA+ **(22%)** and non-2SLGBTQIA+ **(16%)** respondents but flagged as least important for **gay respondents (-7%)**.

Gender affirming care is a high priority for trans individuals compared to non-2SLGBTQIA+ respondents, particularly as it pertains to hormone replacement therapy (82% compared to 5%) and gender affirming surgeries (76% compared to -14%). Intersex and non-binary respondents also stressed its critical importance.

The importance of **hormone replacement therapy (HRT) and gender-affirming surgeries** was consistently higher among 2SLGBTQIA+ respondents compared to non-2SLGBTQIA+ individuals. Respondents identifying as **trans** reported the highest importance for both services, with **82%** identifying **HRT** and **76%** identifying **gender-affirming surgeries** as critically important. High levels of importance for HRT were also observed among **intersex (49%)**, **queer (44%)**, **non-binary (42%)**, **pansexual (41%)**, **genderfluid (41%)**, and **asexual (34%)** respondents. For **gender-affirming surgeries**, importance was also strongly emphasized by **non-binary (41%)**, **genderfluid (35%)**, **questioning (35%)**, **queer (28%)**, and **intersex (26%)** individuals.

In contrast, non-2SLGBTQIA+ individuals reported very low importance for both services, with net scores of just 5% for HRT and -14% for gender-affirming surgeries. Notably, gay respondents reported negative net importance scores of -13% for HRT and -19% for gender-affirming care. These results reveal stark disparities in perceived healthcare needs not only between 2SLGBTQIA+ and non-2SLGBTQIA+ individuals, but also across the 2SLGBTQIA+ umbrella, once again underscoring the critical importance of disaggregating data.

3.2 Ease of Access to Specific Services

2SLGBTQIA+ populations experience unequal access to healthcare. Mental health and gender affirming services are among the least accessible for 2SLGBTQIA+ individuals.

While non-2SLGBTQIA+ respondents reported moderate scores for perceived ease of access across services, 2SLGBTQIA+ individuals consistently reported greater difficulty. **2SLGBTQIA+ respondents reported an alarming access score of only 3% for mental health services, compared to 15% among non-2SLGBTQIA+ individuals.** Notably, ease of access scores were exceptionally low for **asexual (–9%)**, **Two-Spirit (9%)**, and **queer (1%)** respondents, underscoring significant barriers to care within these communities (Figure 18).

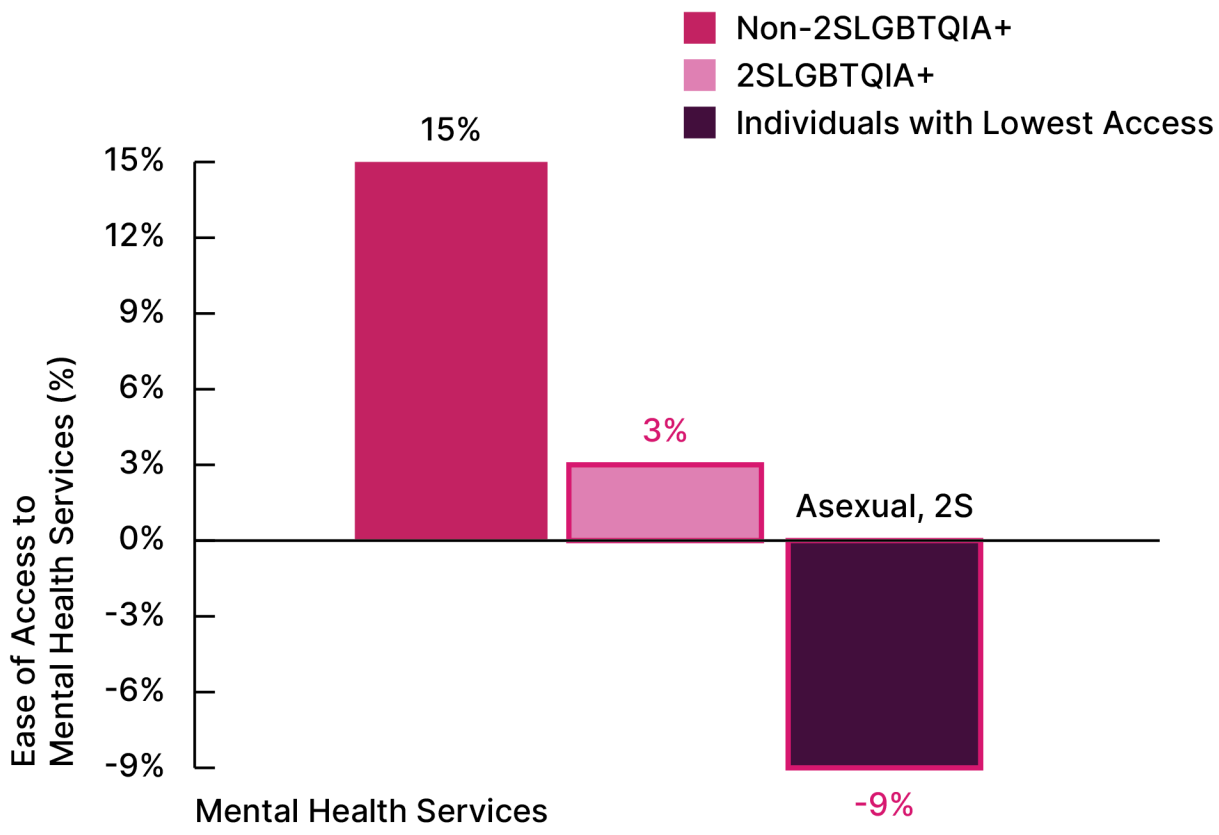


Figure 18: Ease of access to mental health services (%).

The calculated score for access to **hormone replacement therapy (HRT)** was also lower among 2SLGBTQIA+ communities **(8%)** compared to their non-2SLGBTQIA+ counterparts **(12%)**. **Lesbian (2%)** and **questioning (3%)** individuals reported the most limited access (Figure 19). While contemporary media colloquially uses the phrase "gender-affirming surgery" to refer to trans health procedures, it is important to recognize that the procedures this term refers to are widely accessed by cisgender and heterosexual people. In fact, breast augmentation and reduction, body contouring, and cosmetic fillers are more frequently accessed by non-2SLGBTQIA+ individuals, and all of these procedures fall under the label of gender affirming surgery. The disparity between reality and perception reflects the effects of cisnormativity where gender affirmation is accepted for cisgender populations but pathologized or stigmatized when sought out by trans and gender-diverse individuals.

Results show that **ease of access to gender-affirming surgeries is perceived to be significantly limited for 2SLGBTQIA+ individuals** (Figure 19), showing a net negative score **(–2%)** compared to non-2SLGBTQIA+ respondents **(7%)**. **Trans, asexual, and queer individuals** reported the lowest scores **(–8%). These disparities point to systemic inequities with regard to who is supported or obstructed when pursuing gender-affirming care.**

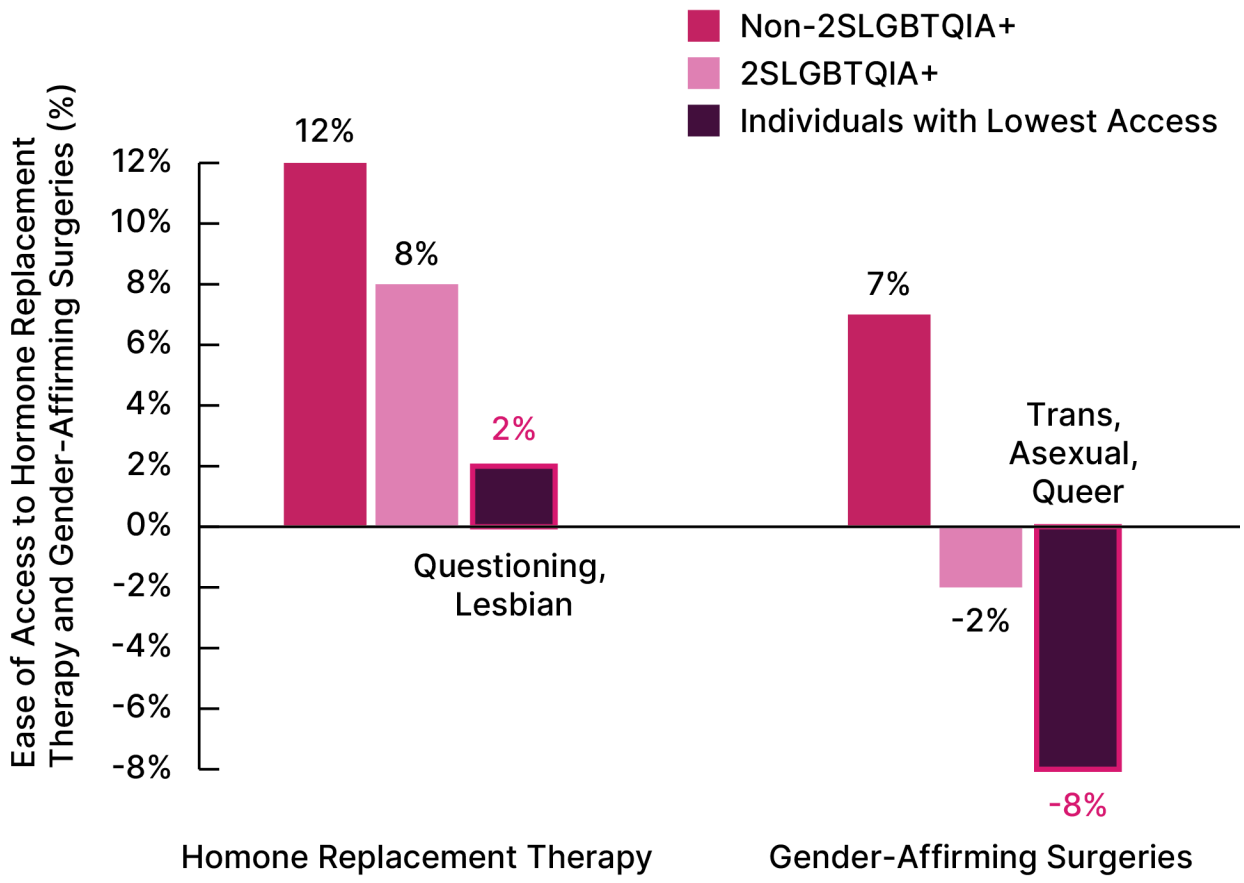


Figure 19: Ease of access to hormone replacement therapy and gender-affirming surgeries (%).

For **reproductive health services**, scores for perceived access were slightly lower for 2SLGBTQIA+ individuals **(26%)** than non-2SLGBTQIA+ individuals **(30%)**, with the lowest access reported by **questioning (16%)** and **gay (19%)** respondents (Figure 20).

Lastly, while **sexual health services** saw relatively higher perceived access among 2SLGBTQIA+ respondents **(46%)** compared to non-2SLGBTQIA+ respondents **(32%)**, some subgroups, such as **genderfluid (35%)** and **questioning individuals (35%)**, reported more challenges compared to overall 2SLGBTQIA+communities **(46%)**.

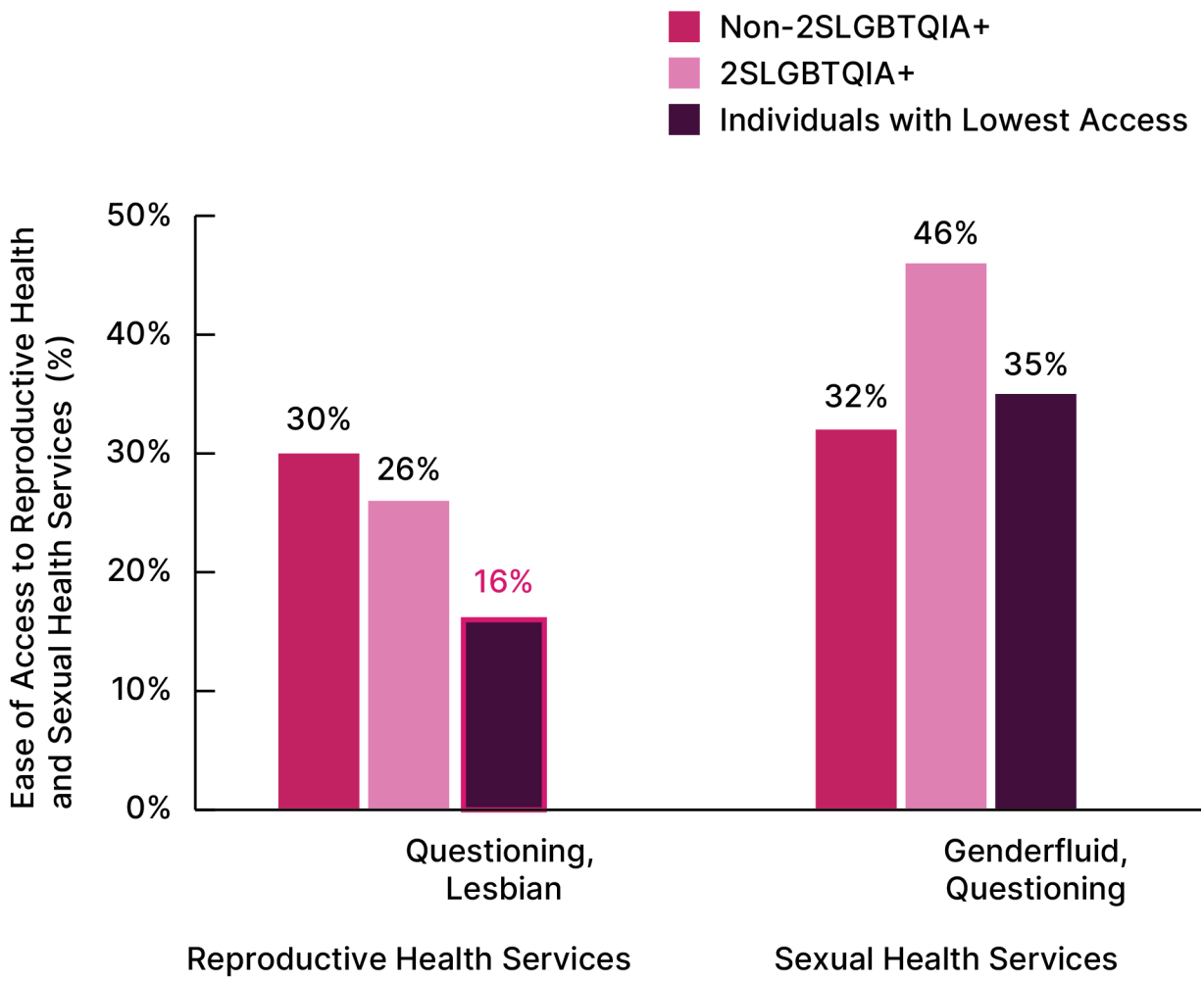


Figure 20: Ease of access to reproductive health and sexual health services (%).

The higher perceived ease of access reported by 2SLGBTQIA+ respondents here may warrant critical reflection. Although this finding could suggest improved access to sexual health services, it may also reflect the enduring influence of systemic biases and hypersexualization tropes that have historically framed queer and trans health primarily through the lens of sexuality. Standard screening frameworks often embed heteronormative assumptions that overemphasize sexual behaviors among LGBTQIA+ clients (Moe et al., 2015), meaning that **greater service utilization in this area does not necessarily indicate more equitable or needs-based care overall**.

> ***Even in my own experiences, my family doctor once assumed that I had HIV… she panicked and said, 'I just assumed you were HIV positive because of your age and sexual orientation.'***
>
> *– Registered Nurse and Educator, Alberta*

This pattern underscores the urgent need for more comprehensive medical education that moves beyond narrow sexual health frameworks. Existing literature shows that medical curricula often portray 2SLGBTQIA+ individuals primarily in the context of sexually transmitted infections (STIs) or HIV, reinforcing stigma and limiting providers' understanding of broader health needs (Kamal et al., 2023; Zumwalt et al., 2022). The hyper-sexualization of 2SLGBTQIA+ individuals is a common misconception and a harmful stereotype that needs to be discarded. While such curricular focus may have improved awareness and accessibility of sexual health services—bringing them closer to parity with non-2SLGBTQIA+ populations—it has also overshadowed other critical areas of health. Our findings here indicate the urgent need for enhanced curriculum content and training to better prepare healthcare providers to meet the unique needs of queer and trans patients. **Strengthening curriculum content and provider training to address the full spectrum of 2SLGBTQIA+ health concerns is essential to achieving genuinely equitable and inclusive care.**

Income inequality and geographic isolation deepen healthcare disparities among 2SLGBTQIA+ communities.

Stakeholder interviews support the survey data, revealing widespread concerns about **inconsistent and inadequate access to healthcare services for 2SLGBTQIA+ individuals across Canada. Trans, non-binary, and Two-Spirit people face the most pronounced barriers**. A consistent theme was the **scarcity of gender-affirming care, which brings with it long waitlists that can extend several years**. One interviewee noted that, in the Northwest Territories, access to care depends on a single clinician, creating heightened vulnerability to service disruptions due to provider burnout or staff turnover.

> ***The trans community wouldn't have had care at all, if not for two physicians who set up a clinic. They're still the only two.***
>
> *– Interview Participant, Community Organization Leader, Newfoundland and Labrador*

Stakeholder interviews also revealed that economic instability is a key concern. Specifically, they point to elevated rates of **poverty, housing insecurity, and precarious employment**. This data is particularly important when considered in relation to accessing and sustaining healthcare.

> ***I think poverty is really important. I know it's not traditionally conceptualized as a health issue, but poverty is strongly associated with every health issue. And there are significant economic disparities within our communities.***
>
> *– Professor in Public Health, Ontario*

> ***Whether or not you are part of the 2SLGBTQ community... if you have money, you can probably get care more easily. And, if you don't, then certainly things are harder... many of our trans and gender-neutral patients are living in poverty.***
>
> *– Physician, Ontario*

Living in rural or remote communities compounds the existing healthcare disparities 2SLGBTQIA+ individuals face. These settings create additional barriers to equitable and timely services. Stakeholders emphasized that many of the **rural, remote, and Northern regions across Canada lack permanent healthcare infrastructure**, such as hospitals or full-time primary care providers. Instead, they often depend on rotating temporary physicians, resulting in fragmented and inconsistent care. **Access to gender-affirming services** is particularly constrained, frequently requiring individuals to travel long distances or out of province at significant financial and emotional cost. These added burdens disproportionately affect people who already face systemic marginalization, highlighting the need for regionally responsive, identity-affirming healthcare solutions.

To close these gaps, healthcare systems must invest in culturally competent, inclusive, and geographically accessible services. Structural challenges must be addressed in tandem with service design.

Stakeholders equally reveal that bureaucratic barriers amplify systemic inequities, especially for trans and non-binary individuals.

An executive director from Alberta described the disproportionate challenge **trans patients** face when it comes to securing access to basic primary care. The interviewee emphasized that discrimination often occurs under the guise of unrelated medical issues:

> ***We can't get people a family doctor... But we see that broken arm syndrome where they're like, 'Oh, I can't because you're trans' and it has nothing to do with their gender... We just need you to help them with their bronchitis.***
>
> *– Interview Participant, Executive Director, Alberta*

Meanwhile, a physician in Ontario recounted how pandemic-related changes to billing codes affect access to virtual care for trans individuals:

> ***A colleague... providing virtual care to trans people throughout the pandemic... had to shut down her clinic... because the OHIP billing codes changed.***
>
> *– Interview Participant, Physician, Ontario*

Policymakers should prioritize funding for gender-affirming and mental health services designed for 2SLGBTQIA+ populations, including those living at the intersections of multiple forms of marginalization. Disaggregated data and meaningful engagement with 2SLGBTQIA+ stakeholders are essential to ensuring healthcare planning reflects lived realities. Without these targeted interventions, disparities in access will continue to erode trust and worsen health outcomes.

3.3 Satisfaction with Healthcare Services

In the preceding sections, the 2025 Pink Paper on Health assessed two key dimensions of healthcare access:

1) the **importance** of being able to access specific services;
2) and the perceived **ease of access** to those services.

In this discussion, we address how the quantitative and qualitative data show asymmetrical patient satisfaction with healthcare services between 2SLGBTQIA+ and non-2SLGBTQIA+ populations with the former consistently reporting lower satisfaction. Measuring satisfaction reveals whether care is affirming and effective for 2SLGBTQIA+ individuals, offering insight into patient experience beyond access alone.

Genderfluid and Two-Spirit (3%) communities report alarmingly low satisfaction with mental health care.

Survey results illustrate a substantial gap in service satisfaction between 2SLGBTQIA+ and non-2SLGBTQIA+ respondents. While **50%** of non-2SLGBTQIA+ respondents reported being satisfied with the mental health care they received, only **29%** of 2SLGBTQIA+ respondents reported being satisfied, highlighting persistent shortcomings in the quality and inclusivity of existing services.

Within the 2SLGBTQIA+ cohort, satisfaction levels with mental health services were highest among **gay and questioning** respondents **(36%)**, followed by **trans and lesbian respondents (33%)** (Figure 21). Satisfaction was shockingly low among respondents who are **pansexual (15%)**, **asexual (12%)**, and **queer (11%)**. Alarmingly they were even lower among **genderfluid and Two-Spirit individuals, with only 3%** of respondents in each group expressing satisfaction with their mental health care.

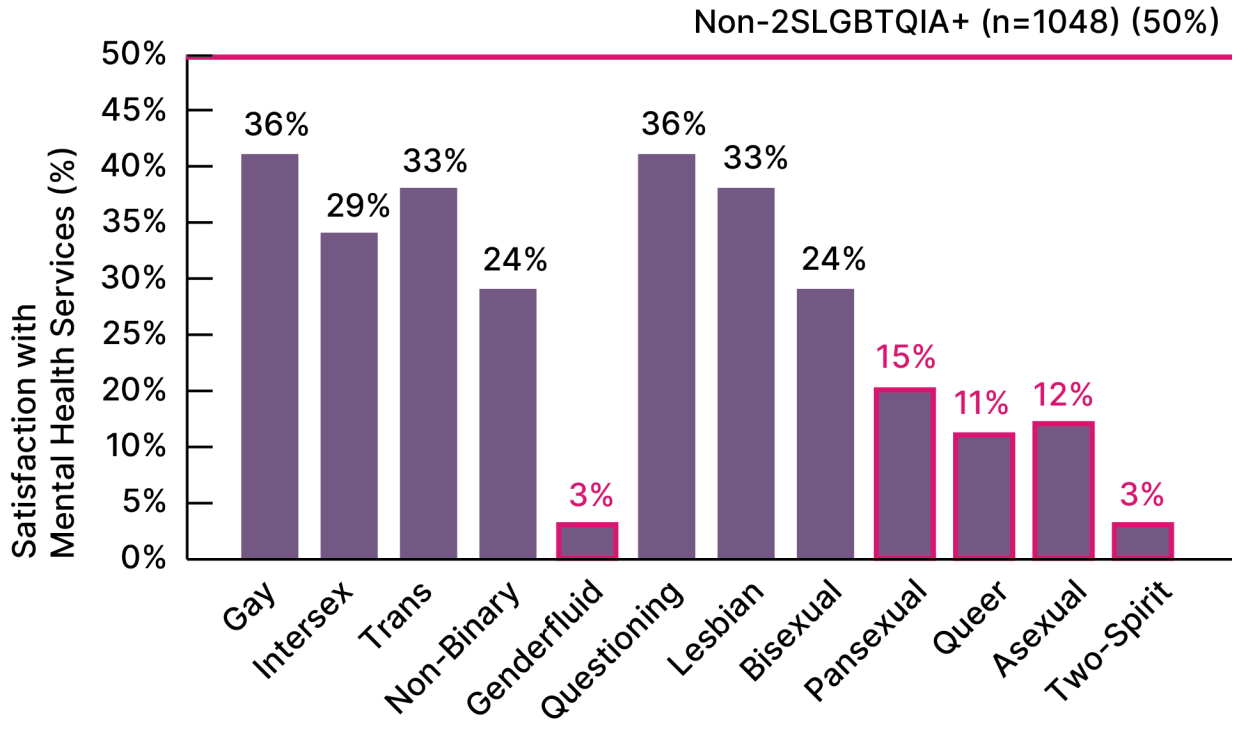


Figure 21: Satisfaction with mental health services (%).

These results highlight major gaps in culturally responsive mental health services, particularly for genderfluid and Two-Spirit individuals. The data underscores an urgent need for more inclusive, personalized, and affirming care models.

Combined with the previous sections, these results show that access to quality mental health services is a widespread challenge in Canada, and that these barriers are felt even more acutely by 2SLGBTQIA+ individuals. **Stigma, discrimination, and chronic stress compound the need for affirming mental health care.** When these services are unsatisfactory, individuals struggle to improve. **In some cases, negative experiences with mental health care can even result in worse outcomes.**

In Canada, the socioeconomic burden of mental health totals roughly $50 billion annually, including direct healthcare costs, lost productivity due to absenteeism, and increased demand for social assistance programs (Casey, 2019). Investing in mental health can therefore lead to significant returns on top of better Quality of Life for all.

There are persistent satisfaction gaps in reproductive and gender affirming care among underrepresented 2SLGBTQIA+ groups.

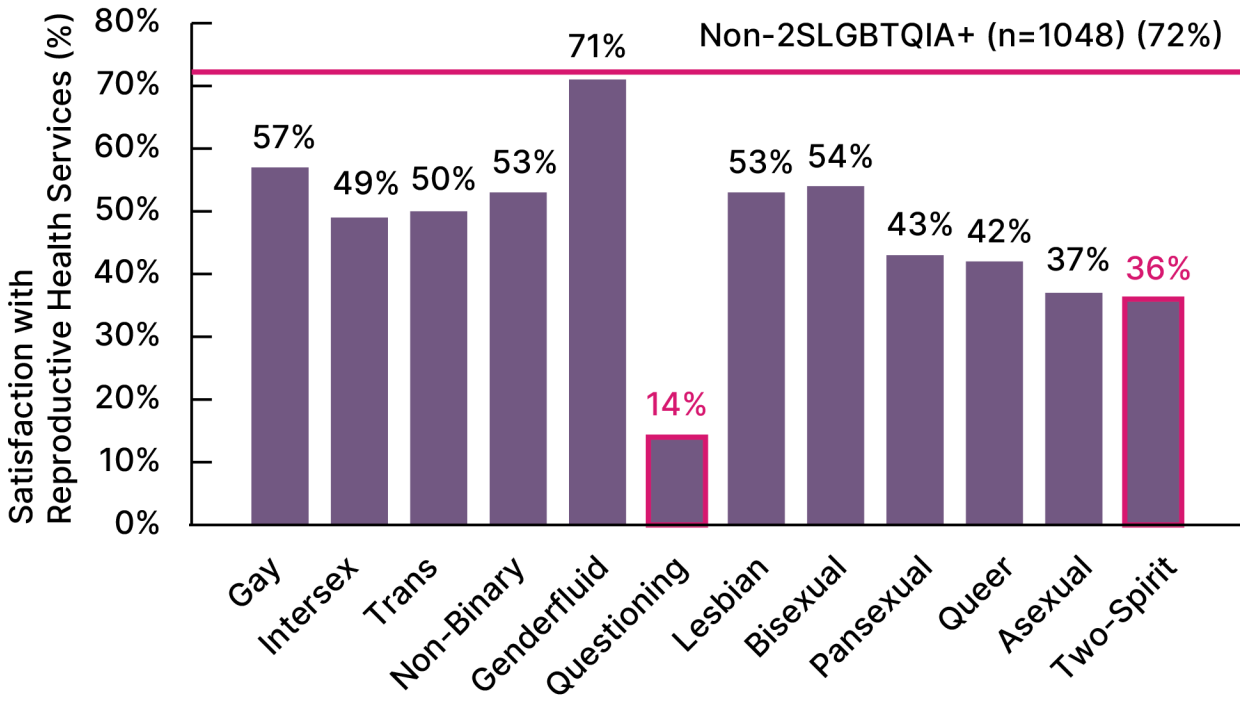


Figure 22: Satisfaction with reproductive health services (%).

Satisfaction with **gender-affirming surgeries** also revealed disparities. Overall, **60%** of non-2SLGBTQIA+ respondents expressed satisfaction with these services, compared to **46% of 2SLGBTQIA+ individuals**. In this context, satisfaction refers to **perceived quality, accessibility, and continuity of surgical care**, including factors such as wait times, aftercare, and provider sensitivity, **not** regret about the procedure itself. Satisfaction was notably lower among **trans (38%), queer (38%), lesbian (31%), asexual (29%), and Two-Spirit individuals (29%)** (Figure 23). These differences highlight significant variation in experiences with gender-affirming surgical care, underscoring the need for tailored interventions to improve service quality and accessibility for all identities.

> ***In all of Edmonton, I think there are 2 or 3 surgeons. We maybe have less than ten in Calgary. There really is a 4 to 5 year wait to get surgery, and so you think about why people have bad mental health....***
>
> *– Co-founder, Trans community organization, Alberta*

> ***Because of Alberta's legislation change, they are no longer offering gender affirming care to youth. And that is a huge problem because our kids keep dying.***
>
> *– Executive Director, LGBTQIA+ Organization, Northwest Territories*

> ***Gender affirming care is patients being able to go to care environments and feel that they aren't going to face … transphobic slurs and comments and microaggressions, and they're going to have their names and pronouns respected. … we still have a long ways to go. I still have patients tell me about negative experiences they have had related to them presenting in their identity, their gender. So I think that's still one of the biggest challenges.***
>
> *– Physician and Assistant Professor, Ontario*

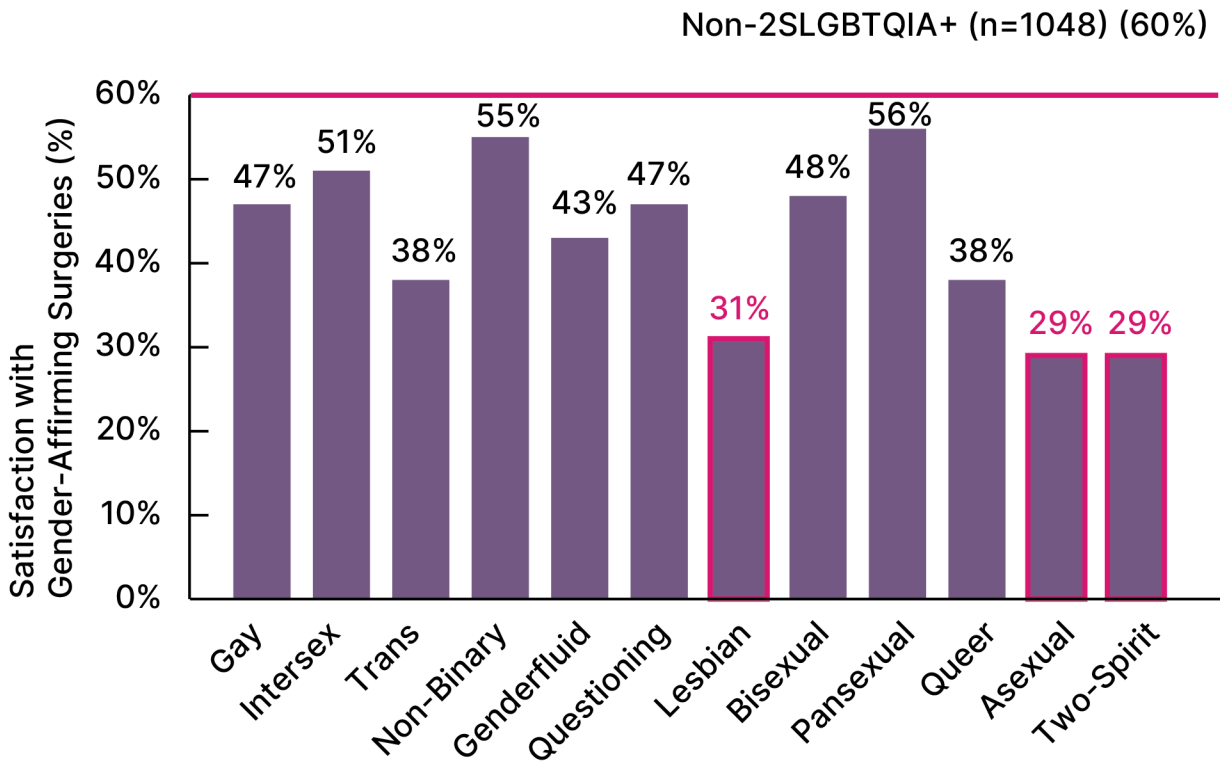


Figure 23: Satisfaction with gender-affirming surgeries.

Taken together, these findings highlight consistent patterns. **Mental health services**, for example, are widely regarded as critical among **trans, pansexual, and queer** individuals, yet these same groups reported some of the lowest levels of perceived access and satisfaction. Similarly, **gender-affirming care** emerged as a high priority for **trans, non-binary, intersex, and genderfluid** respondents, who simultaneously reported greater difficulty accessing these services and lower satisfaction when they did.

These trends across multiple dimensions of healthcare engagement suggest that unmet needs are not limited to access alone. They also extend to the quality, relevance, and inclusivity of care. This data highlights the need for healthcare systems that address structural barriers to access and improve overall care quality for 2SLGBTQIA+ people.

3.4 Overall Experience Accessing the Healthcare System

2SLGBTQIA+ populations report longer delays and lower quality care than their cisgender and heterosexual counterparts.

Survey results show that 2SLGBTQIA+ communities face increased wait times when accessing health care services. Although the survey did not identify specific causes, stakeholders identify possible contributing factors such as systemic discrimination, a shortage of culturally competent providers, socioeconomic barriers such as lower income, and geographic barriers. Moreover, 2SLGBTQIA+ individuals report receiving significantly less time with health care professionals, around half as much as their non-2SLGBTQIA+ counterparts (Figures 24-25). These results highlight a critical disparity in the quality of patient-provider interactions.

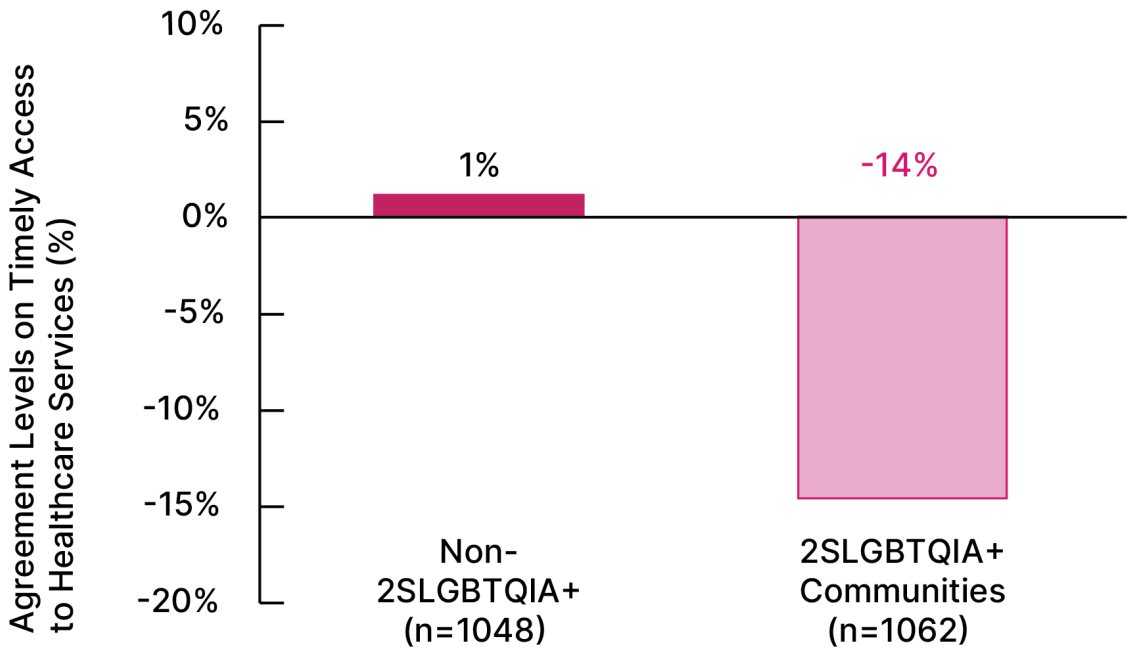


Figure 24: 2SLGBTQIA+ vs. non-2SLGBTQIA+: Wait times to access health services I need are appropriate.

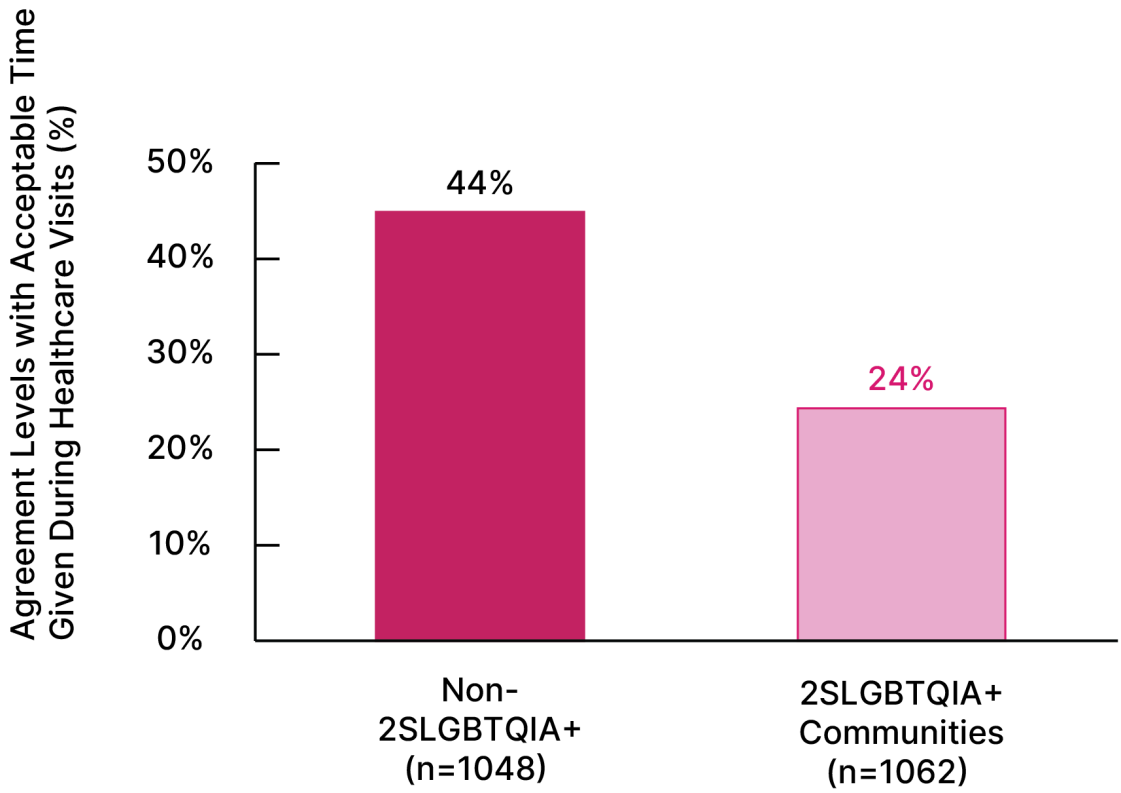


Figure 25: 2SLGBTQIA+ vs. non-2SLGBTQIA+: Time given by healthcare professionals is appropriate (%).

Respondents were asked whether they agreed with the statement "The quality of services provided at health centers or clinics is acceptable." 2SLGBTQIA+ respondents reported significantly lower levels of agreement **(37%)** compared to non-2SLGBTQIA+ individuals **(50%)** (Figure 26). This gap highlights a disparity in how healthcare quality is experienced across populations.

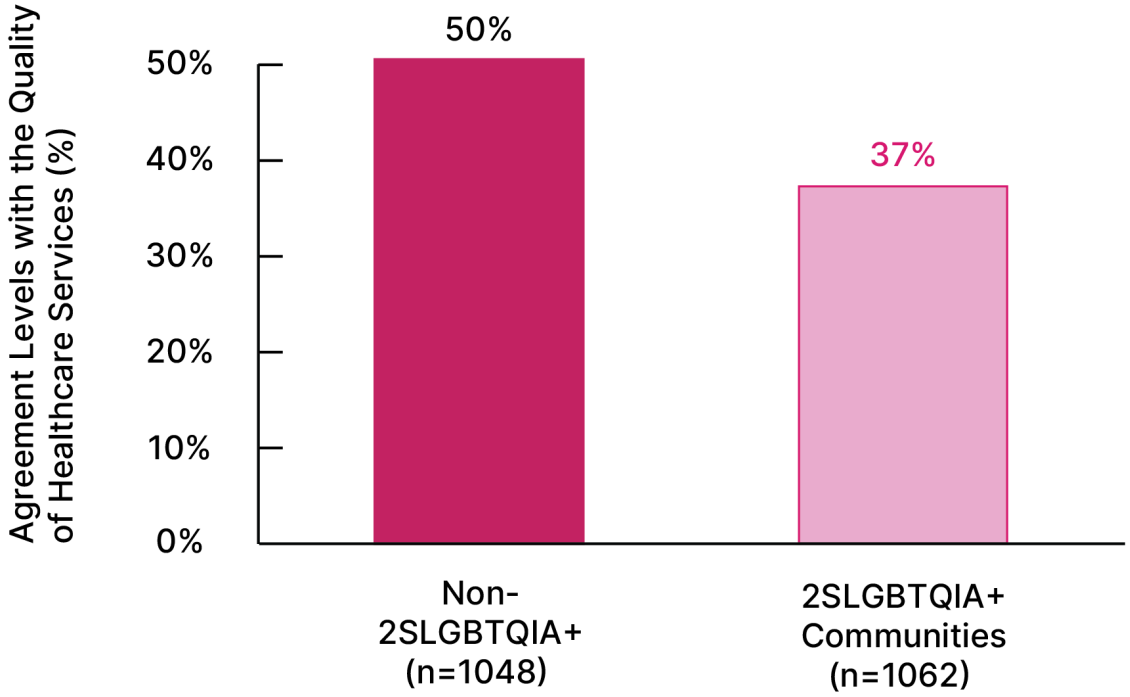


Figure 26: 2SLGBTQIA+ vs. non-2SLGBTQIA+: Quality of healthcare services.

Healthcare providers often fail to understand 2SLGBTQIA+ backgrounds.

Respondents were also asked whether they agreed with the statement: "Healthcare professionals understand my background." Results varied markedly by identity (Figure 27). **Trans** respondents showed an agreement score of **1%**, indicating very low perceived understanding by healthcare professionals. **Genderfluid individuals** reported a score of 0%, reflecting a complete absence of positive agreement. **Queer respondents** had a net negative score of **–6%**, showing that significantly more respondents disagreed than agreed with the statement. **Asexual individuals** also reported a negative score of **–3%**. By contrast, **gay** respondents had the highest score among 2SLGBTQIA+ subgroups. At **49%**, their score closely approaches the benchmark set by non-2SLGBTQIA+ respondents (50%). These findings highlight ongoing inequities with respect to whether individuals feel understood by their healthcare providers.

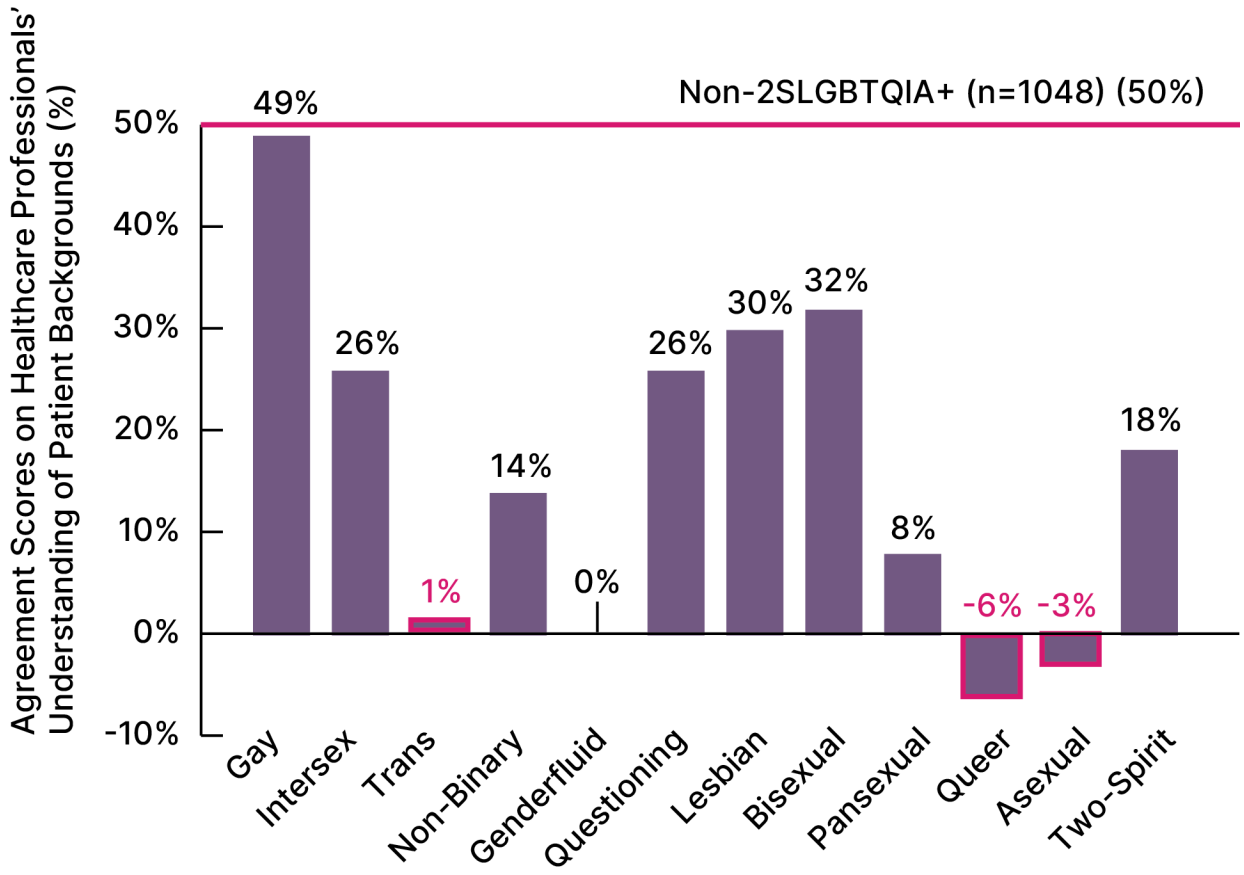


Figure 27: Understanding of patient background (%).

Systemic failures and lack of adequately trained providers undermine inclusive care for 2SLGBTQIA+ individuals.

According to stakeholder interviews, healthcare services fail to meet the nuanced needs of 2SLGBTQIA+ people, not only because of systemic fragmentation but also because patients regularly encounter providers who are uninformed, unprepared, or visibly uncomfortable. Stakeholders described scenarios where healthcare professionals lacked the training or confidence to address basic 2SLGBTQIA+ health concerns, leading to inappropriate referrals, repeated misdiagnoses, or patients being passed from service to service without resolution. In many cases, 2SLGBTQIA+ individuals were left to educate their own doctors or chose to avoid care altogether due to fear of discrimination, misgendering, or being involuntarily outed.

Critical non-medical supports tend not to be publicly funded, exacerbating health inequities for 2SLGBTQIA+ communities. Even though these supports are essential for holistic well-being, health insurance and public funding schemes frequently exclude them. For example, mental health counseling, administration supplies for HRT, and post-surgical follow-up care incur out-of-pocket costs. Policy language and funding frameworks frequently omit such "support services" beyond core procedures, limiting their impact on overall health outcomes and discouraging sustained engagement in care (Bond et al., 2022; D'Angelo et al., 2025). Without funding these supports, accessibility challenges persist even when procedural care is technically available. Gaps in mental healthcare and aftercare amplify stress, increase discontinuity in care, and reinforce the inequities faced by marginalized identities (Berrian et al., 2025).

Lack of formal training means providers often have to learn about 2SLGBTQIA+ care on the job.

A professor based in Ontario addressed deficits in health professional education that contribute to ongoing disparities in care:

> ***When we have done studies with health professionals, [we found] they have mostly learned how to work with queer and trans communities on the job. So, it's not something that they're graduating from their professional programs feeling adequately equipped to address.***
>
> *– Interview Participant, Professor, Ontario)*

3.5 Online Healthcare Information

2SLGBTQIA+ individuals rely on online health information more than their non-2SLGBTQIA+ counterparts.

Given the documented disparities in healthcare satisfaction, access, and experience among 2SLGBTQIA+ individuals, it is not surprising that many turn to the internet for health information. **56%** of 2SLGBTQIA+ survey respondents report trying health advice found online, and **45%** indicate doing so specifically due to a lack of access to healthcare professionals (Figure 28). These rates are significantly higher than those reported by non-2SLGBTQIA+ individuals. Additionally, **33%** of 2SLGBTQIA+ respondents stated that they had followed online advice instead of guidance from a doctor or healthcare provider.

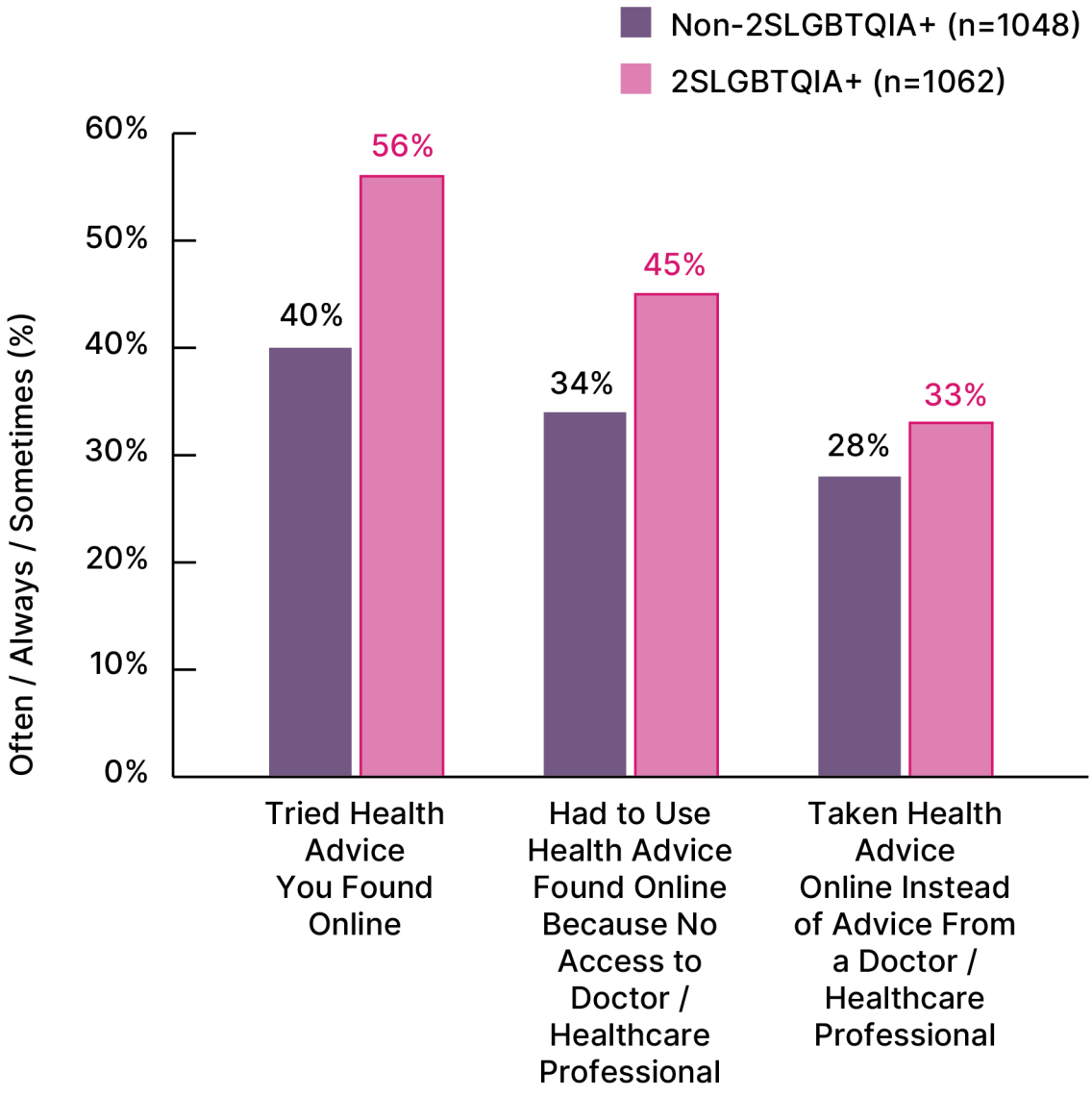


Figure 28: Online information.

This shift toward online health-seeking behaviours underscores systemic barriers faced by many 2SLGBTQIA+ individuals. Moreover, these results point to distrust developed through unsatisfactory interactions with Canadian healthcare systems.

While online sources are not a replacement for care, it is important to acknowledge that not all digital health content is unreliable or harmful. In recent years, a growing number of licensed healthcare providers and physicians, many of whom identify as 2SLGBTQIA+, have used platforms such as Instagram, TikTok, and Facebook to share accessible, evidence-based, affirming information. These digital spaces can help fill critical gaps in health education and support by addressing questions and concerns often overlooked in mainstream healthcare. In this context, it is understandable that 2SLGBTQIA+ individuals may turn to social media as a complementary tool for access to accurate health information and to foster community connection when formal care is exclusionary.

Future research should explore how 2SLGBTQIA+ individuals evaluate and engage with health information online, including the steps involved in differentiating trustworthy sources from misleading information. This knowledge can help inform strategies to amplify credible, inclusive health communication and can better integrate online engagement into formal healthcare pathways. This work also reinforces the need for healthcare systems to invest in digital outreach and content creation that meet communities with compassion, competence, and credibility.

3.6 Summary of Key Findings

- 2SLGBTQIA+ individuals, particularly **trans, queer, pansexual, asexual, non-binary, intersex, Two-Spirit, and genderfluid** respondents, prioritize **mental health** and **gender-affirming services** more than non-2SLGBTQIA+ individuals, yet consistently report the lowest scores of perceived ease of access and satisfaction. This data exposes critical service delivery gaps for those who need them the most.
- Survey and interview data reveal that **trans, non-binary, and Two-Spirit** individuals face some of the most severe healthcare barriers, including longer wait times, shorter clinical encounters, and lower perceived quality of care. In some regions, interviewees also described an over-reliance on single providers, leading to heightened vulnerability to service disruptions.

- Stakeholders emphasized that **economic instability** such as poverty, housing insecurity, and precarious work frequently prevents 2SLGBTQIA+ individuals from accessing or sustaining care. **Trans** and **gender-diverse** people experience these barriers most acutely.
- Healthcare professionals are widely perceived to **lack understanding of 2SLGBTQIA+ identities**, which is felt most keenly by **genderfluid, trans, queer, and asexual** respondents.
- Stakeholders emphasize that **providers often lack formal training in 2SLGBTQIA+ health**, leaving many to learn on the job.
- 2SLGBTQIA+ individuals are significantly more likely than non-2SLGBTQIA+ individuals to **rely on online health advice**, reflecting critical gaps in affirming and accessible health information.
- Overall, the results reveal **concerning disparities in the quality, timeliness, and inclusivity** of healthcare experienced by 2SLGBTQIA+ populations. Nearly all subgroups reported longer wait times, shorter provider interactions, and lower provider understanding. These disparities point to both **service-level shortcomings** and **structural inequities** embedded within the healthcare system.

These findings highlight an urgent policy imperative for healthcare systems, educational institutions, and policymakers to act decisively. Addressing these disparities requires three interrelated actions:

- Conducting research into the drivers of inequity, including systemic discrimination, provider bias, and institutional barriers.
- Implementing system-wide reforms that prioritize equity, trust, and culturally safe care.
- Expanding comprehensive provider education and training on 2SLGBTQIA+ health.

Complementary strategies include:

- Embedding 2SLGBTQIA+ health training in all medical education programs.
- Expanding mental health and gender-affirming services, especially in underserved regions.
- Hiring trained support staff to help 2SLGBTQIA+ individuals navigate care.
- Collecting disaggregated sex, gender, and sexuality data to guide equity efforts.
- Investing in credible, affirming digital health resources.
- Mapping existing services to identify and close critical care gaps.
- Tackling structural determinants of health such as poverty and housing insecurity that limit access.

Stigma and Discrimination in Canadian Healthcare

Stigma and discrimination disproportionately affect 2SLGBTQIA+ communities who continue to face high levels of social exclusion, harassment, and marginalization (Comeau et al., 2023). While Canada has made progress in securing legal protections for some 2SLGBTQIA+ identities, not all are treated equally in law or public discourse. Systemic and interpersonal stigma remain deeply entrenched in many aspects of life, including healthcare, education, employment, and housing.

While 2SLGBTQIA+ individuals experience higher rates of discrimination than their non-2SLGBTQIA+ peers, there remains a need for more granular data to capture diverse experiences across identities, regions, and systems of care. To address this gap, the 2025 Pink Paper on Health measured current levels of stigma and discrimination experienced by 2SLGBTQIA+ individuals in Canada.

4.1 Experiences with Stigma

To capture the everyday realities of patients navigating these systems, we asked participants to report how often they experienced specific forms of stigma in healthcare settings. We used a five-point scale ranging from "never" to "always." Percentages highlight isolated incidents and recurrent patterns of exclusion.

2SLGBTQIA+ patients are more likely to feel unsafe than their cisgender and heterosexual counterparts. Moreover, they are often burdened with educating their own service providers, which points to a widespread lack of foundational training and competence in inclusive care.

39% of 2SLGBTQIA+ individuals reported having to explain their sexual or gender identity to healthcare professionals at least sometimes, more than double the rate of non-2SLGBTQIA+ respondents **(19%)** (Figure 29).

Similarly, **36%** of 2SLGBTQIA+ individuals reported hiding aspects of themselves from healthcare professionals at least sometimes, compared to **20%** of their non-2SLGBTQIA+ peers. This lack of disclosure reflects a fear of judgment or mistreatment and significantly undermines the trust required for effective clinical care.

Feelings of discomfort or lack of safety in healthcare settings were reported by 35% of 2SLGBTQIA+ respondents, higher than the **23%** reported by non-2SLGBTQIA+ individuals (Figure 29). Alarmingly, **nearly one in four (23%) 2SLGBTQIA+ participants said they had lied about their sexual or gender identity to a healthcare provider, compared to 12% of non-2SLGBTQIA+ respondents** (Figure 29).

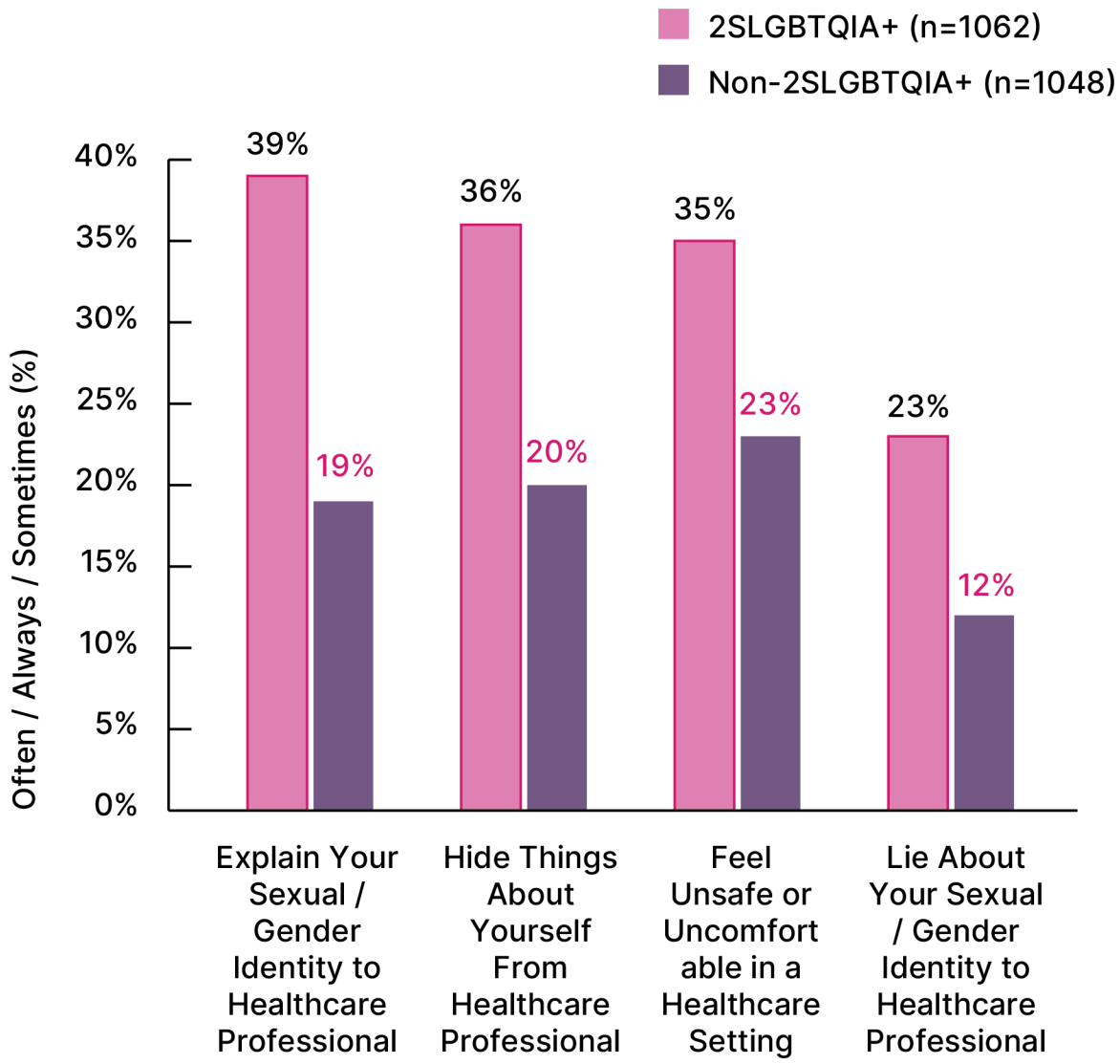


Figure 29: Reported experiences of healthcare-related stigma among 2SLGBTQIA+ and non-2SLGBTQIA+ participants.

These findings provide concrete evidence that stigma is not an abstract concern. It remains an ongoing experience that shapes how 2SLGBTQIA+ individuals engage with healthcare systems in Canada. Measuring these lived experiences is essential to identifying where interventions are needed, whether through mandatory provider training, institutional accountability, or improved community-specific services. Without addressing the frequency and impact of these experiences, efforts to create equitable and inclusive care will remain insufficient and incomplete.

4.2 Discrimination, Denial of Healthcare, and the Risk of Distance

Participants were asked how their healthcare providers responded to identity disclosure. This information is essential because discrimination is not always overt. It can manifest subtly through denial of care, dismissive behaviour, or inadequate treatment. By asking participants how often they felt discriminated against when they tried to access healthcare in Canada, and by identifying the specific reasons they believe led to that discrimination, this study is able to examine how intersecting sexual and gender identities shape health outcomes.

Two-Spirit respondents report the highest rates of healthcare discrimination, with 77% experiencing identity-based bias.

The results show deeply troubling patterns of discrimination. Over half of the **trans (54%)**, **genderfluid (54%)**, and **intersex (51%)** respondents reported feeling discriminated against due to aspects of their identity (Figure 30). Rates were also strikingly high for non-binary **(49%)**, pansexual **(45%)**, queer **(47%)**, asexual **(44%)**, and lesbian **(38%)** individuals. **The experience of Two-Spirit respondents is particularly alarming and demands urgent corrective action. 77% of Two-Spirit respondents experienced discrimination in healthcare settings** (Figure 30). Participants identified sexual orientation and gender identity as the primary causes of discrimination.

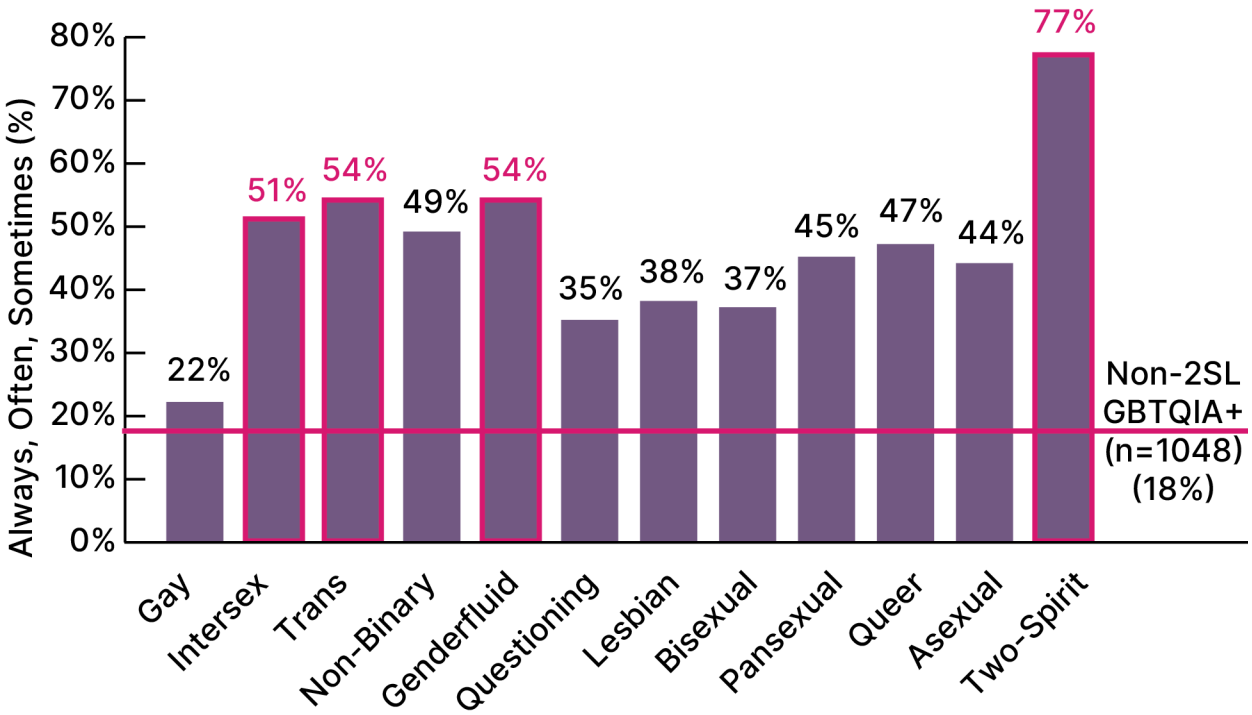


Figure 30: Reported experiences of healthcare-related discrimination among 2SLGBTQIA+ communities.

Intersecting identities deepen healthcare discrimination for Black and Indigenous 2SLGBTQIA+ people.

Among white 2SLGBTQIA+ individuals, **29% reported experiencing discrimination when accessing healthcare, compared to 43% of Black individuals and 57% of Indigenous individuals** (Figure 31).

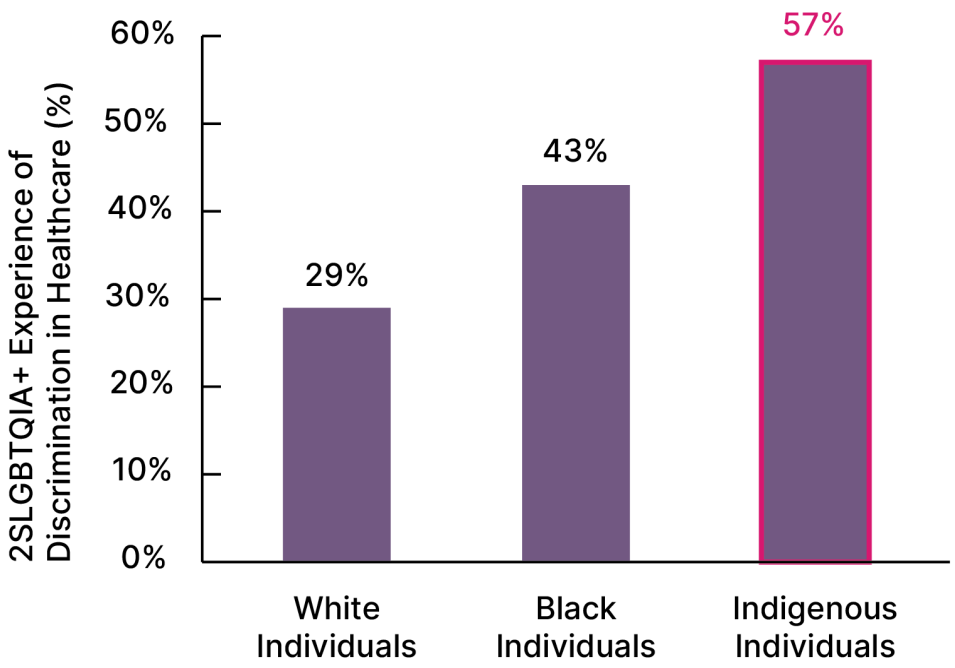


Figure 31: Experiences of discrimination in healthcare for 2SLGBTQIA+ individuals of white, black or indigenous ethnicity.

> ***If you're a trans woman of colour and you get assigned a misogynist therapist, you either endure harm or go back to the bottom of the waiting list.***
>
> *– Academic Researcher, Ontario*

> ***Well, I would just say, generally, you know, there are some Indigenous people who simply just will not enter into a Western healthcare facility. And that is for fear of how they will be treated. And I know a lot of that comes from systemic racism. And then for Two Spirit people that fear is compounded.***
>
> *– Indigenous Community Expert, Saskatchewan*

Rural and small-town 2SLGBTQIA+ individuals report higher rates of discrimination.

Geographic disparities were once again pronounced. Among **2SLGBTQIA+** participants, **29%** in large urban centres reported discrimination, and these rates rise sharply to **46%** among those in small or rural communities (Figure 32).

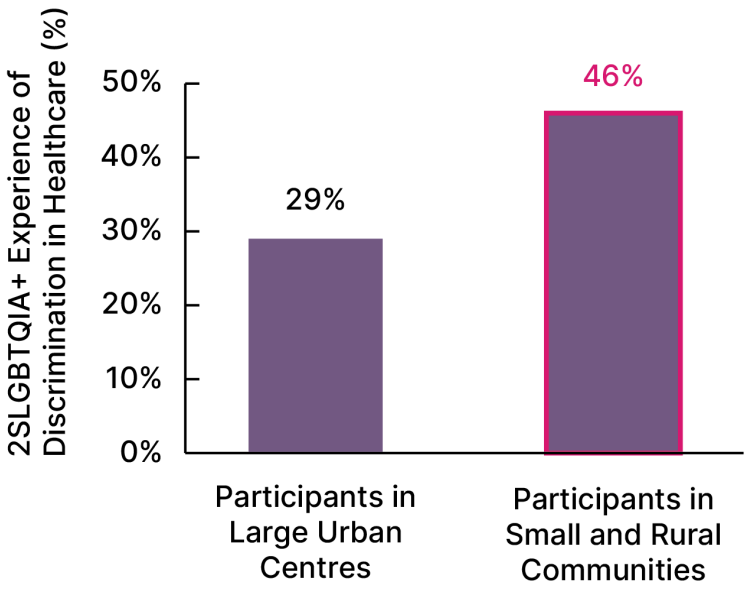


Figure 32: Experiences of discrimination in healthcare for 2SLGBTQIA+ based on community setting.

Discrimination, stigma, and misgendering remain entrenched in Canada's healthcare system.

Stakeholders consistently described healthcare settings as emotionally harmful and unsafe for queer and trans individuals, **particularly in rural and remote settings. Misgendering, deadnaming, and other forms of erasure remain common**, contributing to a sense of alienation and mistrust in care. The threat of being outed, especially in tight-knit communities, leads many to delay or forgo care entirely. Even when discrimination is not overt, patients are frequently burdened with the task of educating their own providers about queer and trans health.

> ***People are afraid or just simply don't want to go in and get treated because of the way that they fear they're going to be treated... Walking into the Saskatchewan Health Authority for many folks is a scary thought.***
>
> *– Executive Director, Indigenous Organization, Saskatchewan*

> ***We have a lot of folks who have chronic health problems, who have chronic pain, and who sometimes again put off seeking medical care because of discrimination or fear of discrimination.***
>
> *– Executive Director, Newfoundland and Labrador*

> ***A client of ours who is trans... was transferred to another hospital. And the physician at the other hospital that wrote the chart acknowledged that they knew the individual was trans but intentionally kept referring to them by their dead name and using the wrong pronouns, even in the chart.***
>
> *– Hospital CEO, Ontario*

These experiences are not just emotionally damaging, they are also medically dangerous. Dismissal and discrimination in care have real, measurable impacts on health. Delayed diagnoses, inappropriate treatment, and neglect ultimately lead to poor health outcomes and long-term harm to both physical and mental health.

Two-Spirit (36%), trans (31%), and non-binary (30%), individuals report the highest rates of healthcare denial among all respondents.

When asked whether they had ever been denied healthcare in Canada, 2SLGBTQIA+ respondents reported significantly higher rates of denial compared to their non-2SLGBTQIA+ counterparts. Only **11%** of non-2SLGBTQIA+ participants reported ever being denied care (Figure 33). In contrast, rates of denial were substantially higher across several identity groups within the 2SLGBTQIA+ population. Those who are **trans (31%)**, **intersex (30%)**, **non-binary (30%)**, **asexual (25%)**, and **genderfluid (24%)** are among the most likely to report having been denied healthcare. Notably, **Two-Spirit participants reported the highest rate of denial at 36%** (Figure 33).

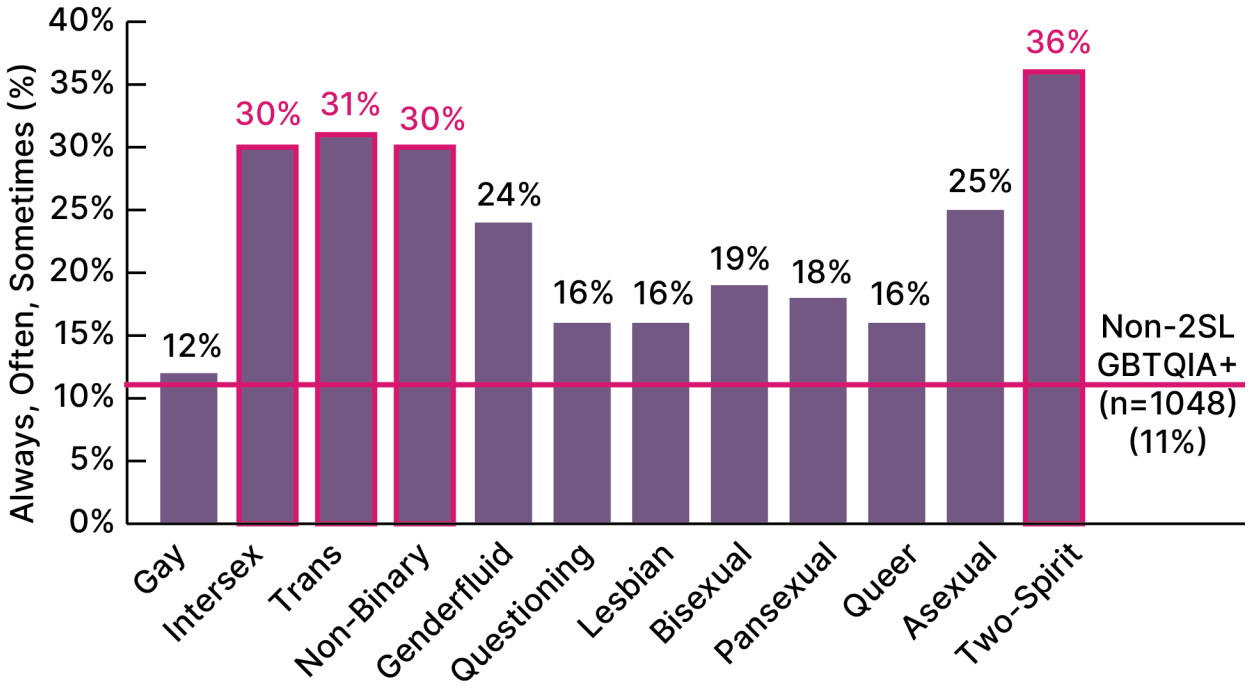


Figure 33: Reported levels of denial of healthcare.

Trans and non-binary respondents frequently reported being denied care or treated unequally, particularly in relation to gender-affirming treatments and screenings. One trans woman wrote:

> ***I was told by a pharmacist that he would not fill a prescription for me … that was for HRT prescription. Also, being a trans woman, the fact that I still have a prostate seems to be dismissed… Yet a 65-year-old cisman would be regularly checked.***
>
> *– 2SLGBTQIA+ Respondent*

Black, Indigenous, and rural 2SLGBTQIA+ individuals face higher rates of healthcare denial.

When examining the frequency of outright denial of healthcare services, the data reveals similarly disproportionate outcomes. Among 2SLGBTQIA+ participants, **30% of Black respondents and 21% of Indigenous respondents reported being denied care, compared to 14% of white respondents** (Figure 34).

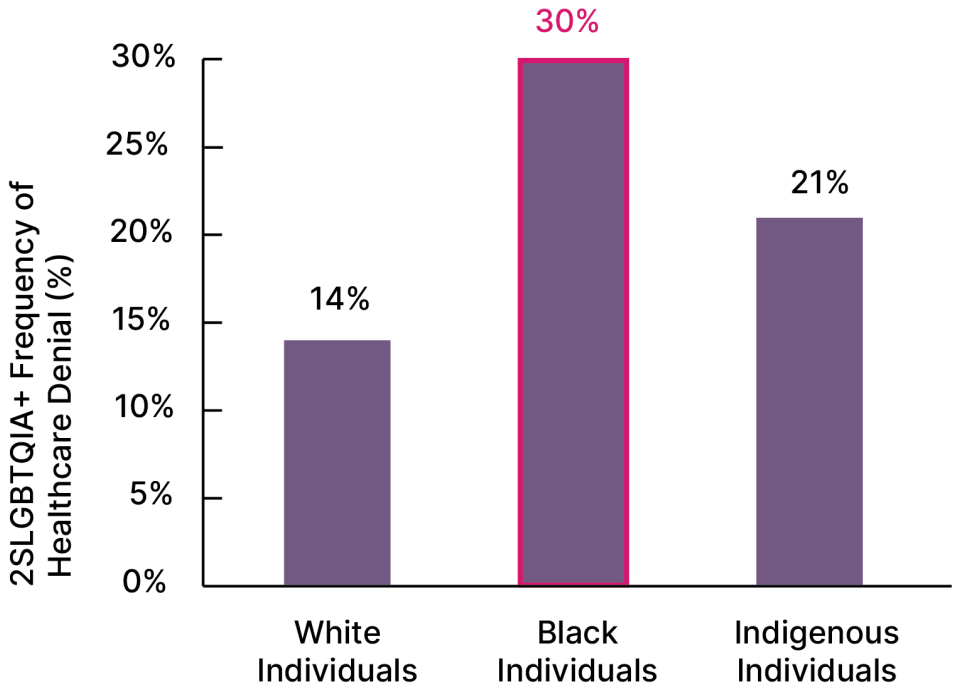


Figure 34: Frequency of healthcare denial for white, Black, and Indigenous 2SLGBTQIA+ participants.

Geographically, **13% of 2SLGBTQIA+ individuals in large urban areas reported being denied care, while this number nearly doubled to 25% among those living in small or rural communities** (Figure 35).

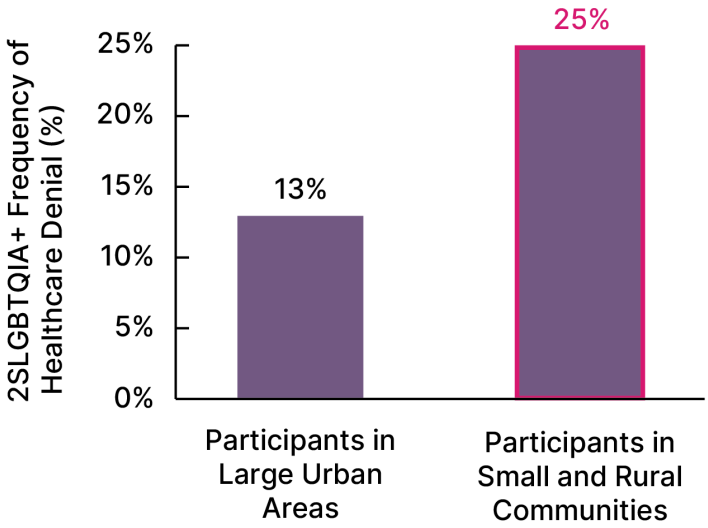


Figure 35: Frequency of healthcare denial for 2SLGBTQIA+ living in large and small/rural communities.

2SLGBTQIA+ patients face backlash for disclosure, which leads to fear of disclosing in the future.

Survey and interview findings reveal that for many 2SLGBTQIA+ individuals, disclosure of identity in healthcare settings is a double-edged sword. It is often met with backlash when it occurs, and fear or avoidance when it does not. To assess how healthcare professionals respond to disclosure of one's sexuality, gender identity, or partner status, participants were asked whether they noticed any change in how they were treated by providers after disclosure. If they responded in the affirmative, we asked how they would characterize that change.

25% of **2SLGBTQIA+ respondents** reported noticing a change in provider behaviour following disclosure, with the **majority describing the change as negative**. Conversely, only **8%** of non-2SLGBTQIA+ participants reported a change, indicating that disclosure of identity is uniquely impactful for 2SLGBTQIA+ people (Figure 36). Among 2SLGBTQIA+ respondents, **trans (59%)**, **non-binary (48%)**, **queer (48%)**, **Two-spirit (46%)**, **genderfluid (46%)**, and **intersex (45%)** individuals reported the most frequent and significant shifts in provider behaviour after disclosing their identity (Figure 36). This shift was described as **very negative or negative**, which contributes to reduced trust in care, avoidance of future healthcare encounters, or self-censorship during medical consultations.

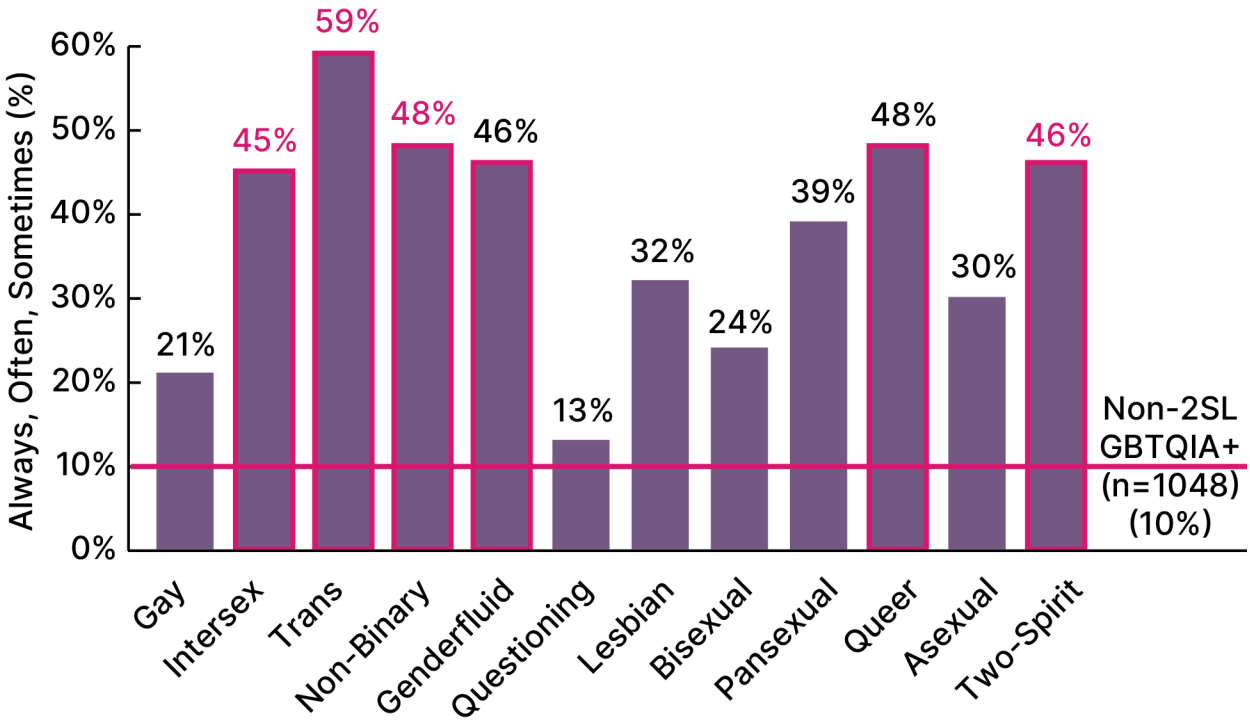


Figure 36: HCP reactions to disclosure.

Consistent with these findings, a prevailing theme across stakeholder interviews was patients' **fear of disclosure**, coupled with the emotional toll of being judged or dismissed by healthcare providers. Several participants described that disclosing 2SLGBTQIA+ identities leads to disbelief or outright rejection by providers, particularly when those identities fell outside normative expectations.

> ***I always fear being honest with healthcare workers for fear of dismissal or rejection / hate. I don't think I can ever truly be honest. People look at me differently once I revealed the fact that I feel queer. I feel like it makes me get taken less seriously.***
>
> *– 2SLGBTQIA+ Respondent*

> ***Healthcare workers don't believe me when I tell them that I'm asexual. I've been told to 'not lie' & 'be honest' when I have told them about my sexuality... Believe women.***
>
> *– 2SLGBTQIA+ Respondent*

These experiences have eroded trust in healthcare systems. One non-binary respondent explained:

> ***Experiencing discrimination due to my being nonbinary has at times made me untrustworthy of healthcare providers.***
>
> *– 2SLGBTQIA+ Respondent*

Further, several participants highlighted the importance of **visible inclusion**. The absence of clear signs of 2SLGBTQIA+ support, such as signage or flags, led some to **withhold their identity or avoid disclosure altogether**:

> ***Fear that I won't be accepted. If there are no [2SLGBTQIA+] flags or any inclusive space signs I don't feel like I can share my identity.***
>
> *– 2SLGBTQIA+ Respondent*

These findings suggest that, for many 2SLGBTQIA+ individuals, identity disclosure in a clinical setting is anything but neutral. It is a catalyst for differential treatment that often reinforces stigma. These experiences contribute to broader patterns of inequity in healthcare. Once again, the data highlights the need for provider education, trauma-informed care models, and institutional accountability mechanisms to protect against bias after disclosure.

Stakeholders reported that concerns around disclosure are exacerbated by the documented shortage of trained, affirming healthcare providers. In fact, they shared that **queer and trans health remains largely absent from formal medical education, leaving most providers underprepared to deliver competent care.** Where affirming providers do exist, they are often overburdened, professionally and emotionally, by the demands of filling systemic gaps.

> ***So people go there [Montreal] and then they get discharged and come home and always have complications. They end up in emergency where [the] physician here has no idea, has never seen that before... they have a terrible experience. Like, it's awful.***
>
> *– Executive Director, Alberta*

Beyond clinical gaps, stakeholders emphasized that many patients' needs are deeply relational, requiring trust, affirmation, and respect, yet these were frequently reported as lacking.

> ***People still can't go in and talk openly about their activities or who they are... there's still a lot of homophobia and transphobia, and sex-negativity in general.***
>
> *– Community Health and Wellness Director, Manitoba*

> ***I want to work myself out of a job - when every doctor can do this confidently.***
>
> *– Physician, Alberta*

Results reveal that healthcare denial is not experienced evenly across 2SLGBTQIA+ populations. Instead, denial is concentrated among those whose identities challenge binary gender norms and those who occupy multiple marginalized positions.

Two-Spirit participants reported the highest levels of discrimination and healthcare denial, underscoring the compounding impact of colonialism, racism, and cisheteronormativity. Addressing these inequities requires stronger provider accountability and enforcement of anti-discrimination protections, especially for the most marginalized subgroups. Provider education must go beyond **surface-level inclusion to actively confront bias and reduce harm in clinical interactions.** Without these measures in place, the healthcare system will continue to perpetuate the very inequities it should be dismantling.

Together, this study's findings on discrimination, denial of healthcare, and negative reactions to disclosure point to an urgent need for healthcare systems to address implicit and explicit bias. These patterns reflect deeper structural norms that continue to make identity disclosure a source of risk rather than empowerment. The fact that 2SLGBTQIA+ individuals are denied healthcare in Canada today on the basis of sexual or gender identity is a serious and unacceptable reality. Addressing this inequity requires institutional reform and **comprehensive training and education** for healthcare providers. Combined, these solutions can ensure safe, inclusive, respectful and affirming care for all.

4.3 Ending Discrimination: What Does it Take?

In response to the open-ended question "What do you think is needed to bring an end to that discrimination?", 2SLGBTQIA+ participants identified a range of structural, interpersonal, and cultural changes. Thematic analysis revealed four major areas of focus:

- **advocacy and education;**
- **respect and acceptance;**
- **provider training and representation in healthcare;**
- **and legal accountability.**

These perspectives offer a comprehensive roadmap toward inclusion, backed by qualitative narratives and quantifiable themes.

4.3.1 Advocacy and Education

Education and awareness-building were among the most frequently cited solutions. Many participants emphasized the need for public education campaigns and advocacy, highlighting the importance of shifting both provider and societal attitudes through accurate information and greater visibility.

- **28%** of respondents said **education** was necessary.
- **17%** pointed to the need for **inclusion advocacy**.
- **13%** emphasized improving **knowledge and understanding**.
- Others called for **public awareness campaigns** (9%) and more **open conversations** (6%).

> ***That requires a combination of education, policy changes, and cultural shifts. Education & awareness, stronger laws & protections. Representation & visibility, safe & inclusive spaces... We can create a more equal and inclusive society.***
>
> *– 2SLGBTQIA+ Respondent*

> ***Doctors being taught it in school... I believe much of this younger generation has a much more open attitude to gender issues in general.***
>
> *– 2SLGBTQIA+ Respondent*

> ***More education for doctors and healthcare professionals [...] might help. It is not a choice to be different... Seminars with guest speakers who have suffered by just being different.***
>
> *– 2SLGBTQIA+ Respondent*

4.3.2 Advocacy and Education

Calls for greater **respect, empathy, and social acceptance** were also common, reflecting the need to shift cultural attitudes and interpersonal norms. Participants described the emotional harm caused by judgemental or dismissive care and stressed the importance of compassion and open-mindedness.

- **25%** called for **open-mindedness and acceptance**.
- **14%** cited the need for **empathy and compassion**.
- Other recurring themes included changing **societal attitudes** (11%); focusing on **respectful behaviour** (10%); promoting **mutual respect** (3%); and ensuring **equality of treatment** (3%).

> ***Open and transparent communication, understanding an individual's feelings and listening to them as they open up... can create an environment that is more respectful, inclusive, and responsive to the needs of marginalized communities.***
>
> *– 2SLGBTQIA+ Respondent*

4.3.3 Provider Training and Representation in Healthcare

Participants emphasized the importance of **sensitivity training** and overall provider **competency**, increased **diversity**, and stronger **professional standards** to improve healthcare interactions.

- **17%** advocated for mandatory **sensitivity training**.
- **10%** called for more **diverse representation** within the medical profession.
- **10%** wanted **increased awareness among healthcare providers**.
- **9%** called for **better professional training** overall.

> *Better anti-discrimination training in medical schools and mandatory requirements for maintaining a medical license. Also, checklists doctors have to go through to combat implicit bias.*
>
> *– 2SLGBTQIA+ Respondent*

Community-led solutions are working, but they need support at the federal, provincial, and provider level.

Stakeholder interviews highlighted the critical role that 2SLGBTQIA+ community leaders and organizations already play in filling systemic gaps in care. Interviewees described a range of grassroots solutions in place, including **peer-based navigation supports, training initiatives for healthcare workers, and informal support networks for patients**. While these community-led responses are essential, stakeholders emphasized that they are **often underfunded, temporary, and heavily reliant on the unpaid labour of those already facing marginalization**. Stakeholders were very clear that **ending discrimination in healthcare cannot rely solely on community efforts. Sustainable, system-wide investment is urgently needed to support both provider training and community-driven care models**. These reflections align with the broader priorities identified by 2SLGBTQIA+ survey participants, most notably the need for advocacy, provider education, and inclusive care.

4.3.4 Legal Accountability: Protections and Enforcement in Healthcare

Although less frequently cited, some participants identified the need for legal protections and stronger enforcement to ensure accountability for discrimination in healthcare settings.

- **5%** supported **penalties for discrimination.**
- **3%** called for **stronger legal protections and anti-discrimination laws.**

Together, these responses point to a broad and intersectional understanding of what is required to eliminate discrimination in healthcare. Participants overwhelmingly called for **education, cultural competency, compassionate care, and institutional accountability**, delivered through reforms in both **professional practice** and **public discourse**. However, calls for accountability must also grapple with the reality that Canada's legal and institutional systems are themselves shaped by colonial and systemic inequities. This is particularly evident in the experiences of Two-Spirit and Indigenous participants, who consistently reported the most severe barriers to care and the deepest mistrust of institutions. **Achieving meaningful accountability therefore requires not only policy reform within existing structures, but also transformation of those very systems** that have historically marginalized Indigenous and 2SLGBTQIA+ peoples. These findings reinforce the need for a multi-pronged approach that addresses **bias at the individual level, barriers at the institutional level, and prejudice at the societal level**.

4.4 Summary of Key Findings

- 2SLGBTQIA+ individuals are significantly more likely to experience stigma, discrimination, and denial of healthcare than their non-2SLGBTQIA+ peers.
- Two-Spirit, trans, non-binary, and intersex individuals report the highest rates of both discrimination and healthcare denial.
- Black, Indigenous, and rural 2SLGBTQIA+ individuals face compounding barriers, with markedly higher rates of discrimination and care denial.
- Disclosure of sexual or gender identity often leads to negative provider behaviour, further eroding trust and deterring care-seeking.
- Many 2SLGBTQIA+ patients hide their identities or lie to providers due to fear of judgment, undermining effective healthcare delivery.
- A widespread lack of provider training and inclusive care contributes to patients having to educate their own doctors.
- Stakeholders identified community-led solutions such as peer support and provider training, but these remain underfunded and unsustainable.
- Participants emphasized the urgent need for structural reforms, including mandatory provider education, increased representation, and legal protections.

Health Priorities

5.1 Healthcare Priorities as Expressed by Survey Respondents

Improving healthcare for 2SLGBTQIA+ communities improves healthcare for everyone.

When asked what 2SLGBTQIA+ inclusive healthcare services they would like to see more of, respondents identified a range of improvements, many of which echo broader public health priorities across Canada. **This data underscores how addressing the needs of 2SLGBTQIA+ communities will lead to healthcare improvements for everyone.** At the same time, responses reveal heightened needs related to **gender-affirming care, mental health**, and **inclusive provider practices**, reflecting longstanding gaps in how the healthcare system serves 2SLGBTQIA+ individuals.

5.1.1 Systemic and Policy-Level Changes

Participants widely called for **equity-driven reforms**, including the need for structural accountability, greater awareness of 2SLGBTQIA+ health issues in policy design, and system-wide support for queer and trans communities (Figure 37).

- **19%** of 2SLGBTQIA+ respondents called for increased **awareness of 2SLGBTQIA+ issues in healthcare**.
- **18%** advocated for more **equitable treatment in healthcare**.
- **7%** highlighted the importance of **institutional support for 2SLGBTQIA+ communities**.

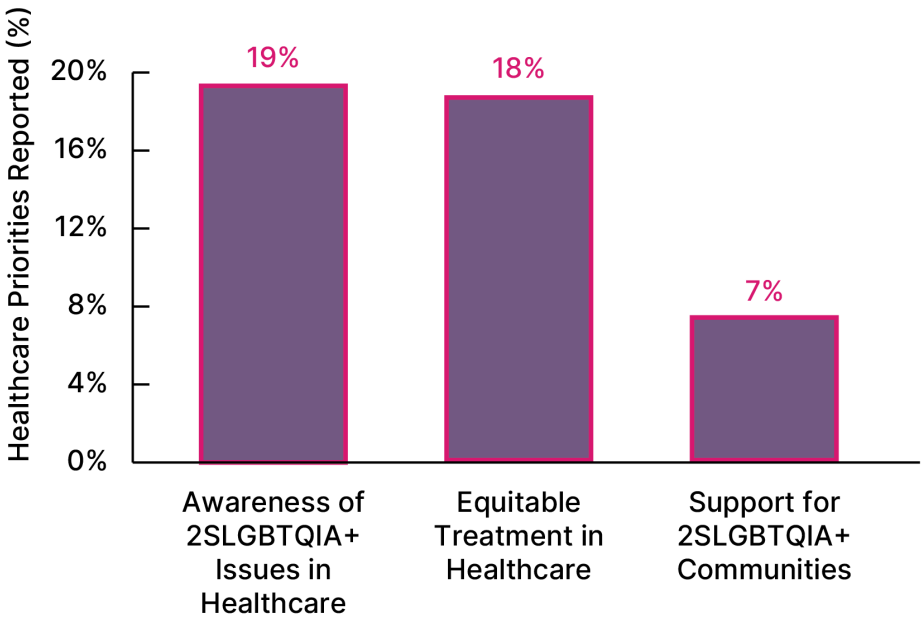


Figure 37: Healthcare priorities reported related to system and policy-level changes (%).

5.1.2 Services Access and Inclusion

Improved **access to specific healthcare services** was another major theme, particularly for mental health, sexual health, and gender-affirming care (Figure 38).

- **15%** of 2SLGBTQIA+ respondents prioritized general improvements in **access to care**, versus **9%** of non-2SLGBTQIA+ participants.
- **11%** called for expanded **gender-affirming care**, more than three times higher than non-2SLGBTQIA+ respondents **(3%)**.
- **10%** requested more inclusive **mental health services** and **sexual health counselling**.

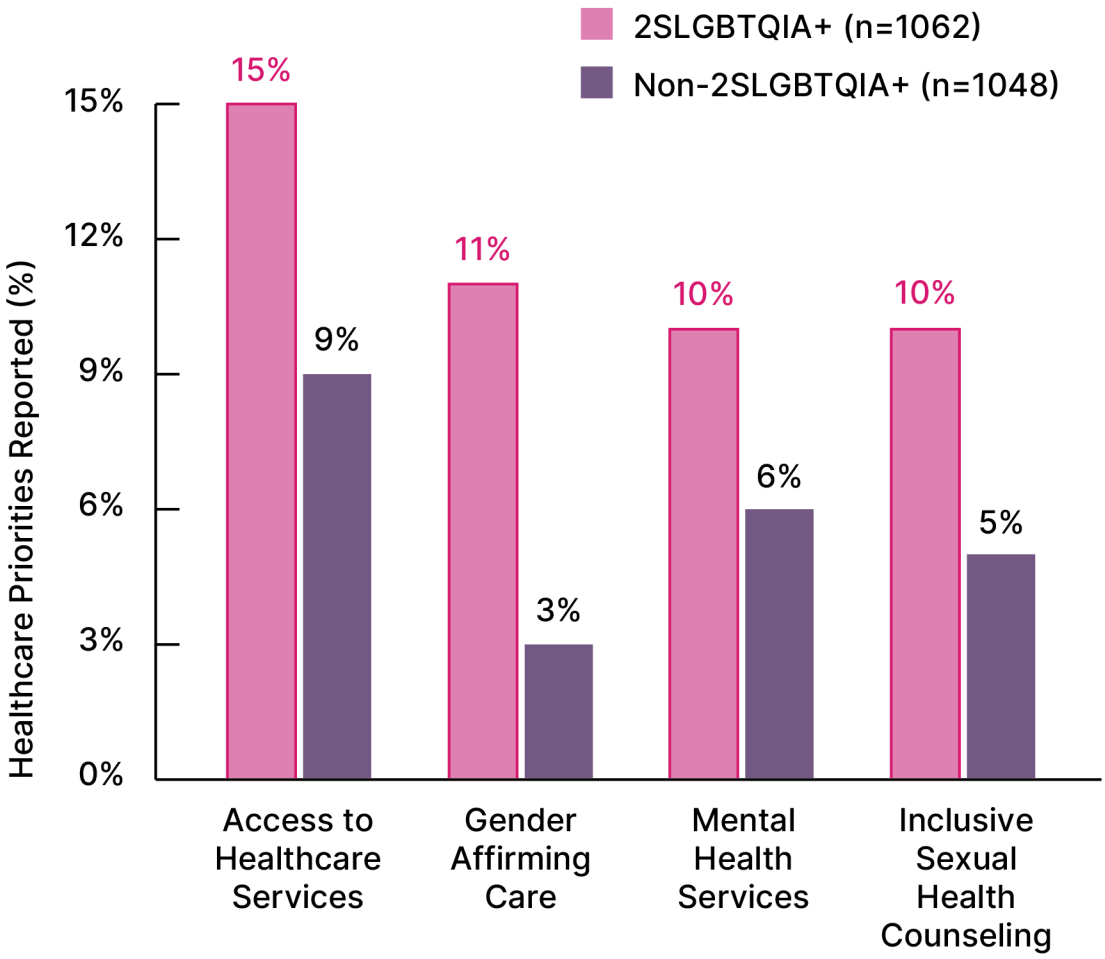


Figure 38: Healthcare priorities reported related to system and policy-level changes (%).

5.1.3 Provider Competency and Compassionate Care

Another frequently mentioned concern was the **quality of provider-patient relationships**, with many advocating for more inclusive, open-minded, and respectful care environments (Figure 39).

- **15%** of 2SLGBTQIA+ respondents called for **non-discriminatory healthcare providers**, versus **7%** of their non-2SLGBTQIA+ peers.
- **11%** emphasized the importance of **open-minded providers**, with 8% asking for **safe and open communication environments**.
- **7%** highlighted the need for provider **sensitivity to sexual orientation**.

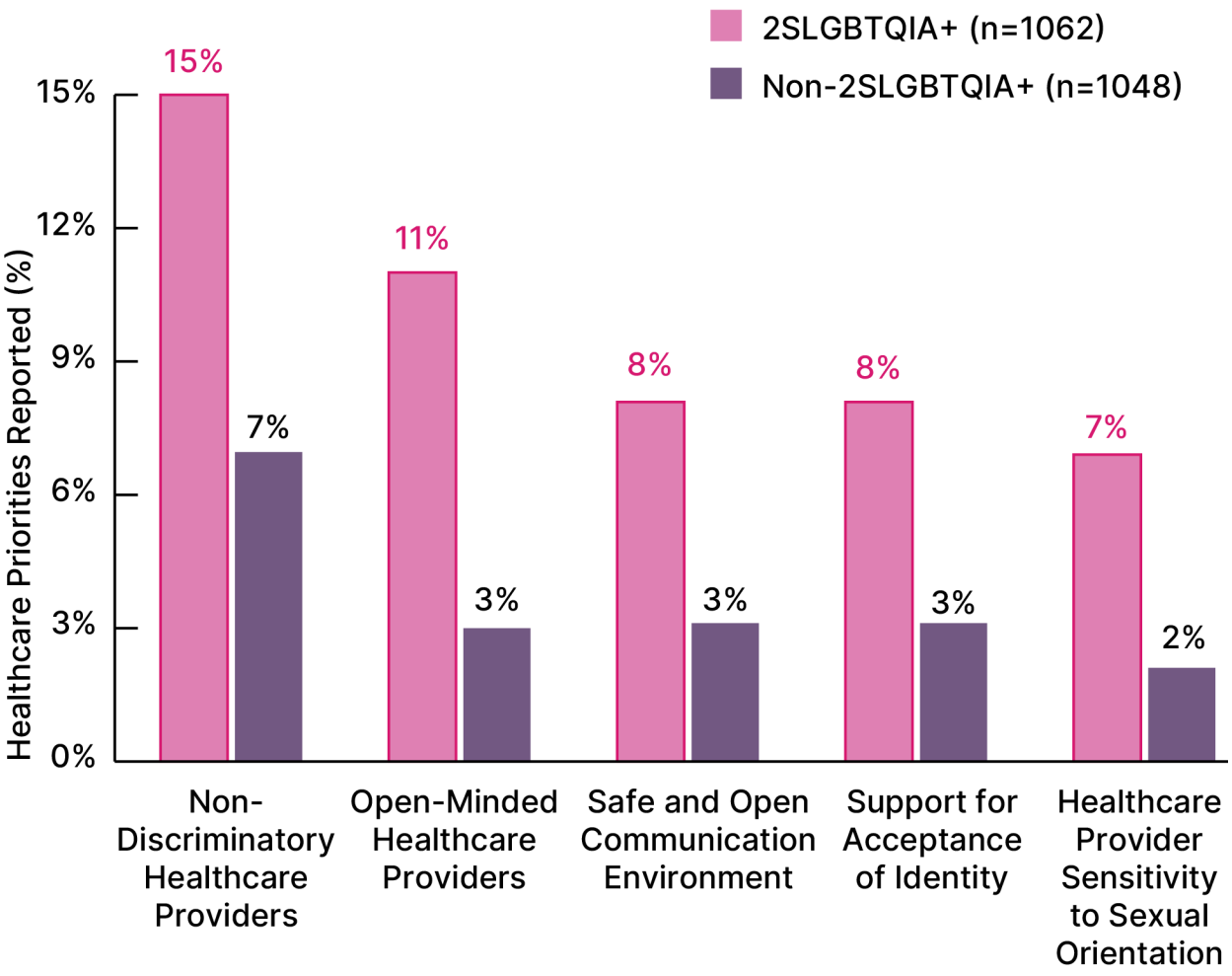


Figure 39: Healthcare priorities reported related to provider competency and compassionate care (%).

5.1.4. Additional Observations

While 2SLGBTQIA+ respondents were more likely to identify specific service gaps and opportunities for improvement, a notable proportion of respondents across both groups reported uncertainty (Figure 40):

- **19%** of 2SLGBTQIA+ respondents answered, **"Do not know"** and **19%** indicated **"Nothing specific."** Among non-2SLGBTQIA+ respondents, these numbers were even higher (**32%** and **30%**, respectively).
- A small portion (**5%** of 2SLGBTQIA+ and **11%** of non-2SLGBTQIA+ respondents) opposed the idea of placing specific focus on 2SLGBTQIA+ health, pointing to persistent stigma and misunderstanding about the role of inclusive care.

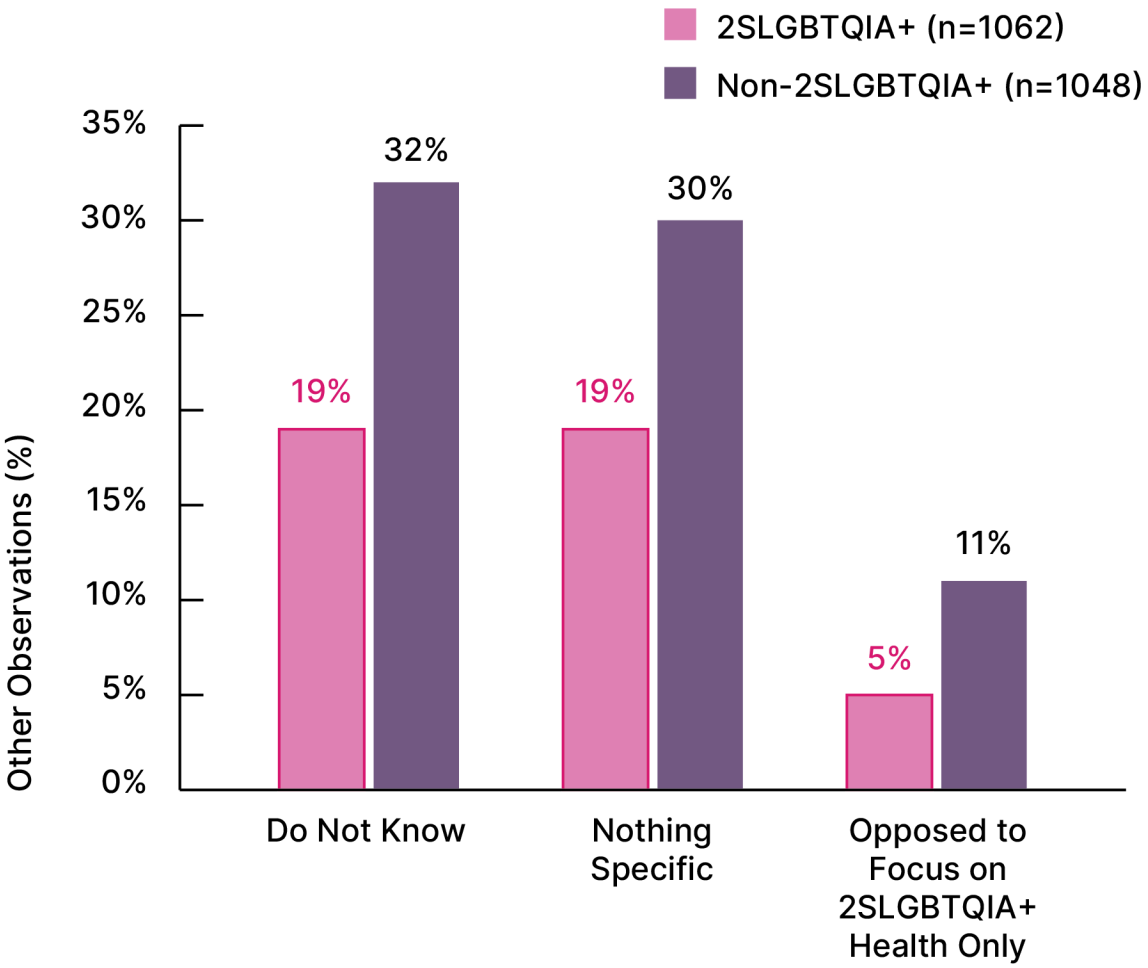


Figure 40: Other observations (%).

These findings demonstrate that while many 2SLGBTQIA+ healthcare priorities align with those of the general population, there remains a critical need for **identity-affirming services, sensitive provider practices,** and **systemic policy changes** that recognize and address the unique barriers faced by 2SLGBTQIA+ individuals. Investing in these priorities is not only a matter of equity, but also a step toward strengthening the healthcare system for everyone.

5.2 Most Important Healthcare Issues in Canada

When asked to identify the top five most pressing healthcare issues in Canada, 2SLGBTQIA+ and non-2SLGBTQIA+ respondents highlighted many of the same systemic concerns. **A shortage of doctors and healthcare professionals (58–59%)**, **long wait times (55–60%)**, and **lack of access to primary care (48–50%)** were cited most frequently, reflecting broad concern about the capacity and responsiveness of the healthcare system (Figure 41).

While these challenges are widely shared, **2SLGBTQIA+ respondents were significantly more likely to identify** gaps in mental health care (34% vs. 24%). Additionally, they highlighted **unequal care for 2SLGBTQIA+ populations (15% vs. 5%)**, a **lack of gender-affirming care (10% vs. 5%)**, and a lack of **culturally sensitive services (10% vs. 7%)**. These findings suggest that 2SLGBTQIA+ communities experience the same systemic pressures as their cisgender and heterosexual counterparts, but often face them with additional layers of exclusion, stigma, and inaccessibility.

Interestingly, 16% of both 2SLGBTQIA+ and non-2SLGBTQIA+ participants identified **"unequal access to care in rural communities"** as one of the most pressing healthcare issues (Figure 41). While this concern was shared across populations, the lived realities diverge sharply. Results show that 2SLGBTQIA+ individuals in rural areas face significantly greater barriers to care, including higher rates of healthcare discrimination, longer wait times, and more frequent denial of services compared to their non-2SLGBTQIA+ rural counterparts. This underscores how intersecting geographic and identity-based inequities compound to create distinctly harmful healthcare experiences.

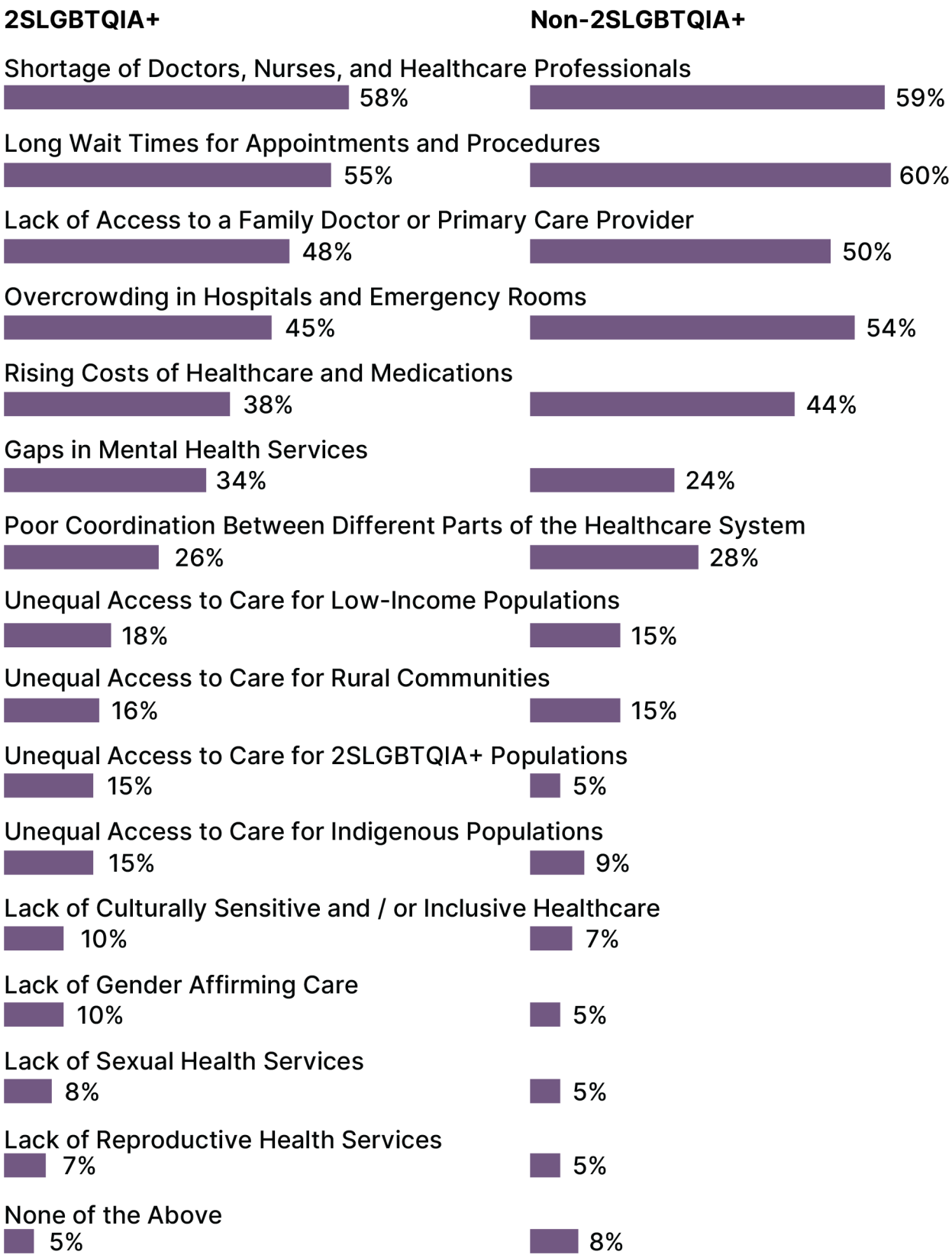


Figure 41: Most frequently cited healthcare issues by 2SLGBTQIA+ and non-2SLGBTQIA+ respondents (%).

Addressing gaps highlighted by 2SLGBTQIA+ communities—particularly around inclusion, mental health, and affirming care—**can strengthen the healthcare system for all**. Equity-focused reforms not only improve access and safety for marginalized groups but also enhance overall system performance, provider competency, and patient trust. Building a healthcare system that works for 2SLGBTQIA+ communities helps ensure a more effective, compassionate, and inclusive system for everyone.

5.3 Improving the Experience with the Healthcare System

Among 2SLGBTQIA+ and non-2SLGBTQIA+ respondents, there was strong alignment on the most urgent improvements needed in Canada's healthcare system (Figure 42). The top three shared priorities were:

1. **Shorter wait times for appointments and procedures (56–60%);**
2. **More access to family doctors and primary care providers (56–57%);**
3. **Lower costs of healthcare and medications (41–43%).**

All these priorities reflect widespread concern about access, affordability, and system capacity.

Once again, clear differences emerged when we looked closer at identity-specific needs. **2SLGBTQIA+ respondents were nearly four times more likely than non-2SLGBTQIA+ respondents to select "more healthcare professionals trained in 2SLGBTQIA+ health needs" (26% vs. 7%)**, pointing to a critical gap in provider competency and inclusive care delivery (Figure 42). The fact that so few non-2SLGBTQIA+ individuals identified this need may reflect a **lack of awareness of the barriers, discrimination, and inadequate care that many 2SLGBTQIA+ people face in clinical settings**. This disparity underscores the importance of centring the voices of those with lived experience when designing healthcare reforms. In addition, 2SLGBTQIA+ respondents more frequently identified the need for **easier access to mental health services (38% vs. 27%), less discrimination in healthcare settings (19% vs. 12%),** and **more culturally inclusive care (13% vs. 9%)**.

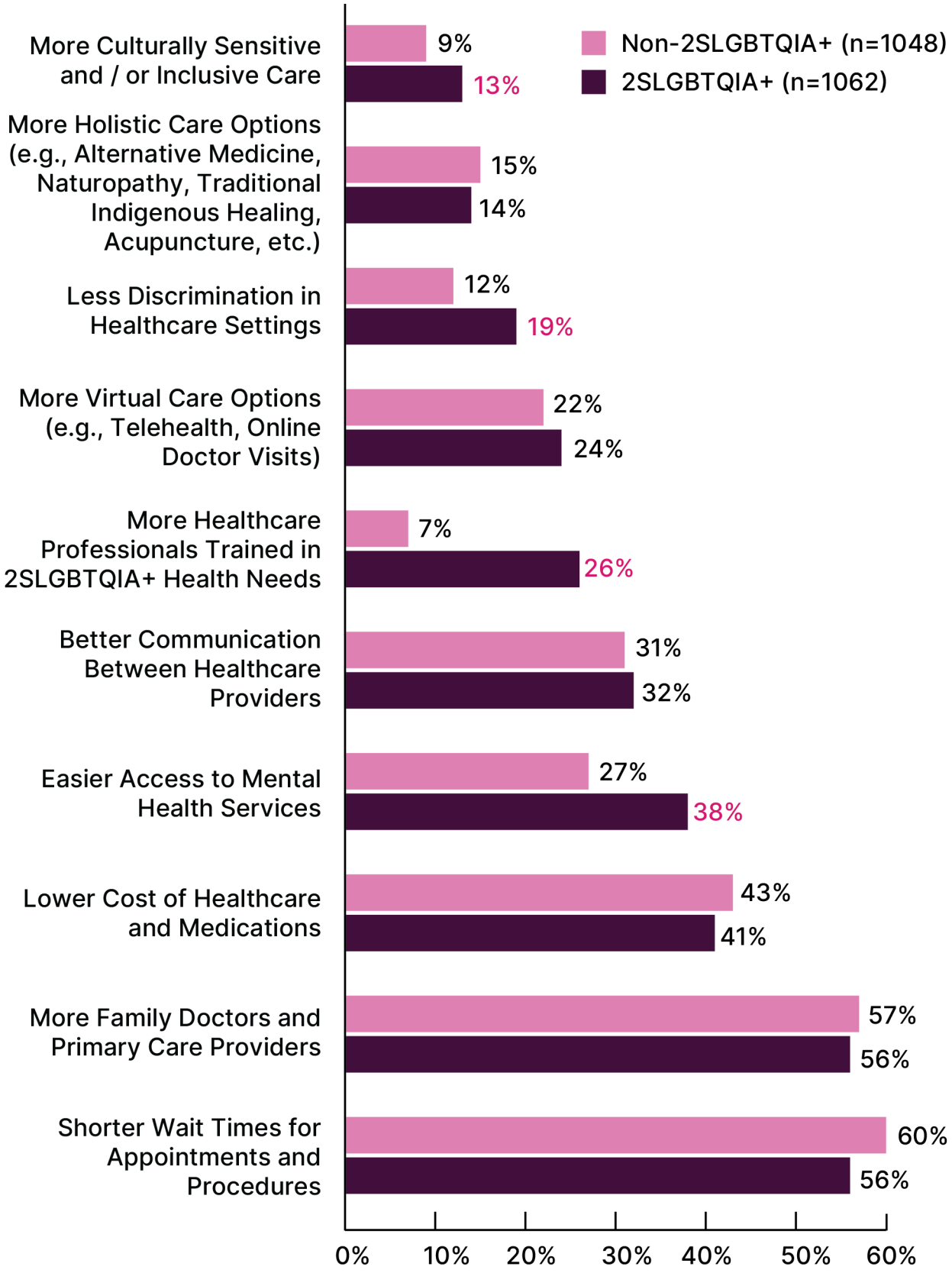


Figure 42: Top answers chosen by 2SLGBTQIA+ and non-2SLGBTQIA+ respondents in regard to improving their experience with the healthcare system (%).

These findings affirm that, while many system-wide improvements are broadly supported, 2SLGBTQIA+ individuals continue to face unique challenges that require targeted solutions. Investing in **specialized provider education, inclusive clinical environments**, and **anti-discrimination efforts** will not only reduce harm but also contribute to a more responsive and equitable healthcare system for all.

5.4 Stakeholder Vision for Transformative Change

In qualitative interviews, key stakeholders from across the healthcare system expressed visions for urgent transformative change. Rather than focusing solely on repairing existing gaps, stakeholders called for systemic redesign rooted in equity, safety, trust, and relational care. Their visions emphasized the need to enact alternative approaches to healthcare delivery that reflect the lived realities and diverse needs of 2SLGBTQIA+ communities.

1. A new vision for inclusive care

Stakeholders consistently described the need for a healthcare system that **affirms identity, fosters trust, and enables access without fear of discrimination, judgment, or harm**. From gender-affirming services to mobile outreach in rural communities to safer long-term care environments for 2SLGBTQIA+ elders, their calls were rooted in the belief that care should meet people where they are, both physically and emotionally.

> ***I think the goal would be… anybody can walk into any space, and you do not have to be worried about being discriminated against… it should be like automatically their safe space.***
>
> *– Medical Student, Quebec*

2. Sustained investment in community-led solutions

Stakeholders found consensus around the importance of **fully funded, community-led initiatives,** including **mental health services, peer navigation, housing support, and recovery care**. They expressed concern that many critical supports are currently held together by short-term grants and volunteer labour and emphasized the need for sustained provincial and federal investment to ensure their long-term impact.

> ***Representation on boards and committees making decisions about patients' healthcare access is important... you need to have people who have lived experience involved in those decision-making conversations.***
>
> *– Pharmacist, Nova Scotia*

3. Educational transformation

Many stakeholders identified **education reform** as essential to lasting change. They advocated for the integration of 2SLGBTQIA+ health across medical, nursing, and allied health training curricula, as well as formal **accreditation and education standards**. They also identified a need to have more trans and non-binary medical practitioners, noting that representation is key to ensuring culturally safe and affirming care.

> ***We don't see sufficient representation in who's graduating from medical school and from medical specialties... That's particularly true for trans and non-binary folks.***
>
> *– Professor, Ontario*

> *One of my students created a fellowship in [2SLGBTQIA+] care… it might be great to expand upon that.*
>
> *– Physician, Ontario*

Survey findings strongly echoed this call. **Respondents identify education as a crucial site of intervention for improving 2SLGBTQIA+ health, and satisfaction with healthcare services and experience.** Healthcare professionals should be trained in the language, clinical skills, competencies, and confidence to serve their 2SLGBTQIA+ patients adequately. **Practically, this means building clear Canadian standards and guidelines for medical curricula and following them up with curricula audits and reform.**

4. Federal standards of care to drive accountability across jurisdictions

Several stakeholders emphasized the need for **federal standards of care** to ensure consistency and accountability across Canada's provinces and territories. Rather than relying on fragmented or region-specific initiatives, they called for enforceable, equity-driven strategies tied to federal funding. Such national standards would ensure all 2SLGBTQIA+ individuals, regardless of geographic location, have access to safe, inclusive, and affirming healthcare.

> *[If] they can create systems… that all healthcare systems across the country have to follow… and have a strategy in place… It would be really great.*
>
> *– Community Health and Wellness Director, Manitoba*

Together, these insights offer a clear and actionable roadmap toward a healthcare system accountable to the full diversity of 2SLGBTQIA+ people in Canada.

5.5 Summary of Key Findings

- **2SLGBTQIA+ respondents prioritize inclusive care and equity**, calling for equity, institutional support, and inclusive policy design at a markedly higher rate than their non-2SLGBTQIA+ peers.
- **Mental health and gender-affirming care are critical gaps.** More 2SLGBTQIA+ individuals identified gaps in mental health services, gender-affirming care, and inclusive sexual health counselling.
- **Provider training in 2SLGBTQIA+ health is urgently needed.** Over a quarter (26%) of 2SLGBTQIA+ respondents prioritized more trained providers vs. 7% of non-2SLGBTQIA+ participants.
- **Rural 2SLGBTQIA+ individuals face compounded access barriers.** Both groups flagged rural care gaps (~16%), but 2SLGBTQIA+ respondents in rural areas reported worse outcomes, more discrimination, and higher rates of denial of care.
- **Systemic concerns affect everyone, but they're experienced more acutely by 2SLGBTQIA+ people.** Shared concerns included wait times, provider shortages, and access to care.
- **Non-2SLGBTQIA+ respondents are less likely to identify inclusive care as a priority:** Responses from non-2SLGBTQIA+ participants often reflected indifference or resistance to 2SLGBTQIA+-inclusive approaches, revealing not only gaps in awareness but also persistent homophobia and transphobia within healthcare attitudes.
- **Stakeholders call for inclusive care through community leadership, education reform, and federal standards:** Long-term investment, training reform, and enforceable national standards were seen as essential to ensuring safe, equitable care for 2SLGBTQIA+ communities.
- **Addressing 2SLGBTQIA+ needs improves healthcare for everyone:** Findings affirm that improving care for marginalized groups benefits the healthcare system as a whole.

Recommendations for Actionable Change

Backed by quantitative and qualitative research findings, this 2025 Pink Paper on Health concludes with a list of actionable insights with which to address systemic health disparities faced by 2SLGBTQIA+ communities in Canada. These recommendations are to inform and empower the healthcare professionals, service providers, community organizers, researchers, and policymakers who will advance a more effective and equitable healthcare system.

1

Audit and reform healthcare education, embedding 2SLGBTQIA+ health competencies across all levels of training

Establishing a more supportive environment for 2SLGBTQIA+ communities at the individual and institutional level can advance change. This begins with a comprehensive audit and reform of healthcare education through the efforts of researchers, educators, and healthcare providers in partnership with 2SLGBTQIA+ communities and organizations. Reviewing existing curricula can identify gaps, which co-developed, inclusive, and evidence-based training can address. The data identifies gender diversity, anti-oppressive clinical practices, trauma-informed care, and the impacts of systemic discrimination on health outcomes as core competencies necessary for effective healthcare provider training. Curriculums addressing these competencies can thus improve medical, nursing, allied health, and public health education by being embedded into both pre-licensure and continuing professional development requirements. Only when healthcare spaces are genuinely safe and affirming for 2SLGBTQIA+ patients can trust be rebuilt in systems that have historically caused them harm.

2

Expand and strengthen the mental health workforce with a focus on 2SLGBTQIA+ competency and accessibility

If healthcare professionals and policymakers at all levels work together, they can strengthen and expand public access to mental health services while prioritizing culturally competent, inclusive care. Canada faces a well-documented shortage of mental health professionals, a gap that disproportionately affects 2SLGBTQIA+ communities as shown by data from this 2025 Pink Paper on

Health. Importantly, meaningful change to Canadian mental health services requires that mental health professionals receive mandatory, evidence-based training in 2SLGBTQIA+ cultural competency and trauma-informed care. Publicly funded mental health programs tailored to the needs of 2SLGBTQIA+ individuals, including those requiring gender-affirming care, can reduce reliance on costly and inaccessible private services.

3

Systematically collect accurate and inclusive sex and gender data within healthcare systems

Healthcare service providers and community organizers play a vital role in ensuring data collection is respectful, inclusive, and meaningfully used to advocate for policy and programme reform. Improving outcomes and identifying at-risk patients early requires implementing consistent, standardized practices for collecting sex and gender data beyond binary classifications in healthcare systems across Canada. Accurate and sensitive collection of this information allows for the earlier identification of populations vulnerable to poor outcomes, including those at risk of financial toxicity (the economic burden or distress caused by out-of-pocket healthcare costs). Robust data collection is essential to informing clinical care, supporting research, and addressing inequities in access, treatment adherence, and long-term health outcomes for 2SLGBTQIA+ communities.

4

Develop and implement 2SLGBTQIA+-inclusive cancer screening and chronic disease prevention programs in every province

Prioritizing the development and implementation of inclusive cancer screening and chronic disease prevention programs tailored to the diverse identities within 2SLGBTQIA+ communities will ensure that conditions are discovered and treated early. Knowledgeable healthcare professionals, service providers, and community organizers can aid in the development of such programs to ensure they are both evidence-based and culturally competent. Equitable health promotion campaigns begin by acknowledging the social determinants that uniquely affect 2SLGBTQIA+ individuals, such as discrimination, social exclusion, and healthcare avoidance.

5

Conducting a comprehensive environmental scan of existing services that support 2SLGBTQIA+ healthcare is necessary at the federal level

Together, researchers and academic partners can conduct a thorough environmental scan of existing services that support 2SLGBTQIA+ healthcare to identify clinical capacity, gaps in service delivery, and regional disparities, while also highlighting provinces and territories demonstrating leadership in inclusive care. Much like this paper has done on the patient side, such data can establish an essential baseline against which future progress is measured and help pinpoint where additional investment, provider education, and infrastructure development are most urgently needed. The findings can guide equitable health system planning and evidence-based policy decisions that reflect community needs.

6

Improve access to tailored healthcare in small, rural, and remote communities

Service providers, community organizers, and policymakers have an opportunity to improve healthcare access in underserved regions through targeted incentives, such as relocation support, housing stipends, or practice establishment grants. Funding that supports the development of community-led clinics through both in-person and virtual models will ensure geography does not determine safety or quality of care, filling one of the clearest gaps this study has identified.

7

Make healthcare institutions safer and more supportive by prioritizing leadership and lived experience from within 2SLGBTQIA+ communities

By collaborating with well-informed 2SLGBTQIA+ academics and community members, federal and provincial research partners can promote health literacy that resists bias, reflects lived experience, and respects the full diversity of identities under the 2SLGBTQIA+ umbrella. This includes meaningful engagement with groups that this study has shown remain especially underserved in Canadian healthcare, including those who are Two-Spirit, trans, gender diverse, asexual, intersex, Black, Indigenous, racialized,

low-income, or living in rural and remote regions. At the institutional level, creating safer spaces depends on hiring and training dedicated support roles such as peer navigators, patient advocates, or equity officers. These roles are essential to reduce the emotional burden of self-advocacy, particularly in moments of illness or distress, and are key to rebuilding trust in a healthcare system that has too often marginalized or harmed 2SLGBTQIA+ people.

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Appendix B: Methodology

Research for the 2025 Pink Paper on Health was conducted by Environics Research between March and April 2025 in two stages:

- A 20-minute survey completed by individuals living in Canada who identify as 2SLGBTQIA+ and who do not identify as 2SLGBTQIA+
- Stakeholder interviews meant to enrich the survey findings

The qualitative data collected through open-ended survey questions and stakeholder interviews adds depth, nuance, and context to our quantitative findings. Quotes have been edited for clarity and length but are otherwise provided in participants' own words.

Survey Methodology

Questionnaire Design

The questionnaire was jointly developed by Environics Research and the Pink Paper's authors and consultants. It combined standardized and custom questions to assess socio-demographics, health status, access to and experiences of healthcare, and health priorities. It was available in English and French and took an average of 20 minutes to complete.

Environics Research used **Decipher** to program and test the survey for accuracy. To enhance qualitative insights, they integrated inca (Inquisitive Natural Conversation Agent), an AI-driven tool that mimics one-on-one interviews by prompting open-ended responses using natural language processing. Respondents were provided with the AI's privacy policy prior to participating in this study.

The survey was designed with mobile and desktop in mind and underwent thorough testing to ensure clear language, logical flows, and device compatibility.

Sample Design

The online panel survey targeted Canadian adults (18+) and was stratified by province and territory as well as age to ensure demographic representation. Specific 2SLGBTQIA+ subgroups, such as trans individuals, were oversampled to enable robust analysis. An open link distributed by Pink Triangle Press further oversampled 2SLGBTQIA+ participants; only those identifying as 2SLGBTQIA+ were eligible through this link.

- The panel survey ran between March 19 and April 7, 2025 (n=2,002)
- The open link version ran between March 24 and April 13, 2025 (n=108).

Both were non-probability samples, so no margin of error is reported. In total, **1,062 2SLGBTQIA+** and **1,048 non-2SLGBTQIA+** participants completed the survey.

Data Quality Procedures

Rigorous quality assurance measures were applied during data cleaning to eliminate the following:

- **Duplicates:** Identification and removal of duplicate responses through a two-step verification process.
- **Straight liners:** Respondents who selected the same answer in ≥ 30% of grid questions were flagged for potential removal after further review.
- **Racers:** Surveys completed significantly faster than the median completion speed, were suggestive of insufficient attention. These were assessed and removed.
- **Low-quality open ends:** Some responses that were incoherent, off-topic, profane, or repetitive were removed.
- **"Don't know" responses:** Respondents selecting "don't know" in ≥ 50% of questions were removed.
- **Incompletes:** Incomplete surveys were assessed for data value. If sufficient responses were usable (e.g. before dropout), they may have been retained; otherwise, they were excluded, particularly if demographic data was missing.

Analysis And Reporting

Survey data was analyzed using WinCross to generate summary tables and explore groups differences, including comparisons between 2SLGBTQIA+ and non-2SLGBTQIA+ participants.

Upon being presented with the data from Environics Research, the 2025 Pink Paper researchers issued recommendations for how to code and analyze the data based on best practices in the health and medical sciences. These recommendations included (i) segregating and presenting data for all identity groups individually to avoid masking or erasing disparities between subpopulations; (ii) scoring Likert-scale questions using a standardized method (+1 for favourable, 0 for neutral, and –1 for unfavourable responses) to better quantify disparities between 2SLGBTQIA+ and non-2SLGBTQIA+ cohorts; (iii) offering guidance on clear and consistent graphical representation of results to enhance data transparency and comparability; and (iv) conducting intersectional data analysis to look at the compounding effects of geography, income, education level, as well as other axes of structural and systemic inequity.

For some questions, respondents rated their agreement using a 5-point Likert scale (strongly agree to strongly disagree). Responses were coded/scored as +1 for favourable (agree/strongly agree), 0 for neutral (neither agree nor disagree), and –1 for unfavourable

(disagree/strongly disagree). Net scores were calculated for each identity group and then expressed as a percentage of the overall 2SLGBTQIA+ total score, allowing for meaningful comparison across identities.

Qualitative Interview Methodology

Environics Research conducted 16 virtual one-on-one interviews between March 27 and May 7, 2025. These interviews were conducted with stakeholders across Canada to gain deeper insight into current health disparities affecting 2SLGBTQIA+ communities as well as to better understand perceived challenges within the healthcare system, including gaps in access, quality of care, and systemic barriers.

Discussion Guide Design

The interview guide was designed by Environics Research and Pink Paper authors and consultants. It incorporated open-ended questions with probes that allowed for a conversation between the moderator and participant.

Stakeholder Identification

Pink Triangle Press provided Environics Research with a list of stakeholders who consented to being contacted for research purposes. This list was supplemented by Environics Research. Potential participants were sent individual invitations to participate. Participants did not receive an incentive for their participation. Video and audio was recorded for all interviews for use in subsequent analysis by the research team. During the recruitment process and at the session sign-in, participants were asked to consent to being recorded and were given privacy and confidentially assurances.

Stakeholder Composition

Interviewees included healthcare leaders, medical students, researchers, and healthcare professionals who specialize in 2SLGBTQIA+ health as well as Indigenous stakeholders. These stakeholders were located in Ontario, Quebec, Saskatchewan, Alberta, Manitoba, Nova Scotia, Newfoundland and Labrador, and British Columbia.

Moderation

All interviews were conducted in English by Environics Research using Zoom or Microsoft Teams, based on the interviewee's preferences. Each interview lasted approximately 30 minutes. Interviews were recorded for research purposes in accordance with professional standards and applicable government legislation (e.g. PIPEDA).

Analysis and Reporting

Recorded interviews were transcribed using Sonix, which applies speech-to-text algorithms to convert audio files to text. Environics Research's staff reviewed the transcripts for accuracy and anonymized all identifying information.

Analysis and reporting were conducted using thematic analysis. This approach enabled a systematic and nuanced understanding of participants' responses.

Additional Sociodemographic Characteristics of Study Sample

Age Distribution

2SLGBTQIA+ respondents skewed younger than their cisgender and heterosexual counterparts, with 33% of 2SLGBTQIA+ respondents aged 18–34, compared to 23% among non-2SLGBTQIA+ participants. Conversely, only 12% of 2SLGBTQIA+ individuals were 65 or older compared to 19% of the non-2SLGBTQIA+ group.

Age	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
18-24	10%	5%
25-34	23%	18%
35-44	25%	25%
45-54	14%	15%
55-64	15%	17%
65+	12%	19%

Ethno-Racial Background

There was greater representation of Indigenous (4% vs. 2%) and Black (8% vs. 7%) individuals within the 2SLGBTQIA+ group than the non-2SLGBTQIA group. Both groups had similar proportions of white respondents (69% 2SLGBTQIA+, 70% non-2SLGBTQIA+). Individuals identifying as persons of colour or of mixed backgrounds were distributed fairly evenly across groups.

Background	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Indigenous (First Nations, Métis, Inuit (Inuk))	4%	2%
Black	8%	7%
Person of Color	8%	10%
White	69%	70%
Mixed Background	5%	2%

Living Setting

The majority of respondents in both groups lived in large urban centres (61% 2SLGBTQIA+, 58% non-2SLGBTQIA+). Distribution across rural, small, and medium population settings was also comparable between groups.

Living setting	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
On-reserve	1%	1%
Rural (under 1,000)	7%	9%
Small population centre (1,000 to 29,999)	13%	13%
Medium population centre (30,000 to 99,999)	18%	19%
Large urban population centre (100,000 and over)	61%	58%

Immigration Status

A slightly higher proportion of 2SLGBTQIA+ individuals were born in Canada (78% vs. 74%). Rates of naturalized citizenship, permanent residency, and temporary visa status were relatively consistent across both populations.

Immigration status	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Born in Canada	78%	74%
Naturalized Canadian	11%	13%
Permanent resident	7%	8%
Refugee status	1%	-
Student or work visa	2%	3%

Income Levels

2SLGBTQIA+ respondents were more likely to report lower annual household incomes. 26% reported earning less than $40,000, compared to 20% of non-2SLGBTQIA+ respondents. Only 19% of 2SLGBTQIA+ respondents reported incomes of $120,000 or more, versus 22% of non-2SLGBTQIA+ respondents.

Income status	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Less than $39,999	26%	20%
$40,000 to $79,999	31%	31%
$80,000 to $119,999	19%	21%
$120,000 to $159,999	10%	12%
$160,000 to $199,999	4%	6%
$200,000 or more	5%	4%

Educational Attainment

Education levels were broadly similar between the two groups. However, a slightly higher proportion of 2SLGBTQIA+ respondents had completed some university without obtaining a degree (11% vs. 6%). Moreover, slightly fewer 2SLGBTQIA+ individuals were university graduates (26% vs. 31%).

Educational status	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Less than high school	1%	1%
Completed some high school	4%	4%
High school graduate or equivalent	16%	19%
Technical college, community college or CEGEP	21%	23%
Completed some university, but no degree	11%	6%
University graduate	26%	31%
Completed some post-graduate, but no degree	5%	3%
Completed post-graduate school	12%	11%

Employment Status

Employment patterns also highlighted differences between groups. 2SLGBTQIA+ respondents were less likely to be employed full-time (44% vs. 48%) and more likely to be self-employed (10% vs. 7%). A higher proportion of 2SLGBTQIA+ individuals were unemployed and looking for work (9% vs. 7%) compared to non-2SLGBTQIA+ individuals who were more likely to report being unemployed and not seeking work (16% compared to 11% of 2SLGBTQIA+ respondents).

Employment status	2SLGBTQIA+ (n=1062)	Non-2SLGBTQIA+ (n=1048)
Self-employed	10%	7%
Employed full-time	44%	48%
Employed part-time	11%	10%
Not working, but looking for employment	9%	7%
Not working and not looking for employment	11%	16%

Appendix C: Glossary

2SLGBTQIA+: The acronym 2SLGBTQIA+ stands for Two-Spirit (**2S**), **l**esbian, **g**ay, **b**isexual, **t**ransgender, **q**ueer, **i**ntersex, and **a**sexual. The "**+**" symbol signifies inclusion of a broad spectrum of gender identities and sexual or romantic orientations, such as agender, non-binary, aromantic, and pansexual, among others. The intentional placement of Two-Spirit at the beginning of the acronym acknowledges the longstanding recognition and respect for gender and sexual diversity within Indigenous communities who were the first on this land to honor such identities.

Agender: Agender refers to a person who does not identify with any gender. Individuals who are agender may see themselves as having no gender at all or as being gender neutral. Agender people might also describe themselves as genderless, lacking gender, or having an absence of gender identity altogether. Agender is a valid gender identity within the broader spectrum of non-binary identities, and agender individuals may use a variety of pronouns, including they/them, he/him, she/her, or others, depending on personal preference.

Aromantic: Aromantic refers to a person who experiences little or no romantic attraction to others. This means they do not typically feel the desire to form romantic relationships, though they may still have strong emotional bonds, friendships, or other forms of meaningful connection. Aromanticism is about romantic attraction, not sexual attraction. An aromantic person might still experience sexual attraction (e.g. be heterosexual, homosexual, bisexual, asexual, etc.), or they might not. Aromantic individuals may identify on a spectrum, for example, grey-romantic (rarely experiences romantic attraction) or demiromantic (only experiences romantic attraction after forming a strong emotional bond). Being aromantic doesn't mean being emotionless or incapable of love; many aromantic people form deep, fulfilling relationships that simply aren't romantic in nature.

Asexual: Asexual refers to a person who experiences little or no sexual attraction to others. This means they typically do not feel the desire to engage in sexual activity with others, though they may still form romantic, emotional, or platonic relationships. Asexuality is about sexual attraction, not romantic attraction. An asexual person can still be romantic (e.g. heteroromantic, homoromantic, biromantic, aromantic).

Like aromanticism, asexuality exists on a spectrum. Grey-asexual (grey-ace), for instance, is a label used by some asexual people who occasionally or infrequently experience sexual attraction. Demisexual, meanwhile, is often used by people who experience sexual attraction only after forming a strong emotional connection.

Asexual people may or may not engage in sexual activity for various reasons (e.g. intimacy, partnership, or personal preference). Their orientation is defined by the lack of sexual attraction, not behaviour.

Bisexual: Often shortened to bi, people who experience sexual or romantic (biromantic) attraction to people of more than one gender. The "bi" typically refers to genders similar to and different from one's own. Bi+ is often used to be inclusive of other identities, including pansexual, fluid, and queer.

Cisgender: Often shortened to cis, a term used to refer to a person whose gender aligns with their sex assigned at birth (e.g. cis man, cis woman). The prefix cis comes from the Latin preposition for "on the same side of." It is independent from sexual orientation.

Cishet: People who are both cisgender and heterosexual. This term is not pejorative.

Cisheteronormativity: The dominant cultural attitude that assumes and imposes a continuity between sex, gender, and sexual orientation. The term combines the words cisnormativity (the assumption that everyone is or should be cisgender) and heteronormativity (the assumption that everyone is or should be heterosexual) to reflect the socially-imposed causality between the two. Cisheteronormativity includes the implicit notion that being cisgender and heterosexual is the "default" identity and that all other genders and orientations are consequently outside the norm. As a system of privilege, cisheteronormativity intersects with sexism, racism, ableism, classism, and other forms of systemic oppression.

Cultural competency: A set of overlapping behaviours, attitudes, and policies that allow professionals to interact compassionately and effectively with people from diverse cultural backgrounds. Cultural competency requires a reflective awareness of different values, knowledges, and experiences, and demands that professionals forgo their assumptions in favour of soliciting information from individuals themselves.

Determinants of health: The complex interplay of biological, behavioural, social, environmental, and systemic factors that influence health.

Endosexnormativity: Endosexnormativity reflects a dominant belief system that presumes all people are born with sex characteristics that fit neatly into binary categories of male or female. This norm marginalizes intersex people, those whose sex traits do not fit conventional binary definitions. Endosexnormativity is embedded in medical systems, laws, language, education, and everyday interactions, often leading to:

- Erasure of intersex existence (e.g. lack of inclusion in forms, research, or policies).
- Pathologization of intersex bodies (e.g., unnecessary or non-consensual surgeries to "normalize" sex traits).
- Social invisibility (e.g. being forced to identify within binary categories that don't reflect their bodies or identities).

Much like cisnormativity, endosexnormativity reinforces a rigid binary framework for sex and gender, contributing to the systemic marginalization of those who fall outside of it.

Gay: People who are sexually or romantically attracted to people of the same gender. While it often refers to men who experience attraction to men, people with other gender identities may also use this term to describe themselves.

Gender expression: The external presentation and communication of gender through any combination of clothing, hairstyle, behaviors, body language, mannerisms, vocal patterns, and so on. Pronouns and chosen names can also be a form of gender expression. Given that gender is socially constructed, understandings of gender expressions relating to femininity, masculinity, both, and/or neither may differ across social contexts. A person's gender expression does not automatically correspond to their gender identity.

Gender identity: A person's individual experience of their own gender. Gender itself is a set of socially constructed roles, behaviours, and attributes that a given society ascribes to a person's sex. One's gender identity can be the same as (cis) or different from (trans) their sex and is not necessarily the same as their gender expression. People who do not identify with or experience any gender often use the term agender to describe themselves. Gender identity can change over the course of a person's lifetime.

Genderqueer: Genderqueer is a term often used interchangeably with non-binary, but it emphasizes a resistance to conventional gender norms and categories. Someone who identifies as genderqueer may intentionally defy or blur gender distinctions in how they express themselves or how they experience gender. The term is often associated with a political or activist stance on gender. Genderqueer people may feel partially male and female, neither, or something entirely unique.

Health inequalities: Measurable differences in health status or outcomes across population groups.

Health inequities: Differences in health status or distribution of health resources between different groups as a result of social injustices and systemic oppression.

Heterosexual: Also referred to as straight, either a woman who is attracted to men or a man who is attracted to women.

Homosexual: Due to its history as a clinical term used to pathologize gay, lesbian, bisexual, pansexual, and queer people, this term is no longer commonly used in English. See instead **Gay** and **Lesbian**.

Intersex: An umbrella term that refers to people who are born with sex characteristics medically associated with female and male biology. These characteristics include reproductive anatomy, primary or secondary sex characteristics, hormones, chromosomes, or internal and external genitalia. Intersex refers to biological sex and is distinct from gender identity.

Intersectionality: Coined by legal scholar and civil rights advocate Kimberlé Crenshaw, this term refers to the way multiple social identities overlap with and affect each other, producing distinct experiences of oppression. Importantly, intersectionality is not a theory of addition. A Black lesbian woman does not experience racism, sexism, and homophobia as discrete forms of oppression but as layered forms of inequality that exacerbate one another. Her experience of racism will differ from that of a Black man, and her experience of homophobia will differ from that of a white lesbian. Meaningful efforts to dismantle cisheteronormativity must also be attentive to the way cisnormativity and heteronormativity intersect with racism, sexism, ableism, and other forms of systemic oppression.

Lesbian: Typically, women who experience romantic and/or sexual attraction to other women. However, the above definition relies on a rigid gender binary that excludes people who do not identify as women (e.g. non-binary lesbian; genderfluid lesbian). A more inclusive definition acknowledges relationships outside binary gender norms. This second definition is more representative of our research participants.

Minority stress theory: A framework that foregrounds the disproportionate levels of stress experienced by members of minority groups. Minority stress can be caused by several interrelated factors, including low socioeconomic status, poor social support, prejudice, stigma, and discrimination. Minority stress is experienced asymmetrically by individuals within the 2SLGBTQIA+ umbrella. For example, bisexual people report lower levels of happiness and community belonging than their lesbian, gay, and straight counterparts due in part to their experiences with marginalization from both lesbian/gay and straight groups.

Non-binary: Non-binary is an umbrella term for gender identities that do not fit exclusively within the categories of male or female. Non-binary individuals may identify with aspects of masculinity, femininity, or a different gender entirely, including no gender at all. Some non-binary people may also identify as genderfluid, bigender, agender, or other specific identities. The term challenges the traditional gender binary (masculine vs. feminine). Non-binary people may use a range of pronouns and may or may not seek to medically or socially transition.

Pansexual: Sometimes shortened to pan, this term refers to people who experience sexual or romantic (panromantic) attraction to people of all genders or regardless of gender. Although pansexual is often included under the bi+ umbrella, pansexuality and bisexuality mean different things to different people. When referring to others, it is important to use the terms people use to identify themselves.

Queer: An umbrella term that refers to a wide variety of people across a spectrum of gender identities and sexual orientations. The term has been reclaimed from its pejorative use and should only be used by someone who adopts this label themselves or when quoting someone who does.

Questioning: A term used to describe individuals who are engaged in a process of discovering or determining their sexual orientation, gender identity, gender expression, or any combination thereof. Questioning can be used to refer to an ephemeral period in a person's life, but it can also be a lasting identity in its own right. Importantly, questioning does not imply that an individual is "choosing" a particular identity so much as questioning the default presumptions imposed by a cisheteronormative society.

Romantic orientation: An individual's pattern of romantic attraction regardless of sexual orientation. See also **Sexual Orientation**.

Sex: Also referred to as biological sex, the physiological, genetic or physical attributes that determine if a person is intersex, female, or male. These attributes include primary and secondary sex characteristics, including genitalia, gonads, hormone levels, hormone receptors, and chromosomes. Sex is often erroneously conflated with gender, which is a set of socially constructed roles, behaviours, and attributes.

Sexual orientation: A term that is conventionally used to describe an individual's experience of emotional, sexual, and/or romantic attraction. Some individuals do not experience romantic or sexual attraction (e.g. aromantic or asexual). It is important to note that romantic and sexual orientations are not mutually exclusive; for some people, they are the same (e.g. pansexual and panromantic) while, for others, they are different (e.g. asexual and biromantic). Sexual activity does not define an individual's sexual orientation. For some, their sexual orientation remains the same their entire lives while others experience their orientation as fluid. See also **Romantic Orientation**.

Social determinants of health: In the context of health determinants, these are socioeconomic factors that significantly influence a broad spectrum of health, functional, and quality-of-life outcomes. Such factors include income, education, employment ethnicity, sex, gender identity, and sexual orientation. When these differences arise from systemic disadvantage, discrimination, or marginalization, they become **Health Inequities**.

Transgender: Often shortened to trans, a term that refers to a person whose gender identity does not necessarily match their sex at birth. The prefix trans comes from the Latin preposition meaning "on a different side from." Other groups of people who transcend social expectations around gender identity and expression—including androgynous, gender diverse, and non-binary individuals among others—may use trans as an umbrella term, but not all do. It is important to respect the terms people use to describe themselves. The term trans is independent of sexual orientation.

Two-Spirit (2S): Sometimes written as 2-Spirit or 2S, an umbrella term used by some Indigenous people of Turtle Island (North America) that encompasses sexual, gender, and/or spiritual identity. This term should not be used by people who are not Indigenous and should only be used to describe an Indigenous person if they use it to describe themselves.

Appendix D: Additional Resources

Canadian Medical Association: What is LGBTQ+ inclusive health care in Canada and how does it work?
Information and resources for 2SLGBTQIA+ health and services.
https://www.cma.ca/healthcare-for-real/what-does-2slgbtqia-inclusive-care-mean-canada#:~:text=The%20LGBTQ+%20Healthcare%20Directory:%20A,What%20experts%20are%20saying

The LGBTQ+ healthcare directory
Free, searchable database of doctors, medical professionals and healthcare providers who are knowledgeable and sensitive to the unique health needs of LGBTQ+ people in the USA and Canada
https://lgbtqhealthcaredirectory.org

Canadian Professional Association for Transgender Health
https://cpath.ca/en/

Rainbow Health Ontario
https://www.rainbowhealthontario.ca

TransCare BC
https://www.transcarebc.ca

Qmunity
https://qmunity.ca

PrideHealth Nova Scotia
https://www.nshealth.ca/clinics-programs-and-services/pridehealth

Rainbow Resource Centre (Manitoba)
https://rainbowresourcecentre.org

The 519 (Toronto)
https://www.the519.org

Trans Lifeline
https://translifeline.org

PFLAG Canada
https://pflagcanada.ca

Egale Canada
https://egale.ca

It gets better Canada
https://itgetsbettercanada.org

LGBT Youthline
https://www.youthline.ca

TransPulse Canada
https://transpulsecanada.ca

Asexual Visibility and Education Network
The world's largest online asexual community. It also serves as a robust archive of resources on asexuality.
https://asexuality.org

Intersex Campaign for Equality
An organization promoting human rights and equality for all intersex people through art, education, and action.
https://www.intersexequality.com

Xtra Magazine
Xtra is a non-profit online magazine and community platform covering 2SLGBTQIA+ culture, politics, relationships, and health.
https://xtramagazine.com