

**A Postcolonial Queer Analysis of Aboriginal Queer Clients' Experiences of Health
Care Services in St. John's, Newfoundland**

by

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ABSTRACT

This thesis examines the gaps between health care services aimed at Aboriginal queer individuals living in St. John's, Newfoundland and their health care needs. I used a multi-methods research design that includes interviews and demographic surveys, unobtrusive observation and qualitative content analysis. I conducted semi-structured interviews with institutional representatives from selected health related organizations – Eastern Health, Planned Parenthood Newfoundland and Labrador, the AIDS Committee of Newfoundland and Labrador, and St. John's Native Friendship Center; as well as a transgender activist and three people who identify as Aboriginal and queer. I conducted observational research at two public seminars on Aboriginal people and health. Finally, I carried out qualitative content analysis of organizational reports and webpages of the selected community organizations. Using a postcolonial queer framework that analyzes how Newfoundland and Labrador's colonial history is reflected in current health care realities I argue that the lack of appropriate services and culturally insensitive delivery of services reproduce the historical marginalization of an already vulnerable group.

Key words: Aboriginal, queer, health, postcolonial, Eastern Health, Planned Parenthood Newfoundland and Labrador, AIDS Committee of Newfoundland and Labrador, St. John's Native Friendship Center

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Chapter 1: Introduction

It is a process to know that anybody who doesn't fit in the standard box is going to be a shock to the system for these doctors...and for the system in general. And so, how do you break it to them? You feel (sigh), maybe it's a weird way to say it but you feel like you're disappointing them. Like, 'oh I'm not this person you thought I was'. For every bit of yourself that you identify as 'this is what's unique about me' that that makes you feel like you go down in standing and you potentially become less worthy of care (Mariah, Aboriginal queer participant interview, January 27, 2015).

In this thesis I examine discrepancies between health care services aimed at Aboriginal queer individuals living in St. John's, Newfoundland and their health care needs. This research is significant in that it addresses issues pertinent to the fact that Aboriginal people are among the most marginalized in Canada. This manifests in social problems such as higher mortality rates, chronic conditions, as well as increased rates of mental health issues (Alaghebandan, Sikdar, Collins, & Rossignol, 2010; Noël, & Larocque, 2009; Heath, Cornelisse, Strathdee, Palepu, Miller, Schechter, O'Shaughnessy, & Hogg, 1999). Aboriginal women are particularly vulnerable because they are more likely to live in unstable housing, be unemployed, experience poverty level incomes, and chronic health conditions such as diabetes and heart problems (*Statistics Canada*, 2013).

Queer individuals in Canada are also marginalized and experience discrimination when accessing health services due to invisibility of their health care needs (Brotman, Ryan, & Cormier, 2003). This issue is exacerbated by people's unwillingness to "come out" to their doctors due to fear and past negative experiences. Some research suggests that not disclosing one's sexual orientation to their family doctor results in lower rates of consultation, as is the case for Canadian lesbians (Tjepkema, 2008). Economic, mental,

and social stress brought on by marginalization impacts one's mental health and it increases one's interactions with health care institutions. Thus, economic factors are interconnected with social factors and health outcomes such as depression and HIV infection.

For this study I have chosen the terms "Aboriginal" and "queer" to describe my target sample. Queer is an inclusive term that includes non-heterosexual and gender variant identities such as two-spirit, gay, transgender, and non-gendered individuals. Labels associated with First Nations peoples in Canada have changed over time; these labels serve to designate either a narrow cohort or the wider social grouping. In terms of language used to define a narrow cohort in Canada, "Indian" is used to describe status or registered "Indians",¹ whereas "Aboriginal", "native" or "indigenous" is used to identify both registered and non-registered individuals. Language use also depends on the politics involved in particular descriptions; "First Nations" may be used to convey a sovereign political unit (Milke, 2013). For the purposes of this project I primarily use the term "Aboriginal" as Milke (2013) uses this term, "to describe a larger cohort that includes status and non-status First Nations, Inuit and Métis people" (p. 6).

There are four main Aboriginal groups in Newfoundland and Labrador; Inuit, Innu, Mi'kmaq, and Qalipu. Labrador has a substantial Inuit population, as almost three-quarters of Inuit in Canada live in Inuit Nunangat, which stretches from Labrador to the Northwest Territories and contains four regions: Nunatsiavut (Labrador), Nunavik,

¹ I recognize that the word "Indian" has a problematic history and that many Aboriginal people reject this word partly because it is a label imposed by imperialist powers that ignores differentiation between and within Aboriginal groups (See Meyer-Cook & Labelle, 2004).

Nunavut and Inuvialuit. There are also the southern Labrador Inuit of NunatuKavut, formerly known as the Labrador Métis (Brunger & Russell, 2015). Labrador also has a large Innu population, most of who live in specific communities, such as Natuashish, near Hopedale on the northeast coast of Labrador (Claxton-Oldfield, & Keefe, 1999). In Newfoundland, the Aboriginal population mostly identifies as Mi'kmaq and Qalipu (*Aboriginal Peoples*, 1997; Anderson 2013), however many Aboriginal people are not officially recognized.

My guiding research questions are: what kinds of programs and services designed for Aboriginal queer people, if any, does Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), AIDS Committee Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC) provide? How are these institutions in St. John's addressing Aboriginal, queer, and Aboriginal queer health needs? What are the experiences of Aboriginal queer individuals when accessing health care?

The study

This study takes place in St. John's, Newfoundland and Labrador. Labrador is located northeast of Quebec and the island of Newfoundland is the easternmost part of Canada (see Appendix A). The city of St. John's is located on the Avalon Peninsula attached to the island of Newfoundland and it is Canada's most eastern settlement.

I used a multi-methods research design that includes seven semi-structured interviews, demographic surveys, unobtrusive observation and qualitative content

analysis. I led three interviews with Aboriginal queer participants and one interview with Taylor Stocks, a transgender non-Aboriginal activist. I conducted three interviews with institutional representatives from selected community health related organizations – Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee of Newfoundland and Labrador (ACNL), and St. John’s Native Friendship Center (SJNFC). I decided that Eastern Health, PPNL, ACNL, and SJNFC were the most appropriate organizations to analyze for the purposes of this project based on their social programs, medical services and links to queer, Aboriginal, and Aboriginal queer peoples. In addition, I reviewed two health related surveys and analyzed institutional reports and webpages from the selected organizations.

Eastern Health is the province’s largest, most integrated health authority. They provide a full continuum of health and community services including specialist services for all residents of the province (*Health Council Canada*, n.d., p. 4). Planned Parenthood Newfoundland and Labrador (PPNL) provides medical care, social support, and sexuality education (*Thrive*, 2015). The Aids Committee of Newfoundland and Labrador (ACNL) aims to eliminate HIV/AIDS and Hepatitis from the province and they strive toward these goals by providing education, a clean needle program for intravenous drug users, and a low-barrier shelter that does turn away clients who use drugs or alcohol (*ACNL*, n.d.). The St. John’s Native Friendship Center (SJNFC) is the only organization in St. John’s that specifically focuses on the urban Aboriginal population and they provide cultural education services and social support to all people regardless of their Aboriginal status (*Memorial University*, n.d.).

I interviewed a transgender activist who does not self-identify as Aboriginal and three people who identify as Aboriginal and queer. These interviews show how client experiences compare with health care discourses and services. I conducted observational research at two public seminars about Aboriginal people and health. On March 18, 2014 I attended a discussion circle sponsored by Memorial University's Aboriginal Resource Office called Aboriginal Talks: Empowerment, Status, and Identity which consisted of a presentation about smudging and an opening prayer led by Inuk Elder Emma Reelis followed by an open discussion about Aboriginal identities and empowerment. The second seminar I attended was the Tuned In: Intercultural and Interdisciplinary Roundtable on Health on February 10, 2015 sponsored by the Music, Media, and Place (MMaP) where speakers discussed challenges faced by Eastern Health, Aboriginal conceptualizations of health, and the benefits of music therapy. These seminars helped me understand how the Inuit of southern Labrador conceptualize health and helped me define health for this study. Finally, I carried out qualitative content analysis of organizational reports and webpages of the largest local health authority, Eastern Health, and the selected community organizations. I provide a richer discussion about these organizations and my data sources in the next chapter and in chapter three.

I document health care discourse and available services at the selected organizations and compare this with Aboriginal queer individuals' experiences when trying to access and use health care services. Using a postcolonial queer framework that analyzes how Newfoundland and Labrador's colonial history is reflected by current health care realities I argue that the lack of appropriate services and culturally insensitive

delivery of services reproduce the historical marginalization of an already vulnerable group. Significant discrepancies between services offered and experiences of use negatively impact participation in health care and constrain the capability of Aboriginal queer clients to achieve and maintain good health in St. John's.

In webpages and reports, institutional discourse reveals how Aboriginal queer clients are constructed and situated in St. John's within organizational contexts. My analysis uncovers how this population is perceived as well as the effects of discourse on social inclusion and well-being. Through qualitative content analysis the current research takes into account how dominant discourses of sexuality and Aboriginality shape and limit Aboriginal queer experiences. Postcolonial queer analysis of textual and interview data is used to uncover how Aboriginal queer clients are constructed in ways that connect Newfoundland and Labrador's colonial past to current health care realities in St. John's.

I conducted face-to-face, semi-structured qualitative interviews with institutional representatives from PPNL, ACNL, SJNFC, three Aboriginal queer participants, and a transgender activist to gather data about accessing health care services. Low recruitment numbers may be attributed to the fact that there was no compensation offered to participants and to research-related burnout of queer persons in St. John's. I expand on recruitment issues in chapter nine. Interview questions regarding access and experiences of using of health care services illustrate participants' knowledge of health care services, what they have access to in terms of transportation and institutional barriers such as acquiring a referral, as well as the services they use and why. Questions regarding experience of use and access capture motivations that contribute to health care decisions;

experiences dictate the amount of disclosure clients exercise and whether or not Aboriginal and Aboriginal queer people are willing to access particular health care services. Participants were recruited through public advertising via posters in the Health Science Center, on Memorial University's campus, the Resource Center for the Arts, as well as various clinics and locations in downtown St. John's. Volunteers were also invited to participate by contacting LGBT MUN and the Native Friendship Center in St. John's Newfoundland. Snowball sampling was used in conjunction with both of these recruitment methods in an effort to broaden my sample. Participants were selected from those who have access to Eastern Health services and were 19 years of age or older. I wanted to capture a range of health care needs, levels of use, and experiences of health care services. However, the participants were between the ages of 26-40 which does not reflect as wide a range of health care use as I would have liked. Interviews ranged in time between 20 minutes and two hours.

I describe and problematize institutional data with reference to how client feedback is sought out and used; programming; intake forms; and structural factors, such as invisibility of Aboriginal culture in the province, that impact institutional efforts. Interview data from Aboriginal queer participants is compared to organizations' claims and reports and is grouped according to themes associated with being Aboriginal in St. John's, cultural insensitivity and holistic health care, delivery of health care services, and structural factors that include a lack of available doctors and transportation options. Data analysis was conducted using postcolonial queer theory as expressed by Browne, Smye, and Varcoe (2005); Browne and Smye, (2002); as well as Spurlin (2001). A postcolonial

queer analytical framework helps to interpret access and experiences of using health care services by showing how hegemonic power structures have shaped Aboriginal queer participants' utilization of health care services. This framework allows me to examine health care discourse in relation to marginalization, invisibility, and social exclusion characteristic of Newfoundland and Labrador's colonial past in order to demonstrate how these conditions are reflected in current health care realities to the detriment of Aboriginal and queer clients. My analysis illustrates gaps between available health care services and Aboriginal queer participants' experiences of accessing these services which negatively impacts health care participation and, therefore health.

By addressing the stated research questions through semi-structured interviews, demographic surveys, unobtrusive observation, and qualitative content analysis this study examines institutional health discourses and access to health care services for Aboriginal, queer and Aboriginal queer clients, and explores client experiences in relation to institutional claims. I draw from participant experiences and the results of similar studies to recommend ways institutions can move forward in addressing Aboriginal queerness in a manner that improves health care services and promotes social inclusion. Results from this research can be used to support funding for existing programs and provide direction for meeting any unmet health care needs of Aboriginal queer people.

Social significance

This research is significant because of its potential to shape institutional approaches to Aboriginal queer health care and well-being in St. John's. By assessing

Eastern Health programs and services the current research provides valuable data that speaks to the effectiveness of these efforts in relation to client experiences of these services. In contrast to previous research that has a national focus and does not account for queer participants' ethnicities (Tjepkema, 2008; Moran, 1996), this study illustrates discrepancies between services and experiences of use in relation to Aboriginal queer clients within a St. John's-specific context.

As Tanner (1998) shows, when Newfoundland and Labrador was included in the confederation of Canada in 1949 the Aboriginal people present in this province were treated as invisible by the Canadian government. Although it was assumed that programs and supports that were present in the rest of Canada would be developed this issue was not addressed until several years after confederation. Even though Aboriginal roots were present in Newfoundland and Labrador, Aboriginal identities were often eclipsed by identities that were more amenable to the dominant culture (Bartels, & Bartels, 2005). Because initially no provisions were made for recognition of Aboriginal people in Newfoundland and Labrador, and Aboriginal identities were often effaced due to racism, many people are unaware of their Aboriginal heritage. Therefore, the damaging aspects of colonialism are still applicable in this province in ways that do not necessarily apply to other provinces which experience their own particular brand of colonialism. Research that concentrates on the experiences of Aboriginal peoples in Newfoundland and Labrador is especially needed because of a unique colonial past that shapes the lives of Newfoundland and Labrador residents.

This historical development has been significant for Aboriginal people in the province seeking official status. Nearly six out of ten Aboriginal people in Newfoundland and Labrador do not have federal registered “Indian” status, but to receive certain benefits one must have this registered status. Some of these benefits include tax exemptions for income generated on a reserve, exemption from paying GST or HST on goods bought on a reserve, health coverage by the Non-Insured Health Benefits (NIHB) Program which provides coverage for vision and dental care among other medical services, funding support for on reserve housing renovations and building, and those with registered status can apply for financial aid to attend a post-secondary institution (*CBC News*, 2014). In Newfoundland and Labrador, 31.5% of First Nations people have registered “Indian” status and live on reserve, the lowest proportion among the provinces (*Statistics Canada*, 2011).

Because I am analyzing Aboriginal queer intersections this research is significant for the development and delivery of queer health services in St. John’s. Creating health care spaces where queer clients feel safe to ‘come out’ to their health care providers is especially important to having their health care needs met (Brotman & Ryan, 2001). In order for queer clients to feel comfortable with sharing sensitive sexual information that is important for receiving care they need to feel as though they are respected and welcome. In the current study participants describe their health care experiences in relation to being queer and how that shapes the utilization of health care services. In addition, I discuss ways to improve health care services for queer clients in relation to existing literature and participants’ experiences. Thus, interview data and discussions

from this study can be used to improve the health care experiences of queer clients in St. John's.

Thesis outline

This study of Aboriginal queer access and experiences of using health care services consists of nine chapters. Chapter one is an introductory chapter that provides information on the guiding research questions, scope of the project, methodology and data collection, theoretical perspective, and analysis. The social significance of the research is discussed and the current study is situated within a specific historical context unique to Newfoundland and Labrador. In the second chapter I provide social and historical contextual information about the Aboriginal and queer populations in Newfoundland and Labrador. I outline the history of Aboriginal peoples in Newfoundland and Labrador and social changes that impact how Aboriginal identities are affirmed. I then discuss how queerness has taken shape in Newfoundland and Labrador. Finally, I outline populations at risk of poor health and profile selected institutions.

Chapter three contains a detailed literature review. I begin this chapter by detailing how I operationalize health in the current study. The literature review section is divided into three interconnected themes: exclusion in research, health disparity, and social determinants of health, which refers to key living conditions that direct health outcomes. These themes were chosen based on the high frequency with which they occurred in the current literature. This provides a basis for understanding perspectives within the current area of study, previous research objectives, as well as theories and

methods used in previous studies. The fourth chapter is devoted to my analytical framework. I discuss the merits of postcolonial theory, as well as some of the criticisms levied against this theory and how I have addressed these criticisms within the current study. I demonstrate that a postcolonial queer analytical framework is complimentary to studying Aboriginal queerness because it allows the researcher to account for historical relations that affect current realities. Queerness is often read as a White phenomenon, and postcolonial analysis demonstrates how conditions of colonialism are reflected in health care discourse and continuing health inequities.

Chapter five details the methods I used for my study of Aboriginal queer clients' experiences of using health care services in St. John's. I begin this chapter by outlining the goals of the current study and the methods used to meet these goals: semi-structured interviews, demographic surveys, unobtrusive observation in public seminars, and qualitative content analysis. I then detail every data source generated by using these methods. Finally, each method is discussed in more detail with separate sections about semi-structured interviews and demographic surveys, unobtrusive observation, and qualitative content analysis. I link the use of these methods to my postcolonial queer analytical framework by describing how data was analyzed.

In the sixth chapter I use a postcolonial queer framework to analyze health care discourses and how health care services are mediated by dominant institutions. This chapter focuses on four organizations in St. John's; Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC). These organizations provide

a range of social and medical services that have the potential to facilitate better health and well-being. I problematize and describe interview and textual data which reveals that there is a lack of services for Aboriginal queer clients and the effectiveness of existing services is impacted by insensitive delivery and wider structural factors that impact institutional efforts.

Chapter seven is a detailed postcolonial queer analysis of Aboriginal queer participants' experiences in relation to accessing health care services aligning with themes of being Aboriginal in St. John's, cultural insensitivity and holistic health care, delivery of health care services, and structural factors that include a lack of available doctors and transportation options. This analysis focuses on how experiences illustrate a different picture of health care than what is stated in institutional data. I demonstrate that these experiences in relation to using health care services limit the ability of Aboriginal queer clients in St. John's to achieve and maintain good health.

The eighth chapter links information from chapters six and seven in a discussion that illustrates gaps between services and experiences of use. I review information from chapters six and seven and then discuss discrepancies between available services and experiences of use in detail. I then outline possible practices that could be adopted in St. John's to improve Aboriginal queer clients' experiences. Social circumstances unique to St. John's are taken into account by noting the amount of stigma associated with Aboriginal queerness and how practices can be altered to create safe spaces that do not put clients at risk. In chapter nine I briefly restate key points from each preceding chapter and discuss the limitations of the current study. I end this chapter with a review of

Canadian research done with Aboriginal queer people and a discussion of areas for future research that focuses on institutional responsibility.

Chapter 2: The Social and Historical Contexts of Newfoundland and Labrador

Recognizing social and historical contexts unique to Newfoundland and Labrador is important in order to better understand the circumstances associated with being Aboriginal and queer in St. John's. In this chapter I outline the history of Aboriginal peoples in Newfoundland and Labrador and detail social changes that shift how Aboriginal identities are affirmed by the Canadian government. In 2015, after decades of invisibility in the eyes of the federal government and within Newfoundland and Labrador Aboriginal people are being offered a new avenue for affirming their identities. This has spurred a reawakening of particular Aboriginal traditions and cultures. I discuss how queerness is shaped by dominant forces; Judeo-Christian religions, rurality, and geographic isolation. Although there is not much known about queerness in Newfoundland and Labrador the influence of religion and rural communities has been linked to heterosexism and homophobia. These links are apparent in some of the anti-gay material distributed in the province. To provide further context for the current study I outline populations at risk of poor health in the province, which include Aboriginal and queer peoples. I also discuss the delivery of health care services through local organizations and the institutions I have selected for the current study.

Newfoundland and Labrador is a province that has three recognized cities; Corner Brook, Mount Pearl, and St. John's. Mount Pearl and St. John's are contiguous and Corner Brook is on the west coast of the island of Newfoundland. According to statistics from 2014, at the time of this writing the province has a population of 526, 977 people

(*Population and Demographics*, 2014). Of these, 275, 636 of these people live on the Avalon Peninsula with the St. John's area having a concentration of 211, 724 people and Corner Brook a population of 20, 083. Labrador has a population of 27, 730 with 2, 712 people residing in Labrador Nunatsiavut, an Inuit territory that extends to the Quebec border (*Population and Demographics*, 2014). Thus, an estimated 295,170 people live in rural towns, over half of the provinces' population. The 2006 Canadian Census indicated that there was a total of 23, 450 people who identified as Aboriginal living in Newfoundland and Labrador, which was 0.047 % of the province's population (*Statistics Canada*, 2007). In September 2011, the Qalipu Mi'kmaq First Nations Band officially received status recognition as a landless band from the federal government; to date 103, 000 people have applied for membership which is far greater than what was expected (Robinson, 2014, p. 384). This suggests that Aboriginal people are underrepresented in the 2006 statistics.

Being Aboriginal in Newfoundland and Labrador

As discussed in the first chapter, being Aboriginal in St. John's carries a unique set of circumstances as compared to the rest of Canada. When Newfoundland and Labrador joined the confederation of Canada in 1949 the Canadian government did not officially recognize the Aboriginal peoples present in the province (Tanner, 1998). In addition, Aboriginal identities were often denied in favor of identities more accepted by the dominant culture (Bartels & Bartels, 2005). A lack of recognition by the Canadian federal government combined with factors such as dwindling populations, dispersed

settlement, intermarriage between European settlers and Aboriginal peoples, and absorption into the dominant culture has provided the impression that there are few, if any, Aboriginal peoples present in the province.

Newfoundland and Labrador has been home to a number of Aboriginal groups throughout history, including the Beothuk, Mi'kmaq, Inuit, and Innu. The Beothuk lived in Newfoundland from 800 A.D. to 1829 and are thought to have become extinct around 1829 when Shawnadithit, a captive Beothuk woman, died in St. John's (Neis, 1995). The notion that the Beothuk are extinct may not be accepted by all residents of Newfoundland and Labrador. In an interview excerpt from Mariah, an Aboriginal queer participant, she said "I'm not even one of throngs of people who claim to be part Beothuk" (interview, January 27, 2015).

The Mi'kmaq historically held territory from eastern Quebec through the Maritime Provinces into Newfoundland but as European settlement of Newfoundland increased the Mi'kmaq shifted their activity towards the south coast of Newfoundland and maintained trade relations with European settlers (Neis, 1995). The Mi'kmaq became more dispersed throughout the province as time progressed. The Conne River reserve, in south central Newfoundland, is a Mi'kmaq community. The landless Qalipu Band, on the West Coast of the Island, is also made up of Mi'kmaq people, both are discussed in more detail later in this section. The Inuit in northern Labrador established religious relationships with Moravian missionaries and trade relationships with European settlers which provided the basis for peace and protection of Inuit culture during European expansion into Canada (Neis, 1995). European and Inuit cultures became closely

interwoven as a result, as “during the 19th century, Northern Labrador European traders frequently married Inuit women and adopted many Inuit tools and practices” (Neis, 1995, p. 12). There is also a southern Labrador Inuit group living in NunatuKavut who were once called Métis, signifying Aboriginal and European mixed heritage (Brunger & Russell, 2015). However, persistent distribution of government funds to the northern Inuit and not to the southern Inuit perpetuated the idea that Métis are not truly Aboriginal (Brunger & Russell, 2015). Thus, the Labrador Métis Nation is now called the southern Inuit. The Innu people of the Quebec-Labrador peninsula had strong trade relations with the French where they acted as negotiators between the French and Innu people from further inland (Neis, 1995). Melding of Aboriginal, European, and French peoples and cultures as well as a lack of government records noting Aboriginal heritage may have contributed to a loss of Aboriginal identities and cultures in Newfoundland and Labrador. Decades of invisibility of Aboriginal cultures and identities that stems from a range of sources has fostered the impression that there are few Aboriginal peoples currently present in St. John’s. This has impacted awareness of Aboriginal cultures, including Aboriginal-specific contexts of queerness.

The social landscape of Aboriginal identities has shifted in Newfoundland and Labrador over the last thirty years. In 1984 the Conne River Mi'kmaq became Newfoundland and Labrador's first Aboriginal people to register under the federal Indian Act after years of negotiations (*Heritage Newfoundland and Labrador*, n.d.). Conne River became a status reserve three years later, however various Mi'kmaq land claims remain unsettled. Having official status under the Indian Act allows for Conne River to

obtain government funding for self-governed health, education, and economic development (*Heritage Newfoundland and Labrador*, n.d.). The Inuit settled a land agreement to establish Nunatsiavut in 2004 and became self-governing one year later with the formation of the Nunatsiavut government (*Heritage Newfoundland and Labrador*, 2015). The Innu Nation was recognized with federal status in 2002 and the Innu communities of Natuashish and Sheshatshiu in Labrador were formally recognized as reserve lands in 2003 and 2006, respectively (*Heritage Newfoundland and Labrador*, 2015). The Labrador Métis Nation, consisting of 6, 000 Métis people living in Labrador, filed a land claim in 1991 for land in central and southeastern Labrador which awaits the federal government's decision (*Heritage Newfoundland and Labrador*, 2015). The Labrador Métis Nation later changed the name of their territory to NunatuKavut as an act of resistance to government efforts that undermined the group's identity as southern Inuit and to positively assert its "Inuitness" (Brunger & Russell, 2015). Being able to gain federal status can be a way for Aboriginal peoples to establish autonomy, because "many Aboriginal people in the province and the country see self-government as a way to preserve their culture and attain greater control over their land, resources, and administration of laws and practices that affect their lives" (*Heritage Newfoundland and Labrador*, 2015, p. 1). Aboriginal governments are not entirely autonomous; they work within the framework of the Canadian Constitution and with federal, provincial, and municipal levels of government (*Heritage Newfoundland and Labrador*, 2015).

Most recently, the formation of the Qalipu Mi'kmaq First Nations Band in September 2011 has provided a new way for Aboriginal people in Newfoundland and

Labrador to gain official federal status. The formation of the Qalipu Band has ushered in renewed pride and interest in Mi'kmaq culture and heritage as well as fostered a strong sense of community (Robinson, 2014). The Qalipu Band may be the most westernized Aboriginal group in Eastern Canada because they were considered part of the dominant culture by the federal government until 2011 (Robinson, 2014). Thus, for some reclaiming and promoting Mi'kmaq culture and history are of great importance.

While the official recognition of the Qalipu Band can be viewed as an important triumph of Aboriginal rights, the process is not without conflict. The arrangement was formalized under an agreement which states that federal agencies will determine social and political structures and all rights to land and resources are to be fortified, making the Qalipu Band a landless band (Robinson, 2014). In addition, the criteria for individuals gaining approved status is governed by state agencies and is challenged by Mi'kmaq political organizations, such as the Grand Council and Mi'kmaw Kwikmu'kw Mawklusuaqn Negotiation Office (MKMNO) who, in the interest of seeking fulfillment of treaty rights and obligations, maintain that it is not within the authority of the federal government or the Federation of Newfoundland Indians (FNI) to dictate criteria for inclusion and exclusion in the Qalipu Band (Robinson, 2014). Thus, state recognition of the Qalipu Band is dependent on the repression of land claims and the restricted autonomy of Aboriginal people. Although the formation of the Qalipu Band can be seen as a significant step forward in promoting Aboriginal identities it can also be seen as an exercise that marginalizes Aboriginal people in Newfoundland and Labrador.

One of the issues arising from the process of forming the Qalipu Band stems from the fact that the number of applicants has far exceeded what was anticipated by federal agencies (Robinson, 2014). Subsequently, the Harper government and FNI created a new set of criteria for membership under Bill C-25 (Qalipu Act) that will greatly reduce eligibility (Robinson, 2014). For Anderson (2013), the resurgence of Aboriginal awareness in Newfoundland and Labrador brought on by establishing the Qalipu Band, although it is a contested process, adds to the richness of the province's social fabric and successful Aboriginal leadership.

Aboriginal identities, in particular the reclamation of Aboriginal cultures, are shifting dramatically in Newfoundland and Labrador. This reclamation is a complicated process that encourages uncovering Aboriginal traditions and ways of being as well as subjugation to the state in some cases. These unique social contexts demonstrate the importance of researching how Aboriginal experiences take shape in Newfoundland and Labrador.

Being queer in Newfoundland and Labrador

There is not much written on what it is like to be queer in Newfoundland and Labrador. The province is predominantly rural, there is a strong Judeo-Christian religious tradition, and the island of Newfoundland and the landscape of Labrador are geographically isolated from the rest of Canada. These are unique circumstances that influence how queerness has taken shape. Queer identities in Newfoundland and Labrador are situated within a social context that is characterized by the influence of

Judeo-Christian religions. In the past this has significantly impacted queer people in the province, and, as Shortall suggested in 1998, “the power of the institution of the church over the lives of gays and lesbians in Newfoundland cannot be overstated” (p. 116).

Heterosexism and homophobia are sometimes linked to religiosity and in the past this connection has been documented in Newfoundland and Labrador. For example, in 1996 Saints Peter and Paul Parish in Bay Bulls, located near St. John’s, issued a bulletin that denounced homosexuality in response to the Newfoundland government’s plan to amend the Human Rights Code to prohibit discrimination on the grounds of sexual orientation:

Fair warning has been given you by our government that, during the next sitting of the House of Assembly, they will introduce into the Human Rights Code protection from discrimination on the grounds of sexual orientation, as Ottawa did in April. So you have time to object to the government, or to Labour Minister Kevin Aylward who announced this. The orientation or inclination towards bodily union between two men or two women is evidently a disorder in human nature, and it results from Original Sin. It can and must be controlled and conquered with God's supernatural help, · through his sacraments prayerfully received. People with this tendency deserve respect as persons, especially if they are fighting against it. But giving in to it, and living that way, is morally wrong, against God's plan in nature, as our human reason sees clearly. Rather than a human right, it is an inhuman wrong, and it is the root cause of AIDS. You should not be forced to rent your apartment to such a couple, or accept them as teachers for your children. There is such a thing as rightful discrimination in some matters; you must protect the morals and health of your family. But you will have no protection if the government passes this legislation, approving and encouraging the sinful lifestyle of sodomy. We pray: 'God guard thee, Newfoundland.' But we must also act (Courtney, 2003, p. 67).

Another example of homophobic religious influence in the province comes from Happy Valley-Goose Bay in Labrador. In 2014 Arthur A. Riche, a Happy Valley resident known for distributing religious and anti-gay materials caused an uproar when he mailed

homophobic flyers published by The Peoples Gospel Hour, a religious group based in Halifax, to other Happy Valley residents (*The Telegram*, 2014). The eight-page pamphlet “contains strong language, condemning homosexuality on religious grounds” (*CBC News*, 2014). Thus, as a structural factor that shapes queerness, religion has been a barrier to acceptance in Newfoundland and Labrador and a force that sometimes aims to legitimize discrimination.

Rural areas are also linked to heterosexism and homophobia which can be problematic for queer people in the province because most of Newfoundland and Labrador consists of rural communities. In 1998 Shortall noted that many queer people relocated to the capital city of St. John’s where homosexuality had a larger presence in terms of organizing and number of people who were ‘out’. In addition, many queer people may have left St. John’s for larger urban centers in other parts of Canada, such as Toronto or Vancouver, in order to gain anonymity (Shortall, 1998). While this information from 1998 is outdated, anecdotal evidence suggests that queer people may have left St. John’s for larger centers into the 2000s. The island of Newfoundland is isolated from the rest of Canada; therefore the urban center of St. John’s may not provide desired anonymity or the ability to connect with a larger, more varied population. Even in St. John’s, queer individuals, predominantly gay men, say they experience heterosexism and threats of violence in paid employment (Courtney, 2003) and queer students have been marginalized within the public education system (Shortall, 1998). Although Newfoundland and Labrador is becoming more tolerant and accepting, as is evident in Pride celebrations; the popularity of Camp Eclipse, a queer summer camp; and public

outcry over anti-gay material such as the flyer distributed in Labrador, larger social forces may be influenced by heterosexism and homophobia.

Populations at risk

In this section I outline which populations are at risk of poor health in Newfoundland and Labrador in order to situate my postcolonial queer analysis of experiences within a particular provincial context. Populations at risk of poor health are more likely to require access to health care services and supports. The literature available on populations at an elevated risk of poor health in Newfoundland reflects national trends. Aboriginal people, queer individuals, youth, and women are all at increased danger of experiencing poor health. When these identities intersect individuals can experience increased negative health effects.

Both Aboriginal and sexual minority youth are at increased risk for heavy and problematic use of substances, as noted by Eastern Health. These groups include: “runaway and street-involved youth; youth in custody; adolescents with co-occurring disorders; sexually abused and exploited youth; gay, lesbian, bisexual, and questioning teens; and First Nations, Inuit, and Métis youth” (*Eastern Health*, n.d., p. 77). It is important to note that the populations listed are not mutually exclusive and Aboriginal queer youth may be at even greater risk of abusing substances.

Economic marginalization contributes to low levels of physical activity and overall poor health, as “Canadians with lower income levels are more likely to report barriers to activity such as access to safe places to walk and cycle prevent them from

taking part in regular physical activity” (*Eastern Health*, n.d., p. 39). This mirrors the national study done by Taylor, Clow, and Jantzen (2013) who found that social and economic marginalization are linked to produce poor health for queer and Aboriginal peoples across Canada. Those most at risk of low socioeconomic status (SES) and physical activity rates in Newfoundland and Labrador are women, older persons, Aboriginal peoples, and those who are members of non-White ethnic groups (*Eastern Health*, n.d. p.17). Women are at particularly high risk of overall mental illness and low SES persons are at higher risk for depression, anxiety, and overall mental illness (*Eastern Health*, n.d., p. 71).

Being at increased risk of violence has an important impact on well-being; this risk disproportionately affects Aboriginal and queer residents of Newfoundland and Labrador. An article from the Newfoundland and Labrador website called *Respect Women* uses research done in British Columbia and Ottawa to profile the risks faced by women in Newfoundland and Labrador. The article demonstrates how the impact and severity of violence in a woman’s life is affected by multiple dimensions including ethnicity, sexual orientation, physical, social, and economic factors. Approximately one in every two women in Newfoundland and Labrador will experience at least one incident of sexual or physical violence in her lifetime and only 10% of those women will report the victimization to police (*Respect Women*, n.d.). Aboriginal people are three times more likely to experience violent victimization than non-Aboriginal people and Aboriginal women are 3.5 times more likely than non-Aboriginal women to be victims of violence (*Respect Women*, n.d.). The risks faced by women and Aboriginal peoples in

Newfoundland and Labrador are also reflected in national trends that show these population experience greater risk of violence in all Canadian provinces (Cohen & Maclean, 2004). Some of the financial and social impacts of being a victim of violence include: diminished self-esteem and sense of security; damage to physical and emotional health; self-blame; negative impact of children; negative impact on financial security; and loss of housing and relocation resulting in broken community ties (*Respect Women*, n.d.).

In 2004, gay and lesbian individuals reported 2.5 higher rates of violent victimization than heterosexual individuals; the rate of victimization for bisexual people is four times higher than that of heterosexual people (*Respect Women*, n.d.). Lesbian and bisexual women can be doubly traumatized by the impact of sexual violence due to being oppressed both as women and as members of the gay community (*Respect Women*, n.d.). Long term effects of sexual violence include: feelings of fear, shame, guilt, denial, self-blame, and anger; fear of intimacy; lack of trust; low self-esteem; depression; eating difficulties; sleep problems; as well as internal and external injuries (*Respect Women*, n.d.). Economic and social marginalization as well as violence contributes to health issues that negatively affect well-being. Aboriginal and queer people are disproportionately at risk of poor health related to these factors in Newfoundland and Labrador.

Institutions that deliver services

The current study focuses on Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), AIDS Committee Newfoundland and Labrador (ACNL), and St.

John's Native Friendship Center (SJNFC) as institutions that mediate access to health and wellness services. However, there are also other organizations that provide services to queer and Aboriginal peoples in St. John's such as St. John's Pride, Stella's Circle and Memorial University. In this section I provide background information on each organization and their roles in St. John's. While this is not an exhaustive list of community institutions, these six organizations are among the most prominent in St. John's and they provide services that have a powerful impact on physical, mental, and social health and well-being for their clients.

Eastern Health is Newfoundland and Labrador's largest integrated health authority serving a regional population of 290,000 and they provide a full continuum of health and community services including specialist services for all residents of the province (*Health Council Canada*, n.d., p. 4). Eastern Health serves a total Aboriginal population of 43,400 who come from different areas across the province (*Health Council Canada*, n.d.). According to Health Council Canada, Aboriginal people make up about 15% of the total population that Eastern Health serves (n.d.). These figures are not inclusive of the Qalipu members registered since 2006 and those who do not use government recognition to determine their Aboriginal identity.

Planned Parenthood Newfoundland and Labrador (PPNL) is a valuable resource for people seeking sexual health information, medical care, and social support. Among the services provided, PPNL offers sexuality education; pregnancy testing and counselling; a sexual health information phone line; birth control and emergency contraception; free condoms and lubricant; support groups; and sexual health clinics

where they bring in doctors to provide testing and exams for all persons (*Thrive*, 2015). PPNL also runs Camp Eclipse, a summer camp for LGBTQ youth, ages 16-24, where campers learn about themselves and others while also exploring how to effect positive social change. The camp is open to all residents of Newfoundland and Labrador and empowers young queer people to be confident, respectful leaders. PPNL provides safe spaces for sexual education and medical services such as STI testing and contraception. It may be less intimidating for people to go to Planned Parenthood than to a general practitioner at a clinic because they cultivate a more accepting environment through inclusive sexuality services and their affiliation with Camp Eclipse. PPNL works to affect positive social change and inclusion of sexual diversity in Newfoundland and Labrador which can have a positive effect on the well-being of clients.

The AIDS Committee of Newfoundland and Labrador (ACNL) is a provincial organization that supports people who are affected by HIV/AIDS or hepatitis C and works toward eliminating these diseases from the province. ANCL encourages responsible decision making and empowerment through nonjudgmental education and support (*ANCL*, n.d.). The services and programs provided by this organization includes the Safe Works Access Program which is a needle distribution service that also promotes health through education for people who use drugs; the Tommy Sexton Shelter which is a short term emergency shelter for men; supportive housing for people over the age of 16 who are living with HIV or AIDS; an online support group; and Public Health Agency of Canada education, counselling, and referral services (*ANCL*, n.d.).

The SJNFC is a non-profit, registered charity that serves the urban Aboriginal population, however the associations' programs and services are open to all people regardless of their heritage (*SJNFC*, n.d.). The programs and services offered by the SJNFC include employment assistance; a women's outreach program; the Shanawdithit Shelter; the Aboriginal Arts program which promotes Newfoundland and Labrador Aboriginal visual and performing arts; the Urban Aboriginal Diabetes Initiative; The Resolution Health Support Program that aims to help those that were subjected to the residential school experience in partnership with Health Canada; as well as the APN program (*Memorial University*, n.d.).

The services and programs supported by the SJNFC support a range of issues, such as economic, mental, spiritual, social, and physical health. Importantly, the initiatives that the SJNFC engages in are not limited to Aboriginal participants. Because government recognition of Aboriginal status has been denied to residents of Newfoundland and Labrador for years and many struggle to uncover Aboriginal connections (Bartels, & Bartels, 2005) proving one's Aboriginal identity is potentially problematic. By supporting all those who seek support from the SJNFC, the organization breaks down barriers of race and culture through inclusive initiatives that bring people together for common causes. The SJNFC also works to promote Aboriginal cultures which is a mechanism for increased awareness and social inclusion for both Aboriginal and non-Aboriginal peoples.

St. John's Pride is a community organization that supports social inclusion for queer peoples through Pride events and workshops about queer issues. St. John's Pride is

the only community institution in St. John's that solely focuses on queer issues but they do not have a stable place to organize events or for clients to visit. Taylor, a transgender participant, noted that "St. John's Pride does not have permanent office space which limits the amount of safe, stable spaces in St. John's for queer people" (interview, February 27, 2015). Pride events are important to fostering social inclusion and awareness. For example, a blood drive was the focus of Pride 2010; it was a protest against the existing ban on gay male blood donors as well as a recruitment drive for donors interested in donating in the name of someone who cannot (Fitzpatrick, 2010). Although St. John's Pride does not have a permanent office that can be accessed on a regular basis this organization provides valuable support and encourages awareness of queer issues in St. John's.

Stella's Circle is an organization named after Dr. Stella Burry; a social worker known for her contributions to her church, community, and the province of Newfoundland and Labrador (*Stella's Circle*, n.d.). Stella's Circle is not an Aboriginal, queer, or Aboriginal queer organization but they do focus on challenging systems of power that perpetuate marginalization. Their mission is to "address the impact and root causes of poverty, abuse, and oppression...by developing support services that promote community inclusion and by advocating for social policy changes that transform oppressive systems" (*Stella's Circle*, n.d.). The services provided by Stella's Circle include Emmanuel House, a living space for men and women that offers counselling, therapeutic groups, and life skills support; a Community Support Program that assists people with complex mental health needs to promote wellness, independence, and

community integration; and Just Us Women's Center which provides counselling and support for women who have had a conflict with the law (*Stella's Circle*, n.d.).

Memorial University provides education, research, and social programs for university students. Members of Memorial University are consistently working to make the St. John's campus a more inclusive, safer place. For instance, after decades of there being only gender segregated living quarters on the St. John's campus the Burton's Pond student apartments will be inclusive to all gender identities (*CBC News*, 2015). These apartments will allow students to live together in apartment-style living arrangements separate from traditional residence rooms. Brittany Lennox from MUN's student council said this change will be significant for transgender students and "it's also going to be great for students who maybe have a different gender partner, or a brother and sister who want to live together, friends who want to live together ... it's just going to be a great change overall" (*CBC News*, 2015).

Memorial University's Aboriginal Affairs Department has undertaken initiatives to address Aboriginal issues in Newfoundland and Labrador. Memorial University has established a Bachelor of Education degree for residents of Nunatsiavut in Happy Valley Goose Bay, Labrador; created new scholarships for incoming and continuing Aboriginal students; and established an Aboriginal Student Council on the St. John's Campus (*Memorial University*, n.d.). Memorial University works to improve the experiences of queer and Aboriginal students and makes secondary education more accessible to Aboriginal students from remote areas of Newfoundland and Labrador.

In conclusion, this chapter details the social and historical contexts unique to Newfoundland and Labrador that are associated with being Aboriginal and queer in St. John's. I discuss populations at risk of poor health in the province, which include Aboriginal and queer peoples. In the last section of this chapter I describe the institutions I have selected for the current study and some of the services provided by local organizations. The next chapter is a literature review that details existing research concerning Aboriginal, queer, and Aboriginal queer health and well-being in Canada. In the first section of this chapter I describe how the concept of health is operationalized in the current study. The literature review is organized by interconnected themes that are present in the research. At the end of the next chapter I discuss the postcolonial queer analytical framework used in the current study and why a postcolonial approach is useful in relation to the current health literature.

Chapter 3: Literature Review

This chapter details existing research that addresses Aboriginal, queer, and Aboriginal queer health and well-being in Canada. I begin this chapter with a description of how the concept of health is operationalized in the current study. The section of this chapter devoted to the literature review is organized by interconnected themes present in the research. This provides a basis for understanding research objectives within the current area of study as well as the theories and methods used in previous studies so that any gaps may be seen.

In my review of the literature on Aboriginal and queer health I found three main themes. First, exclusion in research refers to the underrepresentation of Aboriginal and queer peoples in academic studies which has led to invisibility of their health care needs and poor health outcomes. Second, literature focuses on the health disparity between Aboriginal and queer peoples in relation to non-Aboriginal and heterosexual Canadians, respectively. Third, Aboriginal and queer health is often understood as a consequence of the social determinants health, meaning key living conditions, known as social determinants, direct health outcomes. A discussion of the respective influence of the studies reviewed here is presented at the end of the literature review. The current literature demonstrates that Aboriginal, queer, and Aboriginal queer people in Canada experience a disproportionate amount of poor health outcomes. The health care experiences and knowledge of these populations is underrepresented in health research which contributes to poor health.

The literature review leads into a discussion of the postcolonial queer analytical framework used in the current research. I discuss why a postcolonial approach is useful in regards to addressing gaps in the current health literature at the end of this chapter. The next chapter focuses exclusively on the postcolonial queer analytical framework in more detail.

What is health?

In this study of Aboriginal queer experiences of using health care services in St. John's the concept of health and how health is interpreted by individuals and institutions is important. In this section I operationalize health by drawing from research dealing with conceptualizations of health and postcolonial queer literature. This literature demonstrates the interconnectedness of biological, mental, and social health; the importance of structural factors for health research and health outcomes; and power relations that have shaped structural categories and health disparities.

The world health organization (WHO) defines health as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and this definition has not been altered since 1948. Health then is related to more than biological wellness, physical health is connected to social and mental wellness. Within the context of this study health is understood as being interconnected with physical, mental, and social factors. In addition, health is conceptualized as being dependent on structural factors. Structural circumstances guide how people make sense of their experiences, subjective beliefs based on factors such as gender, class and ethnicity

are essential to the search for meaning in the face of illness (Bendelow & Williams, 1995). Bendelow and Williams (1995) note that illness is never strictly a result of anatomy and physiology; it develops at intersections of bodies, minds, and cultures.

Structural factors are important to health, as they shape experiences and opportunities to achieve and maintain good health. There is evidence to suggest biological health is linked to structural factors, in that “education may reshape biochemical brain function to prevent or diminish the likelihood of dementia... [being of a] higher class can prevent the devastating health effects of smoking to a degree” (McDaniel, 2013, p. 834). Thus, structural factors such as class status and educational attainment shape health outcomes.

In addition to structural circumstances based on education and class, sex and gender are embodied social structures (Connell, 2012) that influence health outcomes. Sex and gender differences in the prevalence and expression of illness are often overlooked in research and clinical practice (Poon, Goodman, Yan, Bugiardini, Bierman, Eagle, Johnston, Huynh, Grondin, Schenck-Gustafsson, & Yan, 2012). However, The Canadian Institutes of Health Research (CIHR) states that “accounting for sex and gender in health research has advanced what we know, improved how we do research and made the products of health research more useful” (CIHR, 2012, p. ix). When sex and gender are taken into account queer people are often excluded, since “current uses of gender relations are typically positioned within intimate heterosexual couples whereby single narratives (i.e., either men or women) are used to explore the influence and/or impact of intimate partner gender relations on health and illness issues.” (Bottorff, Oliffe, Robinson

& Carey, 2011, p. 1). Excluding queer people from health research potentially makes this research less relevant to their lives and experiences. This issue reflects a narrow understanding of sex and gender instead of an approach that views these structures as an evolving spectrum of expression.

While previous research shows that structural categories are important to how health and illness are conceptualized and studied, categorizations of people are potentially problematic. Connell writes that the social construction of categories contributes to health outcomes; in the case of gender she says “gender is seen as the active social process that brings reproductive bodies into history, generating health consequences not as a side-effect but in the making of gender itself” (Connell, 2012, p. 1675). Thus, gender is socially constructed and this construction produces differences in health outcomes. This contradicts the idea that health outcomes are related to innate qualities of masculinity and femininity (Connell, 2012). It is inadequate to merely account for structural factors based on categories, which are often dichotomous and mutually exclusive; we must try to understand the effects of such categories. Connell states that a relational approach to health would be more beneficial, this approach recognizes that structural categories are socially constructed through discourse and are open to change (2012). This approach allows conceptualizations of health to accommodate for “patterns of gendered embodiment, including the patterns of ill health and wellness” that are historically and culturally dependent (Connell, 2012, p. 1681).

Race is also socially constructed and racial categorizations produce health outcomes that are related to power relations and hierarchies of race. Racialized health

disparities are not merely a product of cultural variation; differences in health status are related to disruptions in social order under the historical pressures of colonialism, postcolonial poverty, and economic change (Connell, 2012). Structural factors that contribute to health disparities are a reflection of hegemonic power structures:

Massive inequalities of income, investment, education and other social resources are routinely documented (e.g. United Nations Development Programme 2007). These inequalities are not accidents; they have been systematically produced by the operation of the global economy and political order over long periods of time. Colonial conquest ruptured indigenous cultures, and discontinuities within the cultural life of the periphery persist (Connell, 2012, p. 1679).

The current study operationalizes health as a product of mental, physical, social, and structural factors. Structural categories are dynamic and related to power structures that impact the health of individuals. These factors direct health outcomes, therefore it is important to account for them and how they operate in people's lives when conceptualizing of health. Health care discourse that imposes Western conceptualizations of health on Aboriginal peoples while excluding other culturally relevant interpretations of health contributes to health disparities between Aboriginal peoples and other Canadians (Browne, & Smye, 2002). Taking structural factors and internalized understandings of health and well-being into account in health care discourse and practice decolonizes health care by challenging how hegemonic power structures impact clients' well-being (Spurlin, 2001). Thus, health refers to the interconnectedness of biological, mental, and social well-being which is linked to socially constructed structural factors and power relations.

Exclusion in research

Here I review the literature regarding the exclusion of Aboriginal, queer, and Aboriginal queer peoples in academic research. Health care research about Aboriginal peoples in Canada tends to exclude urban populations, women and children, and Aboriginal experiences. The exclusion of queer people from academic inquiry in Canada has limited the visibility of this population's health care needs and negatively affected preventative health initiatives aimed at queer peoples. Those who identify as Aboriginal and queer are often partially excluded from both Aboriginal and queer communities as well as in research contexts. Thus, this population is doubly excluded on the basis of race and sexuality. Much of the research indicates that these populations are under-studied which contributes to invisibility of health and wellness needs, however there are researchers who have conducted studies that focus on including the voices and experiences of marginalized peoples. This section demonstrates that the exclusion of Aboriginal and queer people from academic research is linked to poor health outcomes for these populations. The current study draws from this literature in order to establish analytical and methodological approaches which are discussed at the end of the literature review.

Aboriginal health research

A substantial review of previous Aboriginal health research provides an overview of the research area and demonstrates gaps in inclusion. In 2003, Young conducted such a review by examining 254 academic papers, asking if these studies adequately examined

the health needs of the Aboriginal population in Canada. In order to uncover patterns in Aboriginal health research, Young (2003) undertook a systematic review of journal articles from the Medline medical database published between 1992 and 2001 that focus on Aboriginal peoples' health in Canada. From each abstract Young noted Aboriginal identity, age-sex group, comparison group, geographic location of the study, research topic, and associations between exposure and outcome of the study (2003). Young did not assess the quality of the research used for this review, and research that falls outside of Western scientific traditions, such as studies conducted by indigenous peoples and based on indigenous knowledge, was not included (Young, 2003).

Young found that existing research on Aboriginal health in Canada is concentrated in a few academic areas and focuses on particular groups, such as health status and individuals living on-reserve, while other areas of concern, such as rehabilitation efforts and non-reserve groups such as the Métis, received very little attention. Young notes that only forty-two out of 254 papers reviewed were national in their scope. In regional studies all three northern territories were represented, but only six out of ten provinces appeared. Young (2003) does not specifically mention which provinces are represented. Only two of the papers dealt with Aboriginal peoples living off-reserve. The Inuit were represented in 122 articles, but only two papers addressed data on Métis peoples. The health care needs of Aboriginal women and children have also not been adequately addressed. There were no studies examining the access, use and experiences of Aboriginal queer people in Young's findings.

Young (2003) did not document any studies that focused on the experiences of Aboriginal peoples, suggesting that their knowledge is underrepresented in academic research. Thus, exclusion of Aboriginal peoples in academic research can be addressed by including these marginalized voices in the design and implementation of studies. Minore et al. (2004) used community driven participatory research methods to ask multiple research questions in order to document the impacts and costs of a lack of continuity in the delivery of health services in three northern Ontario Aboriginal communities. Continuity of care for queer individuals is not addressed in Minore et al.'s 2004 study, and thus it is unable to incorporate differences in health care needs by sexual orientation.

In Minore et al.'s (2004) research the questions regarding Aboriginal health services that receive particular attention are: what, if any, disruptions occur in providing care, and why; what affect does any lack of continuity have on client outcomes; what are the impacts of such disruptions in continuity on patients, their families and communities; what are the costs (both monetary and in terms of human resources) to the health system due to lacks of continuity; and how can the health system support communities and care providers in order to achieve better continuity of care? Stability of care is particularly important for ongoing health concerns such as diabetes, counselling, or hormone therapies in the case of some trans-gender individuals.

Qualitative and quantitative data collection techniques were used to answer the author's research questions. First, a five-year retrospective review of oncology, diabetes and mental health was done by examining patients' records held at local nursing stations.

Second, data from the First Nations and Inuit Health Branch, the Shibogama Health Program as well as some referral agencies were used to generate a program-specific cost analysis. Lastly, in-depth interviews were conducted with professional and para-professional health care providers serving each of the three communities.

Minore et al.'s results indicate that comparatively good continuity of care is achievable for the selected First Nations communities (2004). In the communities studied, cancer cases were commonly diagnosed as a result of regular screening for women. Men, who are more likely to ignore symptoms, tended to be diagnosed when the disease was already in advanced stages (Minore et al., 2004). Every suspected or confirmed oncology case was referred to specialists in a timely manner and provided with consistent follow-up. Continuity was also strong for diabetes care, when patients are diagnosed they receive training in self-care through a program in Sioux Lookout. While the results concerning oncology and diabetes are encouraging, mental health services in these communities was demonstrated to be inadequate. Because the suicide rate is high, crisis response has become routinized, meaning that mental health specialists are ready to respond but not prepared to prevent events. For mental health care the emphasis is placed on intervention rather than prevention (Minore et al., 2004). After patients are stabilized they are discharged into the community where follow-up is inconsistent.

To arrive at their conclusions Minore et al. (2004) used community driven participatory action research; developing the study with local community members while employing and consulting community members through every step of the research process. The communities and its members benefit directly from the study because they

are involved in its creation and direct the actions that come out of it (Minore et al., 2004). The authors demonstrate that research focused on including Aboriginal peoples may lead to findings that are more applicable to Aboriginal contexts, and empowers Aboriginal communities to have an active role in their health care.

Queer health research

In 2012, Logie, James, Tharao, and Loutfy noted that queer women living with HIV are largely invisible and understudied even though their risk of infection is higher due to being exposed to violence and discrimination. This led the authors to question what challenges were present in the daily lives of HIV-positive LBQT women in Toronto and what their experiences of accessing HIV services entailed. Logie, et al. (2012) used a community-based qualitative approach and conducted two focus groups with HIV-positive lesbian, bisexual, queer, and transgender women (n=23). Three of the transgender participants self-identified as Aboriginal. The authors then used thematic analysis to determine and understand factors that influence the well-being of HIV-positive LBQT women. Participants described pervasive HIV-related stigma, heteronormative assumptions and discriminatory and ineffective treatment by health professionals as significant barriers to accessing care and support (Logie, James, Tharao, & Loutfy, 2012). The authors concluded that under-representation of LBQT women in HIV research contributes to marginalization and exclusion, which negatively impacts the health and well-being of LBQT women.

Under-representation in health studies is linked to invisibility of health and wellness needs. Thus, it is important that understudied populations have a voice in academic research. Moran's 1996 research asks how lesbian health care needs may differ from those of women in general in Canada. Participants from Moran's study (1996) were recruited from an organizational meeting of a lesbian softball team in Toronto. Moran analyzed questionnaire data that provided information on demographics, health care use, habits, diet, exercise, preventative care, mental health and physical health. The results of Moran's 1996 questionnaire were compared to the outcomes of the 1991 Canadian General Health Survey and the 1986 Health Promotion Survey.

Moran found that respondents visited the same types of health care professionals as other Canadian women of comparable age, but they did so for different reasons. The participants in Moran's (1996) study tended to be less knowledgeable about healthy diets and received Pap smears less often than other Canadian women, even if they were considered high risk. The lesbian group smoked, drank alcohol, used caffeine and exercised somewhat more than women in general. The lesbian participants examined their breasts less frequently, but both groups of women had their blood pressure checked with comparable frequency. The lesbian group had a high incidence of mental health issues and tended to have non-traditional support systems, utilizing friends and partners for support rather than family, whom they felt did not accept them. Lesbians were less prone to gynecological complaints, but had comparable rates of common chronic illnesses, such as hay fever, asthma, digestive problems, diabetes, and migraines (Moran, 1996).

Aboriginal queer health research

Literature on Aboriginal queer health and health care is limited, with very few studies focusing on how Aboriginal and queer identities overlap and shape institutional approaches, health care development and delivery, or access, use and experiences.

Taylor, Clow, and Jantzen (2013) note that there are not many studies that focus on LGBTQ people in general, and information about LGBTQ people of color is much rarer. Within excluded LGBTQ populations people of color are largely absent; they are in effect doubly excluded. Research that has focused on how Aboriginal queerness intersects with health care, namely in form of being two-spirited, has emphasized the uniqueness of two-spirited identities in relation to LGBTQ understandings and the invisibility of their health care needs. The term ‘two-spirit’ refers to one who exhibits both male and female characteristics in terms of gender expression and sexual practices (Wilson, 1996). This term also reflects the dynamic, socially constructed qualities of these expressions and practices (Epple, 1998). Therefore, two-spirit identities are constantly in flux, and encompass a wide range of gender and sexual orientations that differ from Western understandings of static homosexuality.

When Aboriginal queer people are socially excluded in addition to being excluded from academic research they may find that they are isolated from social relationships as well as health and wellness services (Brotman, Ryan, Jalbert, & Rowe, 2002a). Brotman et al. (2002a) asked what the realities and experiences of two-spirit people in Canada are, both within general society and in the context of health care. The authors used data from

a larger study on gay, lesbian, bisexual and two-spirit health and health care access done in 2000 by The McGill Center for Applied Family Studies in partnership with Health Canada. Brotman et al. (2002a) conducted two focus group discussions undertaken with urban and reserve-based two-spirit and self-identified heterosexual Aboriginal people in Quebec. Focus group discussions were transcribed and data was analyzed to develop common and divergent themes to illustrate participants' realities (Brotman et al., 2002a). Recruiting for focus groups was done through local community members who were active in related organizations. Word-of-mouth through local networks of individuals proved to be vital to recruitment efforts. Working with local community members helped to establish trust, however as a result of this sampling technique, the sample tended to be homogeneous in terms of the participants' willingness to talk openly (Brotman et al., 2002a). Their study found that two-spirit people often deal with multiple forms of oppression including those rooted in homophobia and hegemonic power structures (Brotman et al., 2002a).

The authors note that two-spirited experiences and health care needs often go unnoticed both in Aboriginal communities and in the health care literature (2002a). Claiming a two-spirit identity had a positive impact on participants' health and well-being as the Aboriginal term is related to respect, dignity and acceptance (Brotman et al., 2002a). Despite the positive associations, two-spirit identities as a mark of difference can be a barrier to receiving proper health care. Small Aboriginal communities and health care environments often value sameness; two-spirit people sometimes leave their communities in an effort to deny their orientation and create an illusion of being like

everyone else (Brotman et al., 2002a). Although leaving a rural place can offer anonymity, services designed for two-spirit people are rare in both rural and urban areas, therefore participants may give up contact with family and friends for little gain in terms of access to services (Brotman et al., 2002a). Brotman et al. (2002a) illustrates how social factors such as a lack of acceptance and under-representation in health care literature can impose invisibility onto two-spirit people looking for a sense of belonging.

A study from the Urban Native Youth Association (2004) that focuses on Vancouver illustrates the health and social service needs of Aboriginal queer youth, under 24 years of age, in that city. Participants' accounts were gathered via surveys that were given to people who were then asked to return completed questionnaires. The key issues outlined in the report include better education for non-LBGTQ people; 87% of their forty-four respondents felt that more education is needed for heterosexual people about GLBT issues, particularly in school settings (Urban Native Youth Association, 2004, p. 8). Aboriginal queerness is not completely understood in Aboriginal communities, 80% of respondents felt that two-spirit and GLBT issues needed to be better appreciated in their First Nations community (Urban Native Youth Association, 2004, p. 9). In part as a result of the residual effects of residential schooling, homophobia is prevalent in British Columbia Aboriginal communities; however, as these communities reconnect with traditional customs and social norms this may change (Urban Native Youth Association, 2004). The need for two-spirit role models is stressed within the context of this study; the youth participants were seeking understanding and guidance in their First Nations communities. There is a correlation between involvement in the

community and understanding two-spirit and LGBTQ Aboriginal people, “if there were more Two-spirit Elders who were visible, it would help the community move towards acceptance of its Two-spirit people” (Urban Native Youth Association, 2004, p.10). The authors recommend that two-spirit elders become more involved in their communities, including educating members of the community on what it means to be two-spirited (Urban Native Youth Association, 2004, p.11).

Mental health issues were a main point of discussion in this Vancouver study, 43% of participants indicated that they suffer from depression and 30% were ambivalent in their response to this question (Urban Native Youth Association, 2004, p.12). Peer pressure played an important role in the lives of respondents: 71% of participants said that peer pressure was a cause for not disclosing their sexual identity sooner, 43% of participants indicated that they felt they had to keep their feelings hidden out of fear, and 30% chose a neutral response (Urban Native Youth Association, 2004, pp.12-13). When asked if they had a doctor that they felt safe discussing their sexuality with 36% of participants said that they did not, 34% indicated they did, and 30% were neutral in their response (Urban Native Youth Association, 2004, p.14). Participants were evenly divided on this issue; however responses do indicate a need for health care providers to educate themselves on the issues and needs of Aboriginal queer people.

Research from 2001 demonstrates the importance of cultural and social connections for Aboriginal two-spirited men. Monette, Albert, and Waalen conducted research to document the health knowledge, attitudes, behaviors and social conditions of Aboriginal, two-spirited men across Canada (2001). The authors designed a twelve page

survey with help from a focus group consisting of seven Aboriginal gay men, of whom two were transgender sex workers and one had participated in the drug trade (Monette, Albert, & Waalen, 2001). One cis-gender participant in the focus group reported earning an income through sex work and selling drugs. The study captured information on demographics, relationships, life satisfaction, accessing health and social services, health concerns, lifestyle risks, sexual activity, alcohol consumption, knowledge and attitudes regarding HIV/AIDS, as well as HIV testing and prevention (Monette, Albert, & Waalen, 2001).

The authors had 189 respondents; 69 from British Columbia, 2 from Saskatchewan, 62 from Manitoba, 41 from Ontario, 9 from Quebec, and 6 from Eastern Canada (Monette, Albert, & Waalen, 2001). The participants ranged in age from 17 to 62 years with a median age of 34. Almost half of the respondents had experienced being homeless and less than half would have considered moving back to their home community due to a lack of services, acceptance, and employment as the most common reasons (Monette, Albert, & Waalen, 2001). Almost all of the participants had been tested for HIV; half were HIV positive and of those 50% were receiving drug therapy (Monette, Albert, & Waalen, 2001). The most salient social factors that had a negative impact on their lives were unemployment, poor housing, racism, poverty, homophobia, physical abuse and gay bashing (Monette, Albert, & Waalen, 2001). Health concerns for this group included exposure to HIV/AIDS or hepatitis as a result of tobacco, alcohol or cocaine consumption (Monette, Albert, & Waalen, 2001). They also indicated that poor diet and lack of physical activity put them at risk. Respondents named programs that

promote condom use, talking/healing circles, needle exchange, Elder counselling, and the Medicine Wheel as the most effective methods of addressing health concerns (Monette, Albert, & Waalen, 2001). Participants in this study listed effective preventative and healing measures that are culturally relevant to Aboriginal traditions, however many indicated that they had moved from their home communities due to a lack of acceptance and services which could limit their access to these traditions. Participants named friends (81%) and family (68%) as their most important supports followed by Aboriginal AIDS organizations (66%), with doctors being named as an important support by 64% of respondents (Monette, Albert, & Waalen, 2001). This study demonstrated the importance of cultural and social connections as well as access to traditional practices for health and well-being.

The literature on exclusion in health research shows that Aboriginal, queer, and Aboriginal queer populations are under-represented in academic studies. Research that does focus on Aboriginal peoples rarely documents their experiences as areas of interest. In addition, Aboriginal women and children and Aboriginal people who live in urban setting are excluded from most research. The exclusion of Aboriginal and queer peoples from academic inquiry has limited the visibility of their health care needs and made some health care initiatives aimed at these populations less effective. Exclusion in research is linked to poor health outcomes for Aboriginal, queer, and Aboriginal queer peoples in Canada.

Health disparity

Here I discuss what is known about how Aboriginal, queer, and Aboriginal queer peoples' health status compares to that of non-Aboriginal, heterosexual Canadians in order to provide a background to the research area and establish the current study within it. Aboriginal and queer peoples in Canada experiences poorer health outcomes than other Canadians. For queer clients, health disparities are related to health care practices that marginalize them and discourage disclosure of sexual health information. Health disparities for Aboriginal queer clients can be exacerbated by a lack of cultural competency and insensitive health care practices. Health disparity is a recurring theme present across decades of research that illustrates persistent health inequalities as well as inadequacies within health care systems.

Aboriginal health research

A 1996 study by MacMillan, MacMillan, Offord, and Dingle aimed to inform health care providers about the health status of Aboriginal people in Canada. As a result of a literature review from materials published on MEDLINE from 1989 to 1995, MacMillan, MacMillan, Offord, and Dingle's study illustrates significant health disparities between Aboriginal people and other Canadians, in many cases these health disparities still exist today. At the time of this 1996 research both mortality and morbidity rates were higher for the First Nations population; Aboriginal populations in Canada had an increased risk of death from alcoholism, homicide, suicide, and pneumonia

(MacMillan, MacMillan, Offord, & Dingle, 1996). Chronic conditions were also more prevalent among First Nations people,

Of the aboriginal population of Canada 15 years of age and older, 31% have been informed that they have a chronic health problem. Diabetes mellitus affects 6% of aboriginal adults, compared with 2% of all Canadian adults. Social problems identified by aboriginal people as a concern in their community include substance abuse, suicide, unemployment and family violence (MacMillan, MacMillan, Offord, & Dingle, 1996, p. 1569).

In 1996, knowledge about factors contributing to the health status of Aboriginal people was limited because the literature did not commonly assess social causes such as poverty, however it was known that, “Canadian aboriginal people die earlier than their fellow Canadians, on average, and sustain a disproportionate share of the burden of physical disease and mental illness” (MacMillan, MacMillan, Offord, & Dingle, 1996). This research was conducted almost twenty years ago and many of these issues are still a cause for concern.

Kirmayer, Simpson, & Cargo (2003) analyzed health promotion with Aboriginal peoples in order to identify issues and concepts that could guide the development of culturally appropriate mental health promotion strategies with Aboriginal peoples in Canada. While conducting their research Kirmayer Simpson, and Cargo (2003) found that many Aboriginal communities experience high rates of demoralization, depression, substance abuse, suicide and other mental health problems. Through a literature review, they analyzed links between the history of colonialism and government intervention, such as residential schools and exerting bureaucratic control, and current mental health issues of Aboriginal peoples in Canada. Social problems require social solutions, and addressing

historical mistakes means empowering collective Aboriginal identities so that they may strengthen individual identities and self-esteem, elements which are central to health and well-being (Kirmayer, Simpson, & Cargo, 2003, p. S21). Because collective Aboriginal identities have been damaged, individuals' social capital, power, and mobility suffer (Kirmayer, Simpson, & Cargo, 2003). The authors concluded that mental health promotion that focuses on youth and community empowerment is likely to have positive effects on mental health and well-being in Aboriginal communities (Kirmayer, Simpson, & Cargo, 2003).

Queer health research

Aboriginal people in Canada suffer from persistent health inequalities, such as higher rates of obesity, mental illness, and chronic conditions; and Canada's queer population is also at increased risk of poor health. Tjepkema's Canadian research (2008) asked whether consultations with health care providers, not having a regular doctor, unmet health care needs, and receiving preventive screening tests would vary by sexual orientation. Tjepkema (2008) examined health care use among gay, lesbian, and bisexual Canadians, via data from the 2003 and 2005 Statistics Canada's Canadian Community Health Survey (CCHS). Self-perceived general health of gay and lesbian respondents was similar to that of heterosexual respondents, while bisexual men and women were more likely to report fair or poor health (Tjepkema, 2008).

The rate at which respondents consulted health care professionals differed by sexual orientation, regardless of socio-demographic and health status differences. Gay

men and bisexual women reported more chronic conditions than heterosexual respondents. A large proportion of bisexual Canadians reported having mental health problems; bisexual men were more than twice as likely to perceive their mental health as fair to poor compared to heterosexual men, and bisexual women reported fair or poor mental health at three times the rate of heterosexual women (Tjepkema, 2008). Gay, lesbian, and bisexual participants reported they had been diagnosed with a mood or anxiety disorder at higher rates than respondents from the heterosexual population, this was particularly prevalent among bisexual women who reported being diagnosed with a mood or anxiety disorder at a rate of one in four (Tjepkema, 2008).

The apparent differences in rates of poor health between queer and heterosexual Canadians are likely related to clients not feeling as though they can be open about their sexuality with health care providers. Some research suggests that not disclosing one's sexual orientation to their family doctor results in lower rates of consultation, as is the case for Canadian lesbians (Tjepkema, 2008). Health care provider attitudes toward queerness shape the interactions they have with clients as well as clients' comfort levels which in turn impacts queer clients' health. Attitudes and practices that discourage disclosure of important health information contribute to health disparities between queer and heterosexual Canadians that could be avoided.

Goldberg, Harbin, & Campbell (2011) asked whether fears and misunderstandings of queer orientations shaped nurse–patient interactions in eastern Canada, especially in the context of birthing care. Through a feminist and queer phenomenological methodology that focuses on experiential data gathered through

interviewing nurses, birth mothers and non-birth mothers, Goldberg et al. (2011) cultivated an understanding of lesbian couples' relationships with perinatal nurses and queer embodiment in the context of heteronormative birthing care. They concluded that queering the birthing space will require a shift in, and a disruption of, expectations and relations within these spaces to include orientations that reside outside heteronormativity. Goldberg et al. (2011) note that lesbian couples entering birthing spaces are not enough to queer them, and that nurses must be called on to notice, anticipate, or respond to lesbian couples' distinct health care needs. This approach relies on the strength and openness of all participants to rework practices and spaces so that birthing does not entail treating all bodies and births as the same (Goldberg, Harbin, & Campbell, 2011). In the same way that heteronormativity should be challenged to create safe health care spaces in the context of giving birth, health care practitioners must shift their practices and attitudes to improve the health care experiences of queer clients in all aspects of health care.

Aboriginal queer health research

Where queer and Aboriginal identities intersect health disparity can be exacerbated by multiple factors. The literature on Aboriginal queerness in general demonstrates that it is associated with increased levels of poverty, HIV infection, and that this population experiences oppression in the form of homophobia and hegemonic power structures that limit their autonomy (Heath et al., 1999; Brotman, Ryan, Jalbert, & Rowe, 2002a).

A 1999 Canadian study conducted by Heath et al. that focuses on men who have sex with men asks whether sociodemographic characteristics and risk taking behaviors associated with HIV infection of Canadian Aboriginal participants differ from those of non-Aboriginal decent. Data collection was conducted in the greater Vancouver region; men who had not previously tested positive for HIV were asked to complete a self-administered questionnaire via mail and undergo HIV testing on an annual basis (Heath et al., 1999). Participants had to have not tested positive previously because this study focused on factors associated with contracting HIV rather than managing the disease. It was discovered that Aboriginal participants had an elevated risk of poverty and HIV infection compared to their non-Aboriginal counterparts (Heath et al., 1999).

Although health disparities do take the form of elevated risk of HIV infection, they are also present in differing rates of mental illness. This is related to poor access to services and discrimination experienced by Aboriginal peoples. A community-based needs assessment was conducted for the transgender and two-spirit people of Manitoba and Northwestern Ontario in 2006. The goal of this assessment was to gather data on this populations' safety and security concerns, service and support experiences, and their service and support needs (Barnes, Breckon, Houle, Morgan, Paquette, & Taylor, 2006). Seventy-three respondents provided qualitative and quantitative data via online questionnaires and another seventy-three participants provided more in-depth data through interviews and support groups (Barnes, et al., 2006). The authors found that the rate of STI and HIV infection among their sample was much higher than in the general population. Severe and often suicidal levels of depression were also found to be more

common among participants when compared to rates present in the general population, as 28% of respondents reported having attempted suicide at least once (Barnes, et al., 2006). Frustration and anxiety was expressed in relation to not being able to access transgender transition services and other mental and physical health services. Some respondents reported resorting to purchasing hormones off the internet and administering hormone therapy themselves in the absence of having access to physician-guided hormone therapy (Barnes, et al., 2006). When asked about mainstream service providers, participants indicated they encountered a lack of knowledge about Aboriginal cultures and insensitivity to queer health concerns. Many of the participants were living in poverty or near-poverty, often unemployed, underemployed, or unhappily employed due to being unable to express their real identity (Barnes, et al., 2006). Some transgender individuals left their jobs to transition, while others indicated that they were restricted in their place of work due to their visible gender variance. The authors recommended that a dedicated Center for Excellence be established in the area of transgender care to achieve a basic level of transgender competence for the medical and counselling services in the region (Barnes, et al., 2006). In addition, the authors suggested that appropriate training for transgender and two-spirit care be offered to first responders in emergency and police services, as well as the development of trans-inclusive, anti-discrimination policies in the school system and workplaces (Barnes, et al., 2006).

Health disparities are linked to structural oppression that impacts Aboriginal queer clients' ability to maintain good health. Research conducted in Manitoba in 2010 asked what the health concerns were for Aboriginal two-spirit and LGBTQ peoples in the

province. This question was answered by conducting semi-structured interviews and focus groups with Aboriginal queer participants (Ristock, Zoccole, & Passante, 2010). The authors hypothesized that there would be significant barriers that would impact participants' capacity to be healthy: "the impact of structural oppression including homophobia, heterosexism and racism are all likely to play a role in the health and well-being of Aboriginal Two-Spirit and LGBTQ peoples" (Ristock, Zoccole, & Passante, 2010, p. 5). Racism, heterosexism, and homophobia can make interactions with institutions difficult and limit the effectiveness of treatments. Perceiving health care settings as hostile can have devastating effects on accessing services,

Many GLBT people will postpone using services for fear of prejudice, discrimination or misunderstanding, many will not come out even though this constitutes not sharing important health-related information, and in other cases, health professionals focus their energy on fixing their patient's orientation or identity instead of taking care of the presenting concerns (Ristock, Zoccole, & Passante, 2010, p. 10).

Aboriginal and queer identities intersect in ways that produce health-related issues that are unique to these clients. Some of the concerns linked to Aboriginal queer identities are suicidal feelings; depression; isolation; experiences of discrimination and violence; STI and HIV infection. Aboriginal queer people also experience difficulty gaining access to appropriate care as well as employment, housing, education and job training (Ristock, Zoccole, & Passante, 2010). The authors felt that it was the responsibility of Aboriginal two-spirit and LBGTQ people to educate others and participate in creating safe spaces as well as those in the community, school and health care systems.

A review of the literature on health disparities shows that Aboriginal, queer, and Aboriginal queer peoples experience a disproportionate amount of physical and mental illness compared to non-Aboriginal and heterosexual Canadians. The literature on health disparities links discrimination to poor health outcomes (Barnes, et al., 2006). Clients may feel intimidated or fearful of health care spaces and therefore avoid these spaces, which contributes to poor health (Tjepkema, 2008; Ristock, Zoccole, & Passante, 2010). Health disparities are related to a lack of cultural competency and insensitive health care practices that marginalize Aboriginal and queer clients. Therefore, health disparities are influenced by health care practices that negatively impact participation in health care which contributes to poor health outcomes for Aboriginal and queer clients.

Social determinants of health

Despite the pressure to engage in risk prevention measures and take personal responsibility for one's own health (McDaniel, 2013) individual choices are not the most salient contributors to good health. Mikkonen and Raphael note that "the primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health" (2010, p. 7). While the previous sections in this chapter discuss living conditions, such as social exclusion, in relation to health, this section focuses on research that uses a social determinants of health approach that examines health in relation to specific formally recognized social factors that determine health outcomes. A social determinants of health approach to research "examines the social

factors essential to the preservation and optimization of health, prevention of disease, and guarantee of maximum quality of life” (Dysart-Gale, 2010, p. 24).

The fourteen key social determinants of health in Canada are income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety net, health services, Aboriginal status, gender, race, and disability (Mikkonen & Raphael, 2010). Deficits in social determinants of health have a large impact on the health of individuals, “their effects are actually much stronger than the ones associated with behaviors such as diet, physical activity, and even tobacco and excessive alcohol use” (Mikkonen & Raphael, 2010, p. 9).

Here I review the literature on social determinants of health in relation to Aboriginal and queer peoples in Canada. For Aboriginal clients, adverse social determinants of health are linked to marginalization and racism that perpetuate racialized health disparities. Queer Canadians are more likely to be the victims of crime and experience discrimination in terms of employment and housing. Queer populations also experience discriminatory attitudes and practices in health care settings which impacts their ability to live healthy lives. This section demonstrates that health care realities are deeply rooted in social determinants of health. The current study draws from this literature in order to establish research questions as well as analytical and methodological approaches that are discussed at the end of the literature review.

Aboriginal health research

The health of Canada's Aboriginal peoples is inseparably linked with a history of marginalization which

Has taken the form of legislation such as the Indian Act of 1876, disregard for land claims of Métis peoples, relocation of Inuit communities, and the establishment of residential schools. The result has been adverse social determinants of health and adverse health outcomes (Mikkonen & Raphael, 2010, p. 41).

Research from Nelson (2012) examined how power exerted over Aboriginal peoples is reflected in mental health service research, which as Nelson suggests, create social determinates of mental health for Aboriginal peoples. The purpose of this research was to establish a clear definition of mental health, how it is measured, and how these intersect with power exerted over Aboriginal peoples and current mental health realities. Research involving Aboriginal peoples has historically been influenced by 'Western' ways of knowing that involve assumptions about what constitutes mental health (Nelson, 2012, p. 2). Nelson's data was gathered from a literature review of material relevant to government intervention in the lives of Aboriginal peoples and a variety of proposed social determinants of health and mental health in Aboriginal contexts. The databases used include JStor, CINAHL, Medline, PsycInfo, and the Bibliography of Native North Americans as well as select journals and reference lists. Nelson notes that there is a significant gap in the literature, as Young also did in 2003, caused by a deficit in research regarding Métis mental health (2012). Nelson concluded that

For Aboriginal peoples in Canada, colonialism limits available resources and opportunities, thereby making it more difficult to maintain health. More directly, colonialism has impacted Aboriginal peoples' mental

health through the experience of residential schools, as well as government restrictions on ceremonies and movement in and out of reserves (2012, p. 9).

Nelson (2012) used the term ‘colonialism’ to express different forms of power that is exerted on Aboriginal peoples that limits their autonomy at different points in history. The lasting influence of government intervention can be seen as a determinant of health that also has the ability to influence other health determinants. Nelson recommended that hidden colonizing assumptions that marginalize Aboriginal understandings of mental health be challenged in the delivery of health services with the help of Aboriginal people, researchers, clinicians and policy makers with the understanding that the production and acceptance of knowledge is not without culturally-specific ideas and values (2012).

In a study conducted by Allan and Smylie (2015) the roles of racism were examined in relation to social determinants of health and the health and well-being of Aboriginal peoples in Canada. The authors contend that

Policies and practices emerging from imperialistic and colonial ideologies have been extremely destructive to the health and well-being of Indigenous peoples, cutting across the broad spectrum of social determinants of health, impacting access to education, housing, food security, employment and health care, and permeating societal systems and institutions that have profoundly impacted the lives and well-being of Indigenous peoples including the child welfare and criminal justice systems (Allan & Smylie, 2015, p. 1).

Allan and Smylie used mixed methods to explore the roles of racism in health disparities including gathering narratives shared by their Counsel of Indigenous Grandparents and using a critical Indigenous theoretical lens to analyze the impact of policies and practices on the health and well-being of Aboriginal people. Their critical analysis connected

historical and contemporary racism to current realities while countering illustrations of Aboriginal health that pathologize First Nations people as sick, disorganized, and dysfunctional (Allan & Smylie, 2015). The authors also relied on a thorough literature review conducted by searching multiple databases for publications that focus on the intersections of racism, discrimination, health and health care. Allan and Smylie state that historical and contemporary contexts of racism, “negatively shape the life choices and chances of Indigenous peoples in this country [Canada]” (2015, p. 1) and that racism is an intrinsic contributor to severe health disparities between Aboriginal and non-Aboriginal people. The authors noted that out of all other groups in Canada, Aboriginal peoples experience the worst health outcomes; they disproportionately share the burden of mental and physical illness (Allan & Smylie, 2015).

Allan and Smylie concluded that Aboriginal people must be present in research and knowledge production in order to interrupt racism that dehumanizes Aboriginal people, negates their histories, dismisses their health knowledge and practices, and attributes health disparities as being results of individual and collective deficits rather than centuries of violence, marginalization and exclusion (2015). Without Aboriginal voices in academic research racism and discrimination have a greater impact on policies and practices that can perpetuate a false representation of Aboriginal peoples.

Previous research notes that Aboriginal peoples in Canada are disadvantaged in regards to many of the fourteen social determinants of health. A 2014 study by Mitrou, Cooke, Lawrence, Povah, Mobilia, Guimond, and Zubrick aimed to find out if any progress had been made in closing the gaps in education, employment, and income

between the Indigenous and non-Indigenous populations in Australia, Canada, and New Zealand. Within the context of Mitrou, et al.'s study "the term 'Indigenous persons' is used interchangeably to refer to Australian Aboriginal and Torres Strait Islander peoples, Canadian Aboriginal peoples (including First Nations, Inuit and Métis), and New Zealand Māori" (2014, p. 3). Education, employment, and income are all social determinants of health, thus gaps in these determinants between Aboriginal and non-Aboriginal peoples result in health disparities between these populations.

The authors used census data from Australia, Canada, and New Zealand to compare outcomes for the cohort of citizens aged twenty-five to twenty-nine years for each year from 1981-2006 for education, employment, and income (Mitrou, et al., 2014). Mitrou, et al. found that in all three countries Indigenous populations were almost as disadvantaged in 2006 as they were in 1981 on the three social determinants of health examined in this study (2014). Specifically, gaps in employment and income remained largely static from 1981-2006 and Indigenous populations were more disadvantaged in relation to non-Indigenous people in the education domain in 2006 than they were in 1981. In Canada the gap in attainment of a bachelor degree or higher qualification for Aboriginal and non-Aboriginal people grew from 10.9% in 1981 to 17.6% in 2006 (Mitrou, et al., 2014). This study demonstrates that despite high levels of human development, Australia, Canada, and New Zealand have not been able to close important gaps in education, employment, and income. The authors concluded that new approaches for addressing gaps in social determinants of health are required if progress is to be made on achieving equity (Mitrou, et al., 2014).

Queer health research

Although queer status is not officially considered a social determinant of health

Mikkonen and Raphael state that

There is also evidence that gay, lesbian, and transgendered Canadians experience discrimination that leads to stress that has adverse health effects. This is especially a problem during adolescence when gay and lesbian youth need to come to terms with their self-identity. Discrimination is also an ongoing problem when these Canadians enter the work world (2010, p. 45).

Thus, social exclusion, employment, and working conditions are social determinants of health that may disproportionately impact queer Canadians based on the discrimination they face.

A 2006 study found that sexual minority adults in Canada experience discrimination in terms of employment, housing, social interactions as well as crimes that range from property damage to murder (Saewyc, Skay, Pettingell, Reis, Bearinger, Resnick, Murphy, & Combs, 2006). The authors use a social determinants of health approach to examine the relationship between treatment related to being queer and negative health outcomes, as “Health Canada has identified stigma and discrimination based on sexual orientation status as social determinants of health that contribute to health disparities for LGB people” (Saewyc, et al., 2006, p. 197). This 2006 study concentrated on secondary analysis of high school health surveys done in the United States and Canada as well as data from a larger study of health and risk behaviors, stigma, and sexual orientation. The authors asked whether or not there is a link between stigma, abuse and becoming homeless or being brought into the child welfare system

(Saewyc, et al., 2006). They concluded that due to the higher prevalence of abuse among LBG youth they are disproportionately represented in runaway and homeless populations as well as within the juvenile justice and foster care systems (Saewyc, et al., 2006). The authors suggest that child welfare and other youth service providers be aware of the heightened risk faced by LBG youth and offer appropriate care. Saewyc, et al. note that individual and community measures that are intended to prevent child abuse and family violence should “incorporate messages that emotional pressure or corporal punishment will not change a child's most natural gender expression or sexual orientation” (2006, p. 210). Saewyc, et al. (2006) demonstrates that discrimination as a social determinant of health can impact the ability of LBG youth to achieve and maintain good health and well-being.

In 2013 Taylor, Clow, and Jantzen used a social determinants of health approach to study social and economic inclusion and exclusion, referred to as SEI, to evaluate the relevancy of the Public Health Agency of Canada’s Healthy Living Strategy (HLS) aimed at reducing obesity, improving diets and increasing physical activity. This study examined how LGBTQ populations were made invisible or were assumed to conform to dominant, usually heterosexist, understandings of gender and sexuality in measures of healthy living, in particular in the HLS (Taylor, Clow, & Jantzen, 2013). SEI can have devastating results, for people who are “excluded, whether because of poverty, ill-health, gender, race, or lack of education, do not have the opportunity for full participation in the economic and social benefits of society” (Taylor, Clow, & Jantzen, 2013, p.5). SEI is self-perpetuating; social exclusion impacts economic inclusion and economic exclusion

works to restrict social inclusion. The authors concluded that a more inclusive approach to healthy living needs to be adopted, one that includes paying attention to social determinants of health (Taylor, Clow, & Jantzen, 2013). There is an urgent need to address health disparities that affect LGBTQ people and for culturally competent policies and practices to support a comprehensive approach to healthy living beyond measures of weight, diet, and physical activity. This study illustrated how social exclusion restricts access to preventative health measures and negatively impacts the capability of LGBTQ people to live healthy lives.

Research from Dysart-Gale (2010) examined the social and health-related experiences of lesbian, gay, bisexual, transgendered, intersexed, and queer (LBGTIQ) youth in Canada in relation to the WHO's social determinants of health. The WHO defines the social factors that determine health as "peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity" (Dysart-Gale, 2010, p. 24). In order to examine the relationship between LBGTIQ experiences and social determinants of health the author conducted a literature review of articles from PubMed, Academic Search Primer, and Canadian government documents (Dysart-Gale, 2010).

Dysart-Gale (2010) found that the social determinants of health needs of LBGTIQ persons in Canada are often jeopardized. The peace and shelter of LBGTIQ youth may be at risk by being forced from their homes or experiencing abuse within their homes, the author notes that "over 60% of violence against LBGTIQ youth is inflicted by family members" (Dysart-Gale, 2010, p. 24). In addition, LBGTIQ youth are more likely to

experience bullying and marginalization in their schools and community, disrupted education, and poor economic security (Dysart-Gale, 2010). Dysart-Gale (2010) stated that as a result of deficits in social determinants of health experienced by LBGTIQ youth in Canada they are at higher risk of suicide and mental health issues than their heterosexual counterparts. The author concluded that “homophobia and prejudice exert a negative impact upon the health and well-being of all LBGTIQ individuals; young people whose sense of personal and sexual identity is still in development are particularly vulnerable” (Dysart-Gale, 2010, p. 27). Although Canada has removed many of the legal barriers faced by LBGTIQ people in other parts of the world by legalizing same-sex marriage and making discrimination based on sexual orientation illegal, LBGTIQ still experience poor health outcomes due to their social determinants of health needs being unfulfilled (Dysart-Gale, 2010).

Studies that use a social determinants of health approach to examine health outcomes for Aboriginal and queer people indicate that these populations experience significant deficits in social determinants of health which negatively affects their health. Aboriginal peoples in Canada are affected by historical and present-day marginalization, discrimination, and racism that impacts access to a broad spectrum of social determinants of health including education, housing, employment, and health care. The social determinants of health needs of queer people in Canada are often jeopardized by discrimination in terms of employment, housing, economic and social exclusion, and homophobia. Thus, poor health outcomes for Aboriginal and queer peoples is related to key living conditions that make achieving and maintaining good health difficult

Discussion

The known research demonstrates links between marginalization, discrimination and exclusion based on sexual orientation and Aboriginal status that contributes to poor health outcomes and significant health disparities between Aboriginal and queer peoples in relation to non-Aboriginal and heterosexual people in Canada. Aboriginal and queer populations are often absent from academic studies which increases the invisibility of their health needs and limits the effectiveness of health care initiatives directed at them. The current study draws on past research concerning Aboriginal, queer, and Aboriginal queer peoples by cultivating specific approaches and goals. In particular, research such as Young's 2003 review demonstrates an epistemological stance that overlooks Aboriginal research done outside of Western scientific traditions which illustrates the need for a postcolonial theoretical framework that values marginalized voices as experts in their own experiences (Browne, Smye, & Varcoe, 2005). The current study uses a postcolonial analytical framework because Canadian society is postcolonial in nature in that we all deal with the after-effects of colonial expansion (Nelson, 2012). In addition, previous research has linked Aboriginal health outcomes to historical power relations and the continued marginalization of Aboriginal peoples in Canada (Nelson, 2012; Kirmayer, Simpson, & Cargo, 2003; Allan & Smylie, 2015). Postcolonial research can help academic studies become more aware of how colonialism is reflected in current realities in order to create policies and services that aim to decolonize and eliminate health inequities between Aboriginal peoples and other Canadians. Postcolonial theory helps

me to interpret access and experiences of using health care services by showing how hegemonic power structures have shaped Aboriginal queer participants' health care utilization (Spurlin, 2001).

In the next chapter I focus on the postcolonial queer analytical framework used in the current study. I outline the history of European colonial expansion in Canada to provide context for postcolonial research. I then discuss what postcolonial theories are and how they are used. I describe how postcolonial and queer theories intersect and why I am using a postcolonial queer framework. I end the next chapter by describing how a postcolonial queer analytical framework is applied in the current study.

Chapter 4: Analytical Framework

In this chapter I discuss the postcolonial queer analytical framework used in the current study in order to understand what postcolonial theories are, why I am using a postcolonial queer framework, and how I am applying this framework. I begin this chapter by discussing the history of European colonial expansion in Canada to provide historical context and to demonstrate why it is important for academic research to understand colonialism and the effects of colonial relations. I then engage in a general discussion of postcolonial theories and their applications for academic research and activism as well as some of the criticisms of this approach and how I address them. I then demonstrate how postcolonial theories are applied specifically to analyzing health care discourses and practices. This is followed by a discussion of how a postcolonial theoretical lens is complimentary to studying issues related to queerness as well as being Aboriginal by illustrating intersections between postcolonial and queer theories and how these understandings can be combined. Finally, I end this chapter with a summary about what a postcolonial queer theoretical framework adds to my project and how postcolonial queer theory is used within the context of the current study.

Historical context

The colonial enterprise of the nineteenth-century was a result of privileged European epistemological traditions and systems of representation that facilitated European expansion and subservience of non-European cultures (Ashcroft, Griffiths, &

Tiffin, 2003). Postcolonial theories connect the legacy of European colonial expansion with present realities. In order to understand why postcolonialism is important to Aboriginal queer health research we must try to understand colonialism and its effects, including marginalization and social exclusion. Postcolonial theories focus on the voices of marginalized populations as the starting point of knowledge production in order to hold structures of power accountable for the ways in which they shape and limit the lives of individuals.

Every resident of Canada is affected by the legacy of colonialism because Canadian society is postcolonial in nature; “postcolonial societies are those which endure the ongoing and continually evolving ‘after-effects’ of colonial relations” (Richmond, 2007, p. 347). Due to colonialism, Aboriginal identities began as purely a state construction (Alfred, & Corntassel, 2005). Because constructions of Aboriginal identities have historically been creations of the dominant culture and to a certain extent remain so due to continued marginalization, understandings of Aboriginal queer health care needs are also shaped by the dominant culture. Postcolonial research can help reconcile our past with new policies and services that aim to decolonize and eliminate health inequities between Aboriginal peoples and other Canadians. Recognizing the impacts of colonialism helps people see that differences in health outcomes are socially created and that health disparities can be changed,

The after-effects of this legacy contribute to the health and social inequalities we witness across Indigenous populations today, including lower life expectancies, elevated infant mortality, persistence of infectious disease, and increased rates of non-communicable diseases, accidents, violence and suicide (Richmond, 2007, p. 348).

The current study addresses Canadian historical and contemporary relations that marginalize Aboriginal and queer peoples. Although colonial expansion took place in the 1800s, Canada is still marked by its effects. Colonialism effaced many aspects of Aboriginal culture; persisting social and geographic marginalization are a result of imperialist relations of rule (Haig-Brown, & Nock, 2006; Bannerji, 2004; Smith, 1999). Erasing Aboriginal social structures and culture combined with geographic marginalization has formed a Canada where Aboriginal experiences are often absent from academia and other sites. Part of the lasting effects of colonialism is that Aboriginal peoples are sometimes assumed to be a homogeneous population, which ignores the various societies and identities within Aboriginal groups (Meyer-Cook & Labelle, 2004). The current study focuses on Aboriginal residents and identities in Newfoundland and Labrador. If academic pursuits are not reflexive of historical contexts research will not be able to understand colonialism, nor will it be able to counter its effects.

Postcolonial theory

Postcolonial theories are interdisciplinary in nature and encompass a myriad of theoretical, political, and cultural meanings and understandings. As Sugars (2004) notes, the plurality of the postcolonial experience causes any one definition of postcolonialism in a Canadian context to be impossible; while there are similarities in experiences, individuals interpret their experiences differently. The use of postcolonial theories varies across disciplines such as historical literary analysis, studying geographical borders, or studying colonial influences in societies. However, they all share a social, political, and

moral concern about how colonialism continues to shape people's lives. Because of the diverse ways in which postcolonialism manifests, Gandhi (1998) finds it useful to separate postcolonialism's academic and intellectual background from the issues and themes that attract the attention of postcolonial critics. Academically, postcolonialism arises from poststructuralist theorizing (Barker, Hulme, & Iverson, 1996) as well as materialist philosophies, such as Marxism (Gandhi, 1998). While poststructuralist critiques of Western ways of knowing and theorization of culture is important to postcolonial theory, Marxism is more closely related to postcolonial politics; therefore a postcolonial theorist must work toward negotiating between both modes of thought (Gandhi, 1998). Postcolonial theorizing in academic research tends to critique the structural conditions that arise from colonialism and colonial relations; this theoretical lens focuses on the influence European expansion has had over social realities. The politics of postcolonialism is evident in particular types of activism and other public platforms, and can take the form of demonstrating how power relations and cultural marginalization shape and limit the lives of individuals in an effort to affect change in policy, programs, or practices. It is important to note that the distinction outlined here between theory and practice informed by politics and intellectual schools of thought are not mutually exclusive; academic analysis can be a form of activism and advocacy can be supported by scholarly efforts.

Postcolonialism refers to an historical period that has occurred after a phase of imperialism, or the globalization of capitalism, however it is not reducible to these categories in all contexts (Childs, Williams, & Williams, 1997). Although there is a

global dimension to postcolonialism, these theories are not universal in an effort to explain global phenomena. Neo-colonialism refers to economic, political, or cultural pressures that are employed by countries to control or influence other countries, especially former colonies. The 'post' in postcolonial does not mean 'after colonialism' but instead it signifies a reflexive process which allows us to be more aware of our location in history and be "more alert to the possibility that our decisions may be colonizing rather than decolonizing in their consequences, more able to be responsive to new situations of disadvantage and more able to correctly analyze and redress the specifics of local oppressions" (Smye & Browne, 2002, p. 44). Rather than claiming we exist in a period of time 'after' colonialism, postcolonial theory is a response to the persistence of colonial, or neo-colonial, influences in the world and a challenge to universal claims about experiences and ways of knowing (Walder, 2005).

Some of the criticisms levied against postcolonial theories include that they are an effort to ignore history and impose a fictitious 'end' to colonialism (Childs, Williams, & Williams, 1997). It is important to keep in mind that the effects of colonialism are still widely felt and new forms of oppression that exert power over vulnerable groups of people are at work shaping lives and opportunities. Colonialism is not finished business; in Canada the regulation of Aboriginal peoples through social policies, the restrictions placed on Aboriginal self-government, land claims, and economic development in Aboriginal communities are a remnant of our colonial past (Browne, Smye, & Varcoe, 2005). 'Post' does not imply that we have moved past or beyond inequitable social

relations, but rather that emergent, new configurations of inequities are being exerted (Browne, Smye, & Varcoe, 2005).

At present, postcolonial inquiry brings forth voices formerly excluded from Western academia and enables non-Western critics who reside in the West to present their cultural epistemology as knowledge (Gandhi, 1998). However, comparing Western ways of knowing to non-Western schools of thought can have the effect of producing a false dichotomy in which Western culture is taken to be normative and superior.

Postcolonial studies in the West can have the effect of ‘othering’ non-Western knowledge and culture compared to ‘normative’ Western ways of knowing by positioning non-Western knowledge as marginal even if it is foundational in other parts of the world (Gandhi, 1998). This does not have to be the case in postcolonial inquiry, however sensitivity to these issues is important to prevent research efforts from being colonizing rather than decolonizing.

Postcolonial theory in analyzing health care

In relation to health care, a lack of participation on the part of Aboriginal and queer clients may be blamed on the supposed characteristics of those belonging to these groups rather than social conditions that prevent access to appropriate services. I use a postcolonial queer analytical framework to focus on this shift in responsibility as a mechanism that perpetuates health disparities; according to Browne and Smye, “a post-colonial framework leads us to interrogate those contradictions in health care that mistakenly reduce social inequalities to lifestyle choices, racism to ethnocentrism, and

lack of participation in health care as stemming from cultural differences” (2002, p. 38). These contradictions are apparent in discourse that advocates cultural sensitivity or encourages preventative testing while ignoring the fact that many Aboriginal clients continue to feel marginalized in relation to the mainstream health care system, thus resulting in their reduced participation (Browne, & Smye, 2002, p. 38). Health care spaces are not always welcoming and accepting to those who do not fit dominant norms which can lead people to avoid seeking care or to seek care from traditional or alternative health care providers. Advocating cultural sensitivity or preventative testing shifts responsibility onto clients without addressing core issues within health care institutions.

The current study aims to uncover how health care operations contribute to health inequities and social marginalization. Browne and Smye state that “from a post-colonial perspective, we are interested in examining healthcare discourses and related policies as political discourses that have the potential to both mask and perpetuate neocolonial practices in health care for indigenous people” (2002, p. 31). Here the authors conceptualize neo-colonial as “literally, new forms of colonial ideology embedded in institutional policies and practices” (Browne, & Smye, 2002, p. 31). Nelson (2012) uses the terms colonial, colonization, or colonialism to signify power exercised over Aboriginal groups that shapes and limits their experiences. The authors found that within health care discourse there needs to be an analytical shift away from what Aboriginal women clients ‘need’, such as increased participation in Pap screening, to examining why these clients are not participating in such programs in order to increase participation rates (Browne, & Smye, 2002). Browne and Smye’s (2002) study is different than work

discussed earlier in this chapter because they focus on healthcare discourse and the ability of such discourse to be liberating or repressive for Aboriginal women clients. While the authors say that analytical frameworks that focus on culture or cultural sensitivity are beneficial, a postcolonial approach enabled Browne and Smye (2002) to see that advocating cultural sensitivity in health care discourse does not cause Aboriginal clients to feel less marginalized in relation to health care.

Richmond (2007) examined how broad social forces, defined as poverty; government paternalism; and forced assimilation influenced access to social support in Aboriginal communities within a postcolonial context. This research was done by interviewing twenty-six Aboriginal Community Health Representatives from across Canada. Access to social support positively affects health; however Aboriginal communities tend to have high rates of morbidity and mortality that are connected to violence and suicide which suggests people within in these communities may not have appropriate access to such support (Richmond, 2007).

Using a postcolonial approach situates Canada as a postcolonial society that continues to cope with the after-effects of colonialism. Richmond described how a postcolonial context is linked to health in Aboriginal communities by saying, “current patterns of health and social suffering reflect the combined effects of colonial oppression, systemic racism and discrimination, as well as unequal access to human, social and environmental resources” (2007, p. 4). The author found that simply making resources available to Aboriginal communities does not address social conditions such as economic dependency and inequality that underpin issues of access to social support (Richmond,

2007). In Richmond's (2007) study a postcolonial approach was used to demarcate a time period after colonialism while acknowledging that the subjects being researched were affected by a legacy of colonialism and oppression. Thus, the lasting effects of European colonial expansion were acknowledged within a postcolonial context that was characterized by racism, discrimination, and poverty that prevented the utilization of social supports.

In 2012 Kral studied suicide rates of Inuit people in postcolonial Arctic Canada which were among the highest in the world. In this study the author asked two questions: who should control suicide prevention and what is the best knowledge base for suicide prevention? (Kral, 2012). In order to answer these questions Kral (2012) examined the effects of government intervention that affected Inuit kin relations, roles, responsibilities, and romantic relationships in the 1950s and 60s using a postcolonial approach. For this study, a postcolonial approach enabled the author to examine power structures that disrupt and marginalize Inuit culture and their effects on suicide rates. Kral (2012) found that government-based mental health care measures were not working to diminish suicide rates and that traditional Inuit healing practices were not present in mainstream clinics. The author stated that government intervention influenced an increase in suicide rates for the Inuit because it disrupted their social order and marginalized their healing traditions (Kral, 2012). Thus, in postcolonial Arctic Canada where government intervention has led to increased suicide rates for Inuit people it may be best for Inuit people to have more autonomy over managing their mental health care by limiting government-based measures and promoting traditional knowledge and healing (Kral, 2012).

Postcolonial theory helps to interpret experiences of accessing health care services by showing how health care discourse and structural factors such as invisibility, marginalization, and social exclusion have shaped participants' health care utilization. Being a member of any given group shapes how one is viewed by others; being Aboriginal and queer may legitimize or delegitimize health care needs, or contribute to the invisibility of those needs. Historically, the dominant culture has mediated constructions of Aboriginal identities (Alfred, & Corntassel, 2005) and to some degree continues to do so due to continued marginalization. This can result in misunderstanding or invisibility of their health care needs; both of which impact the development and delivery of services as well as access and use of services.

Postcolonial queer theory

Historical relations have also impacted social constructions of sexuality. Greensmith and Giwa (2013) suggest that the dominant culture informs Western-Aboriginal relations to sustain White-normed same-sex politics within queer communities in North America. They argue that the needs of Aboriginal queer people are sometimes assumed to mirror the agenda of predominately White queer organizations, which can limit self-determination for Aboriginal queer people, and is colonizing rather than decolonizing. In order to analyze Aboriginal-specific queer experiences and identities one must take into account how dominant discourses of sexuality shape and limit Aboriginal queer experiences.

Ayedemir (2011) notes that postcolonial and queer academic inquiry are usually separated by distinct programs, journals, and careers, which keeps issues concerning sexuality and race at a distance from each other. However, racialization and sexualization are linked through oppressive power relations; sex and race entail different ways of being but they can never be fully separated because they are both products of social understandings and are influenced by each other. Decontextualizing sexuality from cultural contexts provides the mistaken impression that sexuality is homogenous across cultures (Ayedemir, 2011).

Spurlin (2001) criticizes postcolonial theorizing because it has not adequately analyzed queer desire as a viable way of existing in relation to power structures. Studies of marginalization tend to emphasize “national identities and borders, and its attention to race, gender, and class, postcolonial studies have seriously neglected the ways in which heterosexism and homophobia have also shaped the world of hegemonic power” (Spurlin, 2001, p. 185). Similarly, queer research has paid little attention to cross-cultural variations of expression and representation of same-sex desire, “by remaining otherwise narrowly Eurocentric in perspective, the discipline helps to underwrite nationalist strategies at work in many colonial and postcolonial contexts that read homosexuality as foreign to non-Western societies” (Spurlin, 2001, p. 186).

Sexuality is shaped by cultural understandings and traditions; cultural context is one way multiplicity is recognized in sexual expression. However, as Spurlin notes, “homosexualities in non-Western societies are, at best, imagined or invented through the imperialist gaze of Euroamerican queer identity politics...or, at worst, altogether

ignored” (2001, p. 185). This understanding of queerness has a homogenizing effect on queer identities that decontextualizes unique cultural expressions of same-sex desires.

There is a need for queer inquiry that focuses on comparative, relational, historicized, and contextualized understandings of what queer is in terms of experience, identity, culture, and history in order to better understand how power works in specific processes.

The notion that queerness has Western origins is colonizing; it limits Aboriginal autonomy to define what queerness is within Aboriginal cultures. This can give the impression that queerness is a tool used to marginalize Aboriginal cultures and can encourage homophobia as a method of resistance to Western ways of being. If queerness is conceptualized as ‘belonging’ to Western culture it would mean that it is imposed and that queer identities can be at odds with racialized identities. Postcolonial rejuvenation of lost Aboriginal histories can produce understandings that restrict sexual expression; because sexualities of the ‘West’ are viewed as foreign and impinging on decolonizing efforts (Patton, 2000). However, sexual categories and the ways queerness is understood are socially constructed, meaning that they are amenable to change. Contemporary understandings of queerness are not the same as they were during European colonial expansion because this concept is historically and culturally specific. Thus, in Aboriginal representations of queerness that have been created and re-created overtime, the social construction of sexuality is not static and therefore cannot ‘belong’ to any one culture. Understanding and conceptualizing same-sex desire as a Western phenomenon affects how institutions relate to queerness and racialized accounts of queerness. Organizations should be aware of the issues associated with ‘White-washing’ queerness in order to

decolonize approaches to health care and well-being. Health care and community spaces should be designed to be welcoming to a multitude of ethnicities and sexual identities without imposing a Western understanding onto these identities.

Queer and postcolonial theories share a goal to displace normative understandings of how people are situated in a given social space. Queering postcolonial studies problematizes how these studies are defined and seeks to interrupt “colonial, heteronormative, or otherwise hegemonic stratifications” (Dayal, 2001, p. 305). Postcolonial queer studies draw parallels between homophobia and racism which can be viewed as analogous and sometimes intimately linked as experiences of discrimination. Queer and postcolonial theories are complimentary to each other and they work together to broaden the interrogation capabilities of postcolonial studies and contextualize sexual expression as culturally important.

Conclusion

In conclusion, the current study relies on two separate, but interconnected, interpretations of postcolonial theory. The first is an understanding that colonialism has shaped the lives of all Canadians and current health and social disparities are linked to our imperial past. The second involves recognizing that postcolonial inquiry is about displacing hegemonic power structures in more than nationalist discourse focused on race, gender, and class. Effacing Aboriginal queerness is a colonizing act because it denies unique cultural representations of same-sex desire and limits autonomy for Aboriginal peoples. It is important to write queerness into postcolonial research where it

has previously been erased or viewed as a product of Western queer identity politics (Spurlin, 2001). Postcolonial queer theory and analysis looks for how queerness is contextualized in culturally-specific forms, uncoupled from understandings that view queerness as an export of Western culture.

Postcolonial queer theory provides a guide of what to look for within data sets, namely how health care discourse and policies reflect the effects of colonialism, such as invisibility, marginalization, and social exclusion, and shape Aboriginal queer clients' utilization of health care services. Because of the diverse nature of postcolonial theories the current study draws on Browne, Smye, and Varcoe's work on Aboriginal health in Canada (2005) as well as Spurlin's (2001) work on postcolonial queer intersections and focuses on Newfoundland and Labrador's unique colonial history and social contexts. I apply a postcolonial queer analytical framework to qualitative content analysis of organizational reports, websites, and interview transcripts from institutional representatives and Aboriginal queer clients. Aboriginal queer participants' experiences of accessing health care services demonstrate how institutional practices shape participation in health care for these clients.

Queer individuals are still the subject of hate-crimes and discrimination based on sexual practices. Given the marginalization of both Aboriginal and queer individuals, particular social circumstances cannot be fully addressed by either queer or Aboriginal support networks (Greensmith, & Giwa, 2013). It is reasonable to hypothesize that Aboriginal and queer identities intersect in unique ways that cannot be properly addressed by scholarship that is not directed at analyzing this intersection. Studies that

specifically address Aboriginal queerness, be that two-spiritedness or not, help to transform health care to better serve Aboriginal queer people (Brotman et al., 2002a). Postcolonial queer research provides direction for researchers and health care professionals who seek to address imbalances between Aboriginal and queer peoples and society in general, this is particularly important for eliminating existing health disparities (Browne, Smye, & Varcoe, 2005). Postcolonial theory is particularly relevant to Aboriginal queer health research because it provides an analytical lens for considering the relationship between our colonial past and current hegemonic power structure as the context in which health care realities are formed.

The next chapter focuses on my data sources and research methods. I begin by outlining the goals of current research and the methods I used. Every data source is presented to provide an account of what was generated from my methods. I then discuss specific methods in detail with sections on semi-structured interviews and demographic surveys, unobtrusive observation, and qualitative content analysis.

Chapter 5: Methods

In this chapter I discuss the research methods used for my study of Aboriginal queer clients' experiences using health care services in St. John's. I begin this chapter by providing an overview of the goals of the current study and the methods used to meet these goals: semi-structured interviews, demographic surveys, unobtrusive observation in public seminars, and qualitative content analysis. I provide a detailed account of every data source garnered by using these methods. I then discuss specific methods in more detail with sections about semi-structured interviews, unobtrusive observation, and qualitative content analysis. These methods are linked to my postcolonial queer analytical framework by describing how data was analyzed.

Thesis goals and methods

For this thesis I have studied available health care services and Aboriginal queer experiences of accessing health care services in St. John's, Newfoundland. My research questions reflect the objectives of this project: to examine the gaps between health care services aimed at Aboriginal queer individuals living in St. John's, Newfoundland and their health care needs. I answer three research questions in this project; what kinds of programs and services designed for Aboriginal queer people, if any, does Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee of Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC) provide? How are these institutions in St. John's addressing Aboriginal, queer, and

Aboriginal queer health needs? What are the experiences of Aboriginal queer individuals when accessing health care? Disparities between services and experiences of use are linked in a discussion of ways to address Aboriginal queerness in health care institutions in St. John's that improves client experiences.

The methods used to answer my research questions are interviews and demographic surveys, qualitative content analysis of institutional texts, data collected during unobtrusive seminar observation, and interview transcripts. I outline specific data sources including seminars, reports, and webpages that indicate dominant health care discourses and practices of SJNFC, PPNL, the ACNL, and Eastern Health. I also detail my processes of analysis and connect it to a postcolonial queer analytical framework.

The following section discusses the methods of semi-structured interviews and demographic surveys. I carried out seven semi-structured interviews with institutional representatives from PPNL, the ACNL, SJNFC, a transgender activist, and three Aboriginal queer participants. I outline recruitment measures and sampling, I then discuss how interviews were analyzed.

Data sources

I interviewed three self-identified female-bodied Aboriginal queer participants who shared valuable, personal information about their health care experiences with me. All Aboriginal queer participants chose their own pseudonym for the current study. The first interview I had was with Mariah who self-identifies as a Métis woman between 36 and 40 years of age. Although Mariah does not readily disclose information about her

sexuality with most people, she identifies as bisexual when speaking to a non-Aboriginal audience and two-spirit when addressing those she knows to be Aboriginal. My second interview was with Lucy Lu, a Native² person between the ages of 36 and 40. Lucy chose their pseudonym based on Lucy Lu being a badass and a superhero; Lucy's understands their³ ethnicity and sexual identities as dynamic and dependent on space, time, location, and context. The last interview was with Billie Reed who is a Chippewa Ojibwa person between 26 and 30 years of age. Billie is not originally from Newfoundland but they have lived in Mount Pearl for five years and uses health care services in St. John's. They felt confident commenting on their health care experiences in the province.

I attended public seminars to gain a more nuanced understanding of health and well-being in Aboriginal contexts. On February 10, 2015 I went to an event sponsored by the Music, Media, and Place (MMaP) Research Center and the Memorial University School of Music; Tuned In: Intercultural and Interdisciplinary Roundtable on Health. The panel of speakers included; Dr. Aaron McKim, Clinical Chief for Long Term Care at Eastern Health and family doctor; Dr. Jane Gosine from the Department of Music at Memorial University; and Dr. Fern Brunger, Health Care Ethics, Memorial University. This roundtable provided valuable insight into challenges that Eastern Health is facing, such as overcrowding and health care provider exhaustion, as well as non-Western cultural approaches to health. The current study draws from the information discussed at this roundtable to provide possible contexts for participant experiences and to broaden the

² Lucy self-identifies as Native instead of identifying with any particular band affiliation.

³ I use the terms "they" and "their" as gender-neutral ways to refer to particular individuals throughout this thesis.

definition of health used to one that incorporates non-Western, Aboriginal concepts of health and well-being.

On March 18, 2014 I attended a discussion circle sponsored by Memorial University's Aboriginal Resource Office called Aboriginal Talks: Empowerment, Status, and Identity. The discussion opened with a presentation about Aboriginal medicines and a smudge by Jenelle and Eastern Owl from the St. John's Native Friendship Center and was followed by an opening prayer by Inuk Elder Emma Reelis. This talk is included as data for the current study because I learned a lot about Aboriginal interpretations of health and well-being, including the importance of non-Western practices such as smudging. Smudging is an Aboriginal ritual where traditional medicines, such as cedar and sage, are burned and the smoke is used to clear away negative energy and invite peace and harmony into a person's life. This process can be particularly helpful when one is faced with a challenging situation or negative environment. The traditional process and medicines used vary by region and specific ceremony; however the purpose of shedding negativity is usually consistent. The current study also draws from open discussions at this event in chapter seven where intervening factors between health care services and experiences of use are discussed. Specifically, I use comments concerning the difficulties associated with claiming an Aboriginal identity in St. John's if one does not look Aboriginal. In particular, people spoke about how important it was to have knowledge of, and be involved in, Aboriginal traditions as opposed to 'proving' one's identity via blood percentage. This contributes to the argument that being Aboriginal in St. John's is

complicated and difficult at times and health care providers need to be aware of these issues.

I interviewed key informants from local organizations including Planned Parenthood Newfoundland and Labrador (PPNL), AIDS Committee of Newfoundland and Labrador (ACNL), Eastern Health, and St. John's Native Friendship Center (SJNFC) in order to gain a better account of how these institutions mediate access to health and wellness services. I interviewed the Executive Directors for PPNL and ACNL who are identified in the current study by their job title instead of their name or a pseudonym. My first interview was with PPNL's Executive Director, who has been working with PPNL for three years and has held their current position since August 2014. PPNL is included in the current study because they provide a range of medical and social services for health and well-being. I also interviewed ACNL's Executive Director, who has been working with the committee for ten years and has also worked as a program manager with Health Canada's AIDS Community Action Program. ACNL is included in the current study because they provide support services including counselling and the Tommy Sexton Shelter, the only low-barrier shelter in St. John's, and are partnered with Eastern Health to provide access to medical services.

The institutional representative I interviewed from SJNFC asked me to choose a suitable pseudonym for them instead of using their job title or name as an identifying marker; I chose the name Riley because it is gender-neutral. They have been working at SJNFC for over seven years and identifies as queer and Inuit. The SJNFC is the only organization in St. John's that specifically addresses the needs of the urban Aboriginal

population. An interview with Taylor Stocks⁴, a prominent local non-Aboriginal transgender activist and writer, is included as data for this thesis. Taylor shared health care and activist experiences which provided direction for my own interview methods and insight into how health care processes in St. John's limit access for LGBTQ peoples.

There were no interview participants from Eastern Health, however I had personal communication with an Eastern Health employee who chose not to have the information they supplied attributed to them. They are a senior executive at Eastern Health and I am including their comments because they help to contextualize why other Eastern Health employees may not have expressed interest in being interviewed. As part of their institutional position, the senior executive provided information on Eastern Health's policies and programs. They informed me that Eastern Health has no policies or programs related to Aboriginal queerness and none are in development, that Eastern Health does not capture client demographics related to sexuality and race, and that there is currently no cultural sensitivity training⁵, although it is being developed for Cancer Care. Thus, because there are no specific programs aimed at Aboriginal queer clients Eastern Health employees may have felt they had nothing to contribute to the current study. I provide a richer discussion of some the issues associated with recruitment in chapter nine.

⁴ Taylor expressed that they wanted to be identified in the dissemination of this research.

⁵ Further inquiries reveal that cultural sensitivity training is available through Eastern Health's Human Resources Department.

Semi-structured interviews and demographic surveys

For the current study I recruited interviewees from three categories: individuals who self-identified as Aboriginal and queer; key informants from Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee of Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC); and Aboriginal or queer advocates and activists. In total, I conducted seven semi-structured interviews for the current study.

Organizations for the current study were selected based on Google searches of key words and phrases. A combination of location signifiers; 'Newfoundland' and 'St. John's'; topic 'health'; and population signifiers 'Aboriginal', 'Indigenous', 'queer', 'gay', 'lesbian', 'two-spirit' and 'transgender' were used to create a list of institutions that could provide appropriate data for analyzing health care and social services in relation to Aboriginal, queer, and Aboriginal queer clients. Eastern Health was chosen because it is largest, most integrated health authority in Newfoundland and Labrador. Planned Parenthood Newfoundland and Labrador (PPNL) was selected because this organization provides medical and social services with a focus on queer health. The AIDS Committee of Newfoundland and Labrador (ACNL) was chosen for their clean needle program, SWAP, because queer and Aboriginal people are more likely to use illegal drugs (*Eastern Health*, n.d.) and their partnership with Eastern Health for client referrals. The St. John's Native Friendship Center (SJNFC) is the only organization in St. John's that exclusively focuses on the urban Aboriginal population and promoting Aboriginal cultures, thus the inclusion of this institution is important. Once organizations

were selected I searched each institution's webpages using the key words and phrases listed above. Other possible institutions I could have included are St. John's Pride for organizing pride-related events, Stella's Circle for their work providing life skills support and counselling among other social programs, and Memorial University for their commitment to Aboriginal and queer issues through research. I decided that Eastern Health, PPNL, ACNL, and SJNFC were the most appropriate organizations to analyze for the purposes of this project based on their connections to medical services and queer, Aboriginal, and Aboriginal queer peoples.

To recruit administrative and front-line staff at Eastern Health I sent emails (Appendix B) to four departments within Eastern Health including their Client Relations Office, Mental Health and Addictions Services, Centre for Cancer Care, and the Aboriginal Patient Navigator (APN) program, the only Aboriginal-specific program provided by Eastern Health. I did not receive any initial interest in the project.

With limited success in recruiting Eastern Health workers as participants after a month of emails, I looked to widen my sample. I applied for an amendment to my ethics application which allowed me to interview representatives of organizations, including but not limited to Planned Parenthood Newfoundland and Labrador (PPNL), Memorial University, and the *'Out'port Magazine*. I chose PPNL because they provide a range of medical and social services; Memorial University for their counselling department, Aboriginal Affairs Office, and LBGT MUN; and *The 'Out'port Magazine* because it is a prominent queer publication in St. John's. LBGT MUN is a student-run organization that supports queer students and promotes queer issues at Memorial University. I sent each

organization, and named department within Memorial University, an email (Appendix B) and was successful in recruiting participants from PPNL, ACNL, SJNFC, and a transgender activist who did not want to be affiliated with any particular organization. The interview schedule for these participants duplicated the one I would have used for Eastern Health employees (Appendix C): they were asked specifically about their official duties, knowledge of Aboriginal queer health initiatives, and whether they saw a need for services directed at Aboriginal queer individuals.

To recruit Aboriginal queer participants I chiefly used public advertising through posters (Appendix D) placed on public boards at the Memorial University campus, the Health Science Center, the Resource Centre for the Arts, the St. John's Native Friendship Center (SJNFC), as well as various health clinics and coffee restaurants downtown. Recruiting was also conducted through the St. John's Native Friendship Center (SJNFC), St. John's Pride and LBGT MUN after two weeks of advertising. Emails were sent to organizations that already had posters at their location because potential participants may not have been aware of the poster or they may have felt more comfortable participating once they received an email from an organization they trust. Snowball sampling was a part of every interview; those who were interviewed were asked to give my contact information to people they knew who may have been interested in participating. My research builds on the sampling technique used by Brotman et al. (2002a) by recruiting participants through the Native Friendship Center and LBGT MUN. Brotman et al. (2002a) note that working with local groups resulted in a somewhat homogeneous sample. In an effort to expand the sample for the current study, recruiting for my study

was conducted with public advertising and snowball sampling in conjunction with recruiting through local organizations.

I interviewed three people who self-identify as Aboriginal and queer. This was slightly disappointing as I had hoped to interview at least six people from this population. However, this project was intended to be about the experiences of marginalized, vulnerable individuals and in retrospect it is not overly surprising that many did not come forward. I reflect on other possible reasons why I may not have had many Aboriginal queer participants in the concluding chapter of this thesis. During the recruitment phase of the study four potential participants contacted me but did not consent to be interviewed. Two people contacted me to arrange an interview, but did not follow through with a meeting in-person. A third person left a nervous, and perhaps even frightened, voice mail message for me. I called them back, but my call was not returned. I had email contact with a fourth potential participant but they did not commit to being interviewed. I am of the opinion that this reluctance to come forward speaks volumes about a hidden, stigmatized Aboriginal queer population in St. John's.

Qualitative, semi-structured interviews help to build on previous studies that are driven by personal narratives as a way of analyzing health care access and experiences of use (Goldberg, Harbin, & Campbell, 2011; Moran, 1996; Brotman et al., 2002a; Barnes, et al., 2006). I chose to interview people because I wanted the experiences of Aboriginal queer people and those who work in health care to be a key aspect of the project. Interview transcripts can provide insight into decision-making which is important to assess how and why people access services. Through qualitative interviews I attempt to

gather data on decision-making in relation to accessing health care services. Moran (1996) demonstrates the importance of documenting agency by illustrating why the lesbians she surveyed made particular health care choices which aids in documenting health care needs. Merely knowing that queer people visit doctors does not tell us why or provide data on the queer populations' knowledge or experience of health care, whereas Moran's (1996) study does. Research that does not account for agency in health care decision-making may overlook social causes, such as perceived discrimination, to explain behaviors. Interview questions (Appendix E) were designed to capture details related to health care use, access and experiences of use. Interview schedules for representatives of local organizations (Appendix C) focused on existing resources for Aboriginal queer individuals and the perceived need for such resources.

I communicated with participants via email prior to confirming a time and location for the interview to take place. During this initial email exchange I sent all of my participants a copy of the consent form (Appendix F). When it came time for the interview I asked whether or not interviewees had any questions before we proceeded. The location of the interview was chosen by individual participants; for the most part they preferred to speak in private locations rather than in public spaces which made it possible to share sensitive, personal information that may not have been shared otherwise. Interviews lasted between twenty minutes and two hours.

During the interviews I took minimal notes and immediately after each interview I transcribed the audio recording. Transcribing directly after each interview helped me connect with the data and link the interview setting to the text. Listening to the interviews

and transcribing the audio recordings was a valuable exercise in developing my skills as an interviewer. I offered all of the participants a copy of my thesis when the project was completed; all of the Aboriginal queer interviewees accepted this offer.

The intended purpose of the demographic survey was to get an idea of what the Aboriginal queer population in St. John's might look like in terms of age, sex, ethnicity and other characteristics (Appendix G). Because I had a small sample there was little consistency in survey results and this method did not fulfill the goals I had for it. In addition, I found the demographic survey to be inadequate in a way that was not related to the number of participants. Personal identities and affiliations were dynamic and dependent on social context. The Aboriginal queer interviewees were from areas other than St. John's and did not hold Aboriginal identities consistent with the commonly ascribed affiliations in Newfoundland and Labrador. Asking participants to disclose what sex was assigned to them at birth could be interpreted as being insensitive to transgender individuals and does not take into account that two-spiritedness can involve identifying as neither male nor female (Wilson, 1996). I learned that identity questions are not readily reducible to categories. I found I was uncomfortable administering the survey and I encouraged participants to write in responses where they felt I had not accounted for their answers. Despite my reservations the participants in this study were understanding and seemed to feel comfortable altering the provided categories to suit their needs, specifically every Aboriginal queer participant chose Aboriginal affiliations that I had not listed.

Unobtrusive observation

I carried out unobtrusive observation at two public seminars; the Tuned In: Intercultural and Interdisciplinary Roundtable on Health and Aboriginal Talks: Empowerment, Status, and Identity. During these seminars I listened and took notes while others spoke and presented ideas and research. I decided to attract as little attention as possible to myself while observing by not commenting or asking questions because I did not want discussions to become about my research, instead I wanted to listen to what others had to say about topics that were related to my thesis without participating in conversation.

Because I did not know what kind of impact my questions or comments would have had on the data I gathered I thought it was best to observe silently. Interference with proceedings could have produced different data (Patton, 2007), particularly at the Aboriginal Talks seminar where much of the seminar was in an open discussion format. However, by choosing to observe I may have affected what others disclosed. Using unobtrusive observation can affect the types of data one has access to, especially if observing is not appropriate for the setting (Blomberg, Giacomi, Mosher, & Swenton-Wall, 1993). People may feel awkward or vulnerable with an observer present. However, I was not the only person at the seminars who choose to remain silent; observing was not out of place in the seminar settings. In addition, I did not feel the need to interject at either of these seminars because I found that all of the contributors made valuable points and I had little to add. Using unobtrusive observation was a personal decision based on a

desire to limit my impact on discussions that worked in the field because of the social settings at the seminars and the speakers present.

Qualitative content analysis

Qualitative content analysis of transcribed interviews and publicly available reports and websites related to Eastern Health and community organizations that focus on queer and Aboriginal peoples is the other main method used in the current study.

Qualitative content analysis refers to the process of interpreting meaning from the content of text data (Hsieh, & Shannon, 2005). I use a directed approach, meaning that I started with a postcolonial queer analytical framework as a guide for coding data. I detail coding techniques at the end of this section.

Textual data was selected according to its relevance to services in St. John's and the possible impact on Aboriginal, queer, and Aboriginal queer clients. Data that did not have commonalities with these themes, such as those concerning services in Labrador, were excluded due to their being beyond the scope of this project which focuses on services and experiences in St. John's. Information about Eastern Health's policies, initiatives, and programs was gathered via webpages from Health Council Canada (n.d.), Eastern Health's Storyline (2014), a public report from Quality Worklife Quality Healthcare Collaborative (2014), Memorial University's Aboriginal Resource Office (n.d.), and community health needs assessment from the Northeast Avalon area (*Eastern Health*, 2010) which includes St. John's and the surrounding area.

PPNL, ACNL, and SJNFC do not engage in their own independent research and they do not require numerous websites to describe the work they do, whereas Eastern Health has a multitude of departments that benefit from having their own webpage and they have the monetary as well as human resources required for engaging in research. Data guiding my analysis for Eastern Health were gathered mainly from official reports, however PPNL, SJNFC and ACNL do not have similar reports available for public use. This is likely due to limited resources; the Executive Director of PPNL pointed out that “to keep the center running, money is a constant source of stress” (interview, May 8, 2015). The ACNL also has to cope with a limited budget, “we only get \$200,000.00 from the federal government to run a province-wide organization and our budget was cut by \$25,000.00 in 2011” (Ex. Director ACNL interview, May 8, 2015). I did not discuss monetary concerns with Riley at SJNFC.

In lieu of public reports I investigated the data available on social media, however I found that sites such as Twitter and Facebook provided limited data. There were no organizational reports and no client comments that could help to answer my research questions, these webpages mainly advertised institutional fundraising opportunities and related accomplishments. For instance, PPNL relies on Facebook, Twitter, and a separate Camp Eclipse website to have a presence on the internet. The PPNL Facebook and Twitter pages mainly promote fundraising efforts for health services, such as encouraging people to donate ten dollars so that PPNL can provide a pregnancy test or fifty dollars for a Pap test, and articles from a range of sources that promote sexual health issues such as sex worker rights and gender neutral bathrooms

(<https://www.facebook.com/PlannedParenthoodNL/timeline>;
<https://twitter.com/nlsexualhealth>). However, I was able to learn that PPNL promotes the rights of sex workers and transgender health issues during my interview with the Executive Director of PPNL who provided a more nuanced discussion of how PPNL works to promote these issues. While the Facebook and Twitter pages for PPNL did help to contextualize the monetary struggles faced by this institution I found the interview I conducted with the Executive Director of PPNL provided more appropriate data for the current study. Similarly, I found that my interviews with the Executive Director of ACNL and Riley, a senior employee at SJNFC, yielded more nuanced and thorough data than the social media pages for ACNL and SJNFC (www.facebook.com/AIDSCommitteeNL;
<https://www.facebook.com/SJNativeFriendship>; https://twitter.com/st_johns_nfc). Therefore, I rely mostly on interview data and official organizational websites outside of Facebook and Twitter to analyze health care discourse and services at PPNL, ACNL, and SJNFC. Although textual material is limited for these institutions I am able to draw from webpages that detail the practices and services offered by PPNL (*Thrive*, 2015; *Camp Eclipse*, 2015), the ACNL (*ANCL*, n.d.), and SJNFC (*Memorial University*, n.d.; *SJNFC*, n.d.) in order to demonstrate the health care discourses employed by these organizations. In addition, I analyzed intake forms from PPNL (Appendix H) and Eastern Health's Adult Central Intake (Appendix I) for mental health and addictions services to demonstrate how communication between clients and institutions is mediated by forms.

Seminar data from the Tuned In: Intercultural and Interdisciplinary Roundtable on Health regarding health care provider burnout are used to discuss the demand on health

care providers and the availability of human resources which has a significant impact on health care provider engagement. Data from the Aboriginal Talks: Empowerment, Status, and Identity discussion circle are used to illustrate structural issues associated with being Aboriginal in St. John's. This was a public event where I did not ask individuals to sign consent forms, thus I draw from this material in a broad sense without quoting people directly. Additional information about institutions, practices, and services was generated through semi-structured interviews with the Executive Directors for PPNL and the ACNL as well as Riley, a senior staff member at SJNFC. These interviews also provide data on structural factors that impact institutional efforts.

Postcolonial queer theory informs my analysis and provides cues for what to look for; namely how health care discourse and experience of using services shapes Aboriginal queer clients' utilization of health care services. A postcolonial queer analysis of textual materials uncovers how health care discourse can guide the delivery of health services in ways that reflect colonial and repressive tendencies (Browne, & Smye, 2002; Spurlin, 2001) in health care for Aboriginal queer people. Health care discourse speaks to how perceptions of Aboriginal queerness are shaping health care realities by influencing access, services, utilization and experiences. As a postcolonial queer analysis of services and experiences of use the current study is engaged in documenting Aboriginal queer experiences while analyzing the forces which may have marginalized them (Walder, 2005).

As discussed in chapter two the historical conditions of colonialism in Newfoundland and Labrador include invisibility, social exclusion, racism, and

marginalization (Tanner, 1998; Bartels & Bartels, 2005; Anderson, 2013; Robinson, 2014). I recognized how Newfoundland and Labrador-specific colonial influences might be reflected in health care discourse and Aboriginal queer clients' experiences by drawing on research that details the history of this province. I worked from my field notes in the case of seminars as well as transcripts and textual materials from the internet.

I coded data manually while reading for themes that shape the development and delivery of health care services and Aboriginal queer clients' utilization of services in seminar presentations, organizational reports, websites, interviews with institutional representatives, and participants' experiences. These themes are sometimes related to social exclusion, invisibility, or marginalization which reflects Newfoundland and Labrador's colonial past. However, structural factors that potentially impact all clients are prevalent as well. For example, a lack of health care providers or inadequate public transportation options may limit access to health care services. Once coding was completed I built hierarchies of themes that are linked to current health care contexts in St. John's, such as health care provider burnout as discussed by Dr. Aaron McKim at the Tuned In: Intercultural and Interdisciplinary Roundtable on Health (presentation, February 10, 2015). I constantly compared data as it was collected in order to document important information about similarities and differences between sources (Glaser & Strauss, 2009).

I used two different coding strategies to account for similar themes present in multiple forms of data and topics that were less common but still important. The first of the two coding techniques is cross-sectional coding; this method categorizes particular

themes across data types. The second coding technique is non-cross-sectional coding (Mason, 2002). Categorization that is not cross-sectional treats data from different sources as distinct. Some of the themes did not appear across multiple sources, therefore a coding technique that captured unique, contextual information was important (Mason, 2002). A non-cross-sectional approach to coding was useful for themes, such as those related to Aboriginal status and sexuality, because they are complicated and polysemic in nature. I tried to preserve the context of narratives and document multiplicity of meaning by categorizing themes within types of data. Non-cross-sectional and cross-sectional coding is used to build explanations out of multiple ways of dividing my data set. Textual, seminar, and interview data are linked to a postcolonial queer analysis of the design and delivery of health care services and experiences of use in St. John's.

Conclusion

In conclusion, this chapter discusses the goals of the current study and the methods used to fulfill these goals. The processes involved in semi-structured interviews, demographic surveys, unobtrusive observation, and qualitative content analysis are described in detail. Postcolonial queer analysis and coding techniques are also discussed. By using these methods I am able to explore any institutional and structural barriers that Aboriginal, queer, and Aboriginal queer clients face that impact their ability to achieve and maintain good health in St. John's. The methods and analysis techniques used also enable me to discuss how client experiences might be improved by drawing on participant experiences and similar studies done in other parts of Canada.

The next chapter is an in-depth postcolonial queer analysis of health care discourse and services offered by Eastern Health, PPNL, ACNL, and SJNFC. Interview and textual data is problematized and linked to Newfoundland and Labrador social contexts and a postcolonial queer framework in order to analyze how access to services for Aboriginal, queer, and Aboriginal queer clients is mediated by society and institutions.

Chapter 6: Health Care Discourse and Available Services

Introduction

Access to health and wellness services is mediated by dominant institutions through discourse and practices. The development and delivery of services impacts the capability of clients to achieve and maintain good health. This chapter focuses on four organizations in St. John's; Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), AIDS Committee Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC). These organizations provide a range of medical and social services that aim to facilitate better health and well-being. I describe these institutions by drawing from interview and textual data that signify the processes involved in developing and delivering services. I then link this data to a postcolonial analytical framework that focuses on themes such as social exclusion, invisibility, and marginalization and how they might be reflected in the development and delivery of health care services.

This chapter on health care discourse and available services at Eastern Health, PPNL, ACNL, and SJNFC answers my first two research questions: what kinds of programs and services designed for Aboriginal queer people, if any, does Eastern Health, PPNL, ACNL, and SJNFC provide and how are these institutions in St. John's addressing Aboriginal, queer, and Aboriginal queer health needs? The chapter is divided into five main sections, the first and second sections describe Eastern Health and PPNL, respectively in terms of how they include clients in the development and delivery of

services, available services, and intake forms that mediate communication between clients and the institutions. Both Eastern Health and PPNL offer medical and social services to their clients, whereas the ACNL and SJNFC have programming that is primarily social. I use Eastern Health's community health needs assessments, website data from Health Council Canada that detail the Aboriginal Patient Navigator program at Eastern Health, PPNL's web pages, interview data, and intake forms to illustrate health care discourses and structural factors, such as marginalization of Aboriginal cultures in St. John's, that impact the development and delivery of services. The third and fourth sections describe ACNL and SJNFC in terms of the populations they serve, how they do so, and why. In the fifth main section I discuss my findings using a postcolonial queer approach. This analytical framework helps to make sense of the elevated health risks faced by Aboriginal and queer clients.

Eastern Health

I begin this section by describing program development through client feedback at Eastern Health. I problematize institutional data and interrogate contradictions in discourse that displace responsibility for health outcomes onto Aboriginal and queer clients (Browne, & Smye, 2002). I focus on the historical conditions of colonialism in Newfoundland and Labrador; invisibility, social exclusion, and marginalization (Tanner, 1998; Bartels & Bartels, 2005; Anderson, 2013; Robinson, 2014) in order to demonstrate how these conditions are reflected in institutional discourse to the detriment of Aboriginal queer clients (Browne, Smye, & Varcoe, 2005; Spurlin, 2001).

Eastern Health incorporates client feedback through community health needs assessments that provide “a better understanding of what communities feel they need in order to be healthier” (*Eastern Health*, 2015). These assessments gather information about the health of particular regions in Newfoundland and Labrador based on what they term “factual and opinion based perspectives” (*Eastern Health*, 2015). Eastern Health’s community health needs assessments are meant to be inclusive of all those defined as belonging to a given community.

The Northeast Avalon Community Health Needs Assessment from June, 2010 includes St. John’s and the surrounding area. In this assessment respondents outline specific barriers to accessing health care services including a lack of public transit outside of Mt. Pearl, a town adjacent to the capital city, and St. John’s; not being able to afford transportation services; depending on others for transportation; needing child care; and a lack of cultural sensitivity (*Eastern Health*, 2010, p. 71). The report is vague about what is meant by ‘cultural sensitivity’, saying that it is a barrier to “accessing family doctors” and that Aboriginal people, seniors, and young children are affected groups (*Eastern Health*, 2010, p. 71). Doctors being insensitive about clients’ reproductive choices and STIs are listed as separate barriers to accessing services (*Eastern Health*, 2010, p. 70). Queer clients are not named as being affected by cultural or sexual insensitivities while accessing family doctors. Barriers to accessing family doctors were also a focal point of this report. Significant obstacles include: doctor availability; length of wait; lack of appropriate documentation such as photo ID and/or Newfoundland and Labrador

provincial health or Medical Care Plan (MCP) card; and not having a family doctor due to relocation or retirement of doctors (*Eastern Health*, 2010, p. 70).

To solve these problems key informant interviews are suggested with individuals in specific target groups: those with disabilities, new immigrants, young women, Memorial University students, as well as talking with people in the community who do not live at a fixed address (*Eastern Health*, 2010, p. 74). Many of the concerns raised by community members such as insensitivity on the part of health care professionals, difficulties associated with an MCP card being a requirement to see a doctor, and chronic illness may disproportionately affect Aboriginal and queer peoples who are at higher risk of being socially and economically marginalized (*Eastern Health*, n.d.; *Respect Women*, n.d.). In a separate report, Eastern Health recognizes that Aboriginal and queer peoples in Newfoundland and Labrador are at increased risk of poor health (*Eastern Health*, n.d.), however queer and Aboriginal people are not represented among Eastern Health's target groups for key informant interviews (*Eastern Health*, 2010, p. 74). There could be Aboriginal and queer people interviewed by virtue of being present in target groups, but they may be unlikely to come forward due to marginalization and past negative experiences (Brotman, Ryan, & Cormier, 2003) or because of the way interviews are shaped to address specific groups. Eastern Health's interview guides do not specifically ask about Aboriginal or queer clients (see Appendix J) which can give the impression that these populations are not anticipated within Eastern Health. It is possible that Eastern Health will change its interview guides when interviewing new target populations, however because Aboriginal and queer people are not listed among their target groups it

seems unlikely that their experiences will be sought out. Eastern Health's services are open to all people regardless of their ethnicity, sexual, or gender identities, however Eastern Health may be able to address the health needs of Aboriginal and queer clients better if these at-risk populations were interviewed as part of community health needs assessments.

Some of the ways programming mediates access to services is through design and target populations. Because Aboriginal, queer, and Aboriginal queer peoples face unique challenges (Greensmith, & Giwa, 2013; Spurlin, 2001; Browne, Smye, & Varcoe, 2005) programs and services that are designed to address these challenges provide significant opportunities to achieve and maintain good health. Eastern Health does not operate any services specifically aimed at queer clients, but they do run one program designed for Aboriginal clients, the Aboriginal Patient Navigator (APN) program. The APN program is a current initiative organized by Eastern Health and networked with the Shanawdithit Shelter, which provides temporary housing for all people but is primarily geared towards visiting Aboriginal medical clients (*Health Council Canada*, n.d., p. 13). The program was born out of the Building Bridges study (2002) and the Report on Cultural Sensitivity (2005) which were designed to assess and address Aboriginal health care needs (*Health Council Canada*, n.d.). The APN program has specific goals: to provide interpretive services; educate health care staff on Aboriginal issues and cultural sensitivity; minimize stress for Aboriginal patients traveling to urban centers; raise awareness of cultural differences, practices, and traditions; enhance coordination of aftercare; and implement a sustainable APN project (*Health Council Canada*, n.d., p. 11). The APN program's key

services include: navigation to appointments, interpretive services, assisting with transportation and accommodations, discharge planning, liaising with internal and external agencies, education and information (*Health Council Canada*, n.d., p. 12).

Eastern Health envisions that “the road to recovery also stretches from the busy corridors of a city hospital to the wide open spaces in places like Conne River or Natuashish” and aims to incorporate Aboriginal communities in providing care (*Eastern Health’s Storyline*, 2014).

The design and implementation of the Aboriginal Patient Navigator (APN) program reveals that the program was not created with urban Aboriginal clients in mind, though they may face some of the same challenges as rural Aboriginal residents. APNs are provided by SJNFC but Eastern Health controls the parameters of the program. When asked if St. John’s residents can access APN services a senior employee at SJNFC, Riley said “no, it is only for visiting clients from other parts of the province” (interview, May 22, 2015)⁶.

In addition to the APN program, there are social work, mental health and addictions, as well as clinical sexology services that Eastern Health provides for all clients. These services offer a variety of counseling, outreach and prevention measures (*Eastern Health*, 2014). It has been demonstrated that both queer and Aboriginal individuals in Canada have an increased need for mental health and social work services (Minore, Boone, Katt, Kinch, & Birch, 2004; Tjepkema, 2008; Kirmayer, Simpson, &

⁶ Further inquiries reveal that the APN program is designed for all Aboriginal clients. Riley’s comment indicates that this mandate is not being effectively fulfilled, or that Riley is misinformed.

Cargo, 2003; Moran, 1996). Thus, the way these services are delivered is particularly important.

Intake forms are the first line of communication between institutions and clients, the forms signify the types of information valued by institutions and the kinds of interactions clients can have with health care providers. Eastern Health's Central Adult intake form for Mental Health and Addictions Services (Appendix I) can be filled out either by clients or referring physicians. When I was forwarded a copy of Eastern Health's intake form I was told that it is under review and that one of the recommended changes is to have clients write in their own conceptualization of their gender identity (*personal communication*, May 2015). However, as it stands one can only choose between 'male' or 'female' when declaring a gender which is not welcoming to those who do not identify with these heteronormative categories. Much of the intake form gathers information that can aid in treatment such as whether or not the client has used other mental health and addictions services, community supports, served in the Canadian military or RCMP, is pregnant, and if they are taking medications. Data from these questions can provide insight into a client's health status, such as elevated stress associated with employment or medication side effects. Thus, Eastern Health's intake form can potentially account for social and medical causes for ill health but that does not necessarily mean that this represents an inclusive document that serves its purpose as well as it could, as previously mentioned this document is under review. It will be interesting then to see the degree to which this document reflects the diversity present within St. John's.

Planned Parenthood Newfoundland and Labrador (PPNL)

In contrast to the Eastern Health community assessment model, Planned Parenthood Newfoundland and Labrador (PPNL) conceptualizes the development of services as something that is ongoing and client-driven through feedback collected on-site that directs the evolution of forms, programs, and services. PPNL operationalizes inclusion by “incorporating client feedback year-round and trying to maintain a diverse client base to receive direction from” (Ex. Director PPNL interview, May 8, 2015). PPNL ensures that they cultivate a diversified client base by advertising on social media and local radio stations; having pamphlets that specifically target queer health issues such as suicide, violence, and a safer sex guide for transgender women; conducting holistic workshops; by accepting provincial health insurance from all provinces and territories except for Quebec; and giving clients the option to pay for services. PPNL also develops their inclusivity by running Camp Eclipse, a summer camp for queer youth that focuses on empowerment and social change. The website for Camp Eclipse has a camp countdown, donation button, and displays quotes from campers such as “Acceptance is overwhelming. Simply put” and “I learned that I am valued. I am equal” (*Camp Eclipse*, 2015). The camp is PPNL’s most successful program and it is “so well-funded we [PPNL] are building a contingency fund for the future” (Ex. Director PPNL interview, May 8, 2015). PPNL receives funding from “individual donations, fundraising, and the United Way” (Ex. Director PPNL interview, May 8, 2015). Eastern Health engages in

fundraising through foundations, such as the Janeway Foundation. The success of Camp Eclipse is indicative of PPNL's efforts to improve the health of queer people in Newfoundland and Labrador.

Programing at PPNL indicates a desire within the organization to raise awareness of queer health issues through Camp Eclipse, support groups, and transgender medical services. PPNL constantly works to incorporate client feedback into the creation of events and programs, however there is no Aboriginal or Aboriginal queer-focused services. The Executive Director at PPNL informed me that this is largely due to there being a lack of information on how to properly address culturally sensitive care, "there will likely be some programs developed for Aboriginal queer clients especially as Aboriginal campers [at Camp Eclipse] become more vocal but people need to ask for what they want because we don't always know" (interview, May 8, 2015). The Executive Director noted that "transgender clients and Eclipse campers have been the most vocal lately about what they want from our [PPNL's] services" which has impacted some practices, such as "increasing the amount of workshops that address transgender issues and using preferred names and pronouns when addressing all clients" (interview, May 8, 2015). PPNL seeks to balance transgender representation with other marginalized voices and "the presence of Aboriginal and Aboriginal queer clients is becoming more visible" (Ex. Director PPNL interview, May 8, 2015).

PPNL's conceptualization of inclusiveness is clear in their intake form (Appendix H) which is constructed with the help of clients' input. The influence of gender variant clients is especially pronounced. There is a space for one's name that appears on health

insurance information and a space for a preferred name and in the area for gender identification there is a space where a client can write in their own answer. The staff at PPNL provide “personalized care by keeping personal information on file and addressing clients by their preferred name, gender, and pronouns” (Ex. Director PPNL interview, May 8, 2015). This information for every client is kept on file and frequently referred to when contacting clients.

The demand for health care services that are accessible by payment means other than an MCP card are also apparent, it clearly states on the front page of the intake form that Newfoundland and Labrador provincial health coverage is not necessary. Clients can claim under a different province’s coverage, as Canadian military members, as a new immigrant or refugee, or as a foreign resident. In addition, the intake form at PPNL contains a confidentiality agreement that informs incoming clients of the organization’s legal responsibilities. If a client discloses being involved in sexual activity that violates Canada’s age of consent laws PPNL must report it to Child, Youth and Family Services. PPNL also has a duty to report to the Royal Newfoundland Constabulary if a client under the age of 16 discloses they have been assaulted, a client indicates they have abused a child, or if a client is threatening suicide or threatening to hurt someone else. While there is no area to declare one’s ethnicity PPNL’s Executive Director said that too is done with client comfort in mind; clients reported that having questions asked about their race made them feel uncomfortable and ‘boxed in’. Thus, PPNL’s intake form is designed in part with input from clients in an effort to make clients as comfortable as possible.

AIDS Committee of Newfoundland and Labrador (ACNL)

How is inclusiveness addressed within the AIDS Committee of Newfoundland and Labrador (ACNL)? This organization provides social support services in a range of capacities. I describe how ACNL conceptualizes inclusiveness through qualitative content analysis of websites and an interview transcript from the Executive Director of ACNL. I link this data to a postcolonial queer analysis of how Aboriginal and queer clients are accommodated in this institution and how social support services are mediated.

ACNL conceptualizes and operationalizes inclusiveness through partnerships with community organizations, providing low-barrier services, and working with stigmatized groups, such as incarcerated men. Some of the supports created by ACNL are designed to fill existing gaps in social supports offered by other organizations. For example, there is little support for problematic substance users in St. John's and the ACNL addresses this gap with "SWAP, a clean needle service, and by operating the city's only low-barrier shelter that serves clients whether they are or not they are using legal or illegal drugs" (Ex. Director ACNL interview, May 8, 2015). ACNL's primary objective is to eradicate HIV, AIDS, hepatitis, and sexually transmitted infections from Newfoundland and Labrador (ACNL, n.d.). To help with this goal ACNL is partnered with the Atlantic Aboriginal AIDS Network as well as PPNL and Eastern Health in order to generate client referrals and public education initiatives.

Inclusiveness is also encouraged by maintaining a holistic approach to health care that welcomes clients who do not want to be tested for STIs. ACNL's Executive Director recognizes that STI testing may not be of primary concern for clients, "people are usually seeking counselling, housing support, or financial support for health care needs that are not covered by provincial health insurance, such as dental care" (interview, May 8, 2015). ACNL rarely approaches people about medical testing as an initial course of action. Inclusion at ACNL means providing support for all peoples regardless of their circumstances while recognizing social factors that impact access to services that facilitate good health and well-being. ACNL does not have many long-term Aboriginal clients because St. John's Aboriginal residents are more likely to "visit the SJNFC and the Atlantic Aboriginal AIDS Network provides services for Aboriginal communities outside of St. John's" (Ex. Director ACNL interview, May 8, 2015). However, ACNL's target populations for education and support include gay men, Aboriginal peoples, men who have sex with men (MSM), and incarcerated people. While ACNL does not have many long-term Aboriginal clients the organization works with Aboriginal peoples "as a result of working with prisoners and through SWAP [a clean needle program for intravenous drug users]" (Ex. Director PPNL interview, May 8, 2015). When ACNL employees work with incarcerated men there is always a guard present, the Executive Director said "having a guard present is a barrier to providing services because prisoners do not open up" (interview, May 8, 2015). AIDS is a reportable and criminalized disease, meaning that if a person tests positive for HIV or AIDS in Newfoundland and Labrador that diagnosis becomes a part of their permanent health record and if they have sex with a

partner without informing that partner of a positive diagnosis they will incur a prison sentence. The thought process among Aboriginal clients who face stigma and over-criminalization seems to be that “they are better off not knowing their HIV status because it may make it difficult to avoid incarceration; they may think ‘why get tested?’” (Ex. Director ACNL interview, May 8, 2015).

St. John’s Native Friendship Center (SJNFC)

The St. John’s Native Friendship Center conceptualizes inclusiveness primarily by being ‘status blind’, the organization does not require proof of Aboriginal status to induct members and provide services. Riley, a senior employee who has worked at the center for over seven years, remarks that “there is still hesitation in the Newfoundland Aboriginal population to learn about Aboriginal cultures and publicly self-identify as Aboriginal” (interview, May 22, 2015). Those who identify as Aboriginal and queer are also hesitant to discuss this intersection, Riley remarked that people are “shy about learning Aboriginal traditions and their comfort level keeps people from being vocal about being Aboriginal and queer” (interview, May 22, 2015). In addition, receiving official status from the federal government is problematic (Robinson, 2014). Therefore, being status blind is a way of being inclusive to those who have not received government recognition of their status. Due to federal government status being denied for many years (Tanner, 1998) self-identification has become an important measure of one’s Aboriginal status in St. John’s. Being aware of this reality, SJNFC operationalizes inclusion by “meeting people where they are” (Riley interview, May 22, 2015); the Center is open to

all peoples, including those who are not Aboriginal, in order to promote Aboriginal culture wherever possible.

SJNFC also facilitates inclusion through events that do not focus on Aboriginal culture. Because Aboriginal identities are relatively new to the public sphere in St. John's people may feel more comfortable seeking supports they are more familiar with, such as playing a sport with other SJNFC members. It can also be difficult to conduct Aboriginal ceremonies in St. John's. When the SJNFC organized a sweat lodge, an Aboriginal tradition where smoke is used in an enclosed space to spiritually cleanse participants, Riley says "people phoned the fire department so we are trying to secure a farm outside of the city for sweats" (interview, May 22, 2015). Thus, practices that could guide culturally sensitive care may be obscured by a lack of access and visibility of Aboriginal health care traditions. Sweat lodges are exactly the type of tradition Eastern Health could facilitate in order to address Aboriginal health care in St. John's in a more culturally sensitive way. SJNFC cultivates inclusion for queer and Aboriginal queer peoples in St. John's by having a strong presence at St. John's Pride events and altering their logo at times to include the image of a rainbow (Appendix K) to communicate that the Center is a safe and queer inclusive space.

The SJNFC has developed a range of programs and services that facilitate social support and a sense of belonging. Primarily, the Center provides a space for people to participate in social events, such as crafting, yoga, and drumming (*SJNFC*, n.d.). SJNFC also has a Community Access program that is open to the public; this program offers computers, printers, photocopy services, and internet access in a supervised environment

(*SJNFC*, n.d.). The Community Access program is mainly used for resumes, contacting government services, and housing and employment searches. In addition to hosting social events and providing access to technology services the SJNFC runs the Shanawdithit Shelter which provides temporary housing for up to twenty-three people on a fee for service basis and is primarily geared for visiting Aboriginal medical clients (*SJNFC*, n.d.). The SJNFC is also working on establishing a child care center for children under the age of six (*SJNFC*, n.d.). At ACNL, the Executive Director suggested “creating a network of Aboriginal-friendly services by using cultural competency education and a sign to market these services, similar to how the rainbow flag stickers signify queer-friendly spaces” to increase social inclusion and pride for Aboriginal peoples in St. John’s (interview, May 8, 2015). When I mentioned this idea to Riley they said it could be something SJNFC can strive for in the future.

Discussion

Eastern Health collects client feedback to help direct the development of services by reaching out to communities, however those community members identifying as Aboriginal or queer are not explicitly sought out even though these populations are at elevated risk of poor health and are under-represented within the assessments (*Eastern Health*, n.d.; Tjepkema, 2008; MacMillan, MacMillan, Offord, & Dingle, 1996). Other at-risk groups in St. John’s and the surrounding area are named as target groups for interviews, such as those with disabilities, new immigrants, young women, Memorial University students, and those who do not live at a fixed address (*Eastern Health*, 2010,

p. 74). The absence of Aboriginal and queer clients from the Northeast Avalon Community Health Needs Assessment (*Eastern Health*, 2010) is not explained or acknowledged within the report. Eastern Health contributes to the invisibility of Aboriginal and queer peoples' health care needs by conducting assessments that, intentionally or not, exclude these at-risk and marginalized groups. If Eastern Health is not conducting other research that includes Aboriginal and queer voices, which seems to be the case, this population's concerns are unlikely to be brought to the attention of those within the institution with decision-making abilities. Thus, Aboriginal and queer clients are limited in their ability to direct their own care through providing feedback to Eastern Health which can negatively impact participation in health care (Browne, & Smye, 2002).

At PPNL clients who are able to better articulate their needs are also better situated to see those needs met. Transgender clients are currently the most vocal at PPNL which has led to an increase in programs designed to meet their needs. There are currently no programs at PPNL for Aboriginal and Aboriginal queer clients, however these clients are becoming more visible and vocal at PPNL. This may be a reflection of Aboriginal culture enjoying a recent resurgence in Newfoundland and Labrador (Anderson, 2013; Robinson, 2014). However, PPNL is not receiving a lot of direction from Aboriginal clients which might be because Aboriginal culture has been relatively invisible for years (Bartels & Bartels, 2005). Thus, what culturally sensitive health care might look like may be obscured by invisibility. People may not know what to ask for because Aboriginal cultures and the strong health care traditions associated with these cultures, such as smudging and sweats, an Aboriginal tradition where smoke is used in an

enclosed space to spiritually cleanse participants, are relatively new in the public sphere of St. John's. A unique social context of marginalization and invisibility in St. John's has made uncovering Aboriginal identities and culture difficult (Bartels & Bartels, 2005; Anderson, 2013). Thus, access to culturally appropriate services is mediated by structural factors, such as invisibility, that interfere with PPNL's efforts to cater to marginalized clients.

The APN program offered by Eastern Health that focuses on Aboriginal health care needs conceptualizes Aboriginal people as existing outside of the urban center of St. John's. This contributes to invisibility of the Aboriginal population in St. John's and assumes that Aboriginal peoples do not reside in the city, relocate to live there, or that urban Aboriginal clients are acculturated into the system. The perception that Aboriginal peoples do not exist in Newfoundland and Labrador is responsible for the disruption of identities as well as shame and stigma associated with being Aboriginal (Bartels & Bartels, 2005). Discourse and practices that characterize Aboriginal peoples as being foreign to St. John's maintain invisibility as a reflection of colonialism that marginalizes Aboriginal peoples (Browne, & Smye, 2002). Invisibility of urban Aboriginal clients at Eastern Health limits the capability of these clients to access appropriate health care services because services designed for this population do not exist.

The primary differences in the information gathered by Eastern Health and PPNL's intake forms are that PPNL's form is queer friendly and Eastern Health's focuses more on potential causes of ill health which suggests they have different purposes and different target audiences. Neither form tracks sexuality and ethnicity information that

can provide important social contexts for providing care. However, asking for this information may be considered intrusive even if clients are made aware that they are under no obligation to provide such information. PPNL's Executive Director specifically said clients reported that having questions asked about their race made them feel uncomfortable and 'boxed in'. Similar to the demographic survey used for this study (Appendix G) that was inadequate for documenting many different Aboriginal affiliations, it seems that identity questions are not reducible to categories in health care settings. It is important that queer clients feel as though they can disclose important sexual health information in order to have their health care needs met (Brotman & Ryan, 2001). However, asking clients to disclose sensitive information in writing can put undue stress on people. Clients may feel disrespected by being asked to declare particular identities because the formation and dynamic qualities of some identities, such as those concerning non-static sexuality and self-identified ethnic affiliations, are too complicated for categorization. Intake forms signify the types of interactions clients can have with health care providers. PPNL's intake form collects and uses information about clients' preferred names and their preferred pronouns. The level of care and compassion communicated through PPNL's intake form likely creates a health care setting where clients likely feel as though they can disclose other sensitive information to their health care provider and it will be treated with respect. Allowing for clients to declare their own conceptualization of their gender identity and their chosen pronouns and then addressing clients in the manner they prefer speaks to creating such an environment where an exhaustive intake form is not needed.

PPNL's intake form communicates that clients' gender self-identifications are valued and respected before they speak with a physician, however Eastern Health's intake form only allows for clients to choose between 'male' or 'female' which can signify that sexual and other sensitive information is not welcome. Feeling as though they are not accounted for or welcomed in health care settings contributes to marginalized clients avoiding these spaces (Tjepkema, 2008; Goldberg, Harbin, & Campbell, 2011). Although Eastern Health provides mental health and addictions services to many residents in St. John's, with or without a physician's referral, their heterosexist intake form may cause marginalized Aboriginal, queer, and Aboriginal queer clients to avoid using their services.

As the Executive Director of ACNL notes, the Aboriginal population ACNL works with is criminalized and at elevated risk of problematic substance use. While ACNL works to support these clients their measures are constrained by a society that stigmatizes and criminalizes Aboriginal peoples. Aboriginal populations in Canada experience higher than average rates of demoralization, depression, substance use (Kirmayer, Simpson, & Cargo, 2003) and incarceration (Barsh, 1994). Imprisonment can make accessing appropriate services difficult and discourages Aboriginal clients from participating in health care, resulting in health disparities demarcated by race (Browne, & Smye, 2002).

ACNL does not have many Aboriginal clients; most of their work with Aboriginal people is a result of working with prisoners and SWAP. Contact with these clients is sporadic and many do not visit ACNL for testing referrals, housing services, or

counselling. The capacity in which ACNL works with Aboriginal people and their lack of participation in ACNL services speaks to the level of stigma associated with HIV/AIDS as well as Aboriginal identities in St. John's. Aboriginal peoples are over-represented in Canadian prisons which is a reflection of factors such as poverty, fractured families and communities, as well as institutionalized racism that criminalizes Aboriginal peoples (Barsh, 1994). The criminalization of Aboriginal peoples is a structural factor that reflects conditions of colonialism by limiting Aboriginal peoples' ability to achieve good health which contributes to racialized health inequities (Browne, & Smye, 2002). Thus, the reason ACNL does not receive many Aboriginal clients may be better explained by structural factors that prevent clients from accessing care and impact Aboriginal peoples' ability to achieve good health in St. John's.

One of the largest barriers to providing Aboriginal-focused services that the SJNFC faces is the invisibility of Aboriginal peoples and cultures, including Aboriginal representations of queerness. Aboriginal cultures and traditions are only recently being recognized in St. John's and government status can be difficult to obtain. Although SJNFC tries to combat invisibility by being status blind it is difficult to mitigate the marginalization of Aboriginal peoples and experiences which can make people hesitant to self-identify as Aboriginal and learn about Aboriginal cultures. Similar to ACNL, structural factors dictate how effective SJNFC's inclusion measures are.

Access to appropriate health care services is not dependent on institutional efforts alone, broader social exclusion in a society has a large impact as well. Invisibility and marginalization in St. John's feeds into Aboriginal and queer clients' ability to have

autonomy over their own care by helping to direct the development and delivery of health care services. Therefore, institutional efforts to increase cultural sensitivity are made less effective. Newfoundland and Labrador's colonial history is reflected in power structures in health care and structural factors that marginalize Aboriginal, queer, and Aboriginal queer peoples in St. John's and this has a negative impact on participation in health care (Browne, & Smye, 2002; Spurlin, 2001).

Conclusion

In conclusion, this chapter discusses health care discourse and services offered by Eastern Health, PPNL, ACNL, and SJNFC. Textual and interview data is described and problematized while linking health care discourse to Newfoundland and Labrador social contexts. I use a postcolonial queer framework in order to analyze how access to services for Aboriginal, queer, and Aboriginal queer clients is mediated by society and institutions. I demonstrate that a lack of culturally appropriate services, insensitive delivery of existing services, and structural factors that perpetuate marginalization have a negative impact on the capability of Aboriginal queer clients to achieve and maintain good health in St. John's.

The next chapter focuses on Aboriginal queer experiences of accessing and using health care services in St. John's as described in interviews with Aboriginal queer participants and seminars. I begin the chapter by discussing how being Aboriginal is experienced in St. John's by presenting data from the Aboriginal Talks seminar and interviews. Experiences of using health care are divided into themes of cultural

sensitivity and holistic health care, delivery of health care services, and structural issues. These themes are then linked to a postcolonial queer analytical framework that shows how client experiences shape how health care services are utilized. I demonstrate that experiences of accessing health care impact Aboriginal, queer, and Aboriginal queer clients' capability to achieve and maintain good health.

Chapter 7: Experiences of Accessing and Using Health Care Services

Introduction

As demonstrated in the previous chapter, access to appropriate health care services may be inadequate for Aboriginal, queer, and Aboriginal queer people in St. John's. The ways in which dominant institutions mediate access to care and structural factors can serve to further marginalize groups already susceptible to poor health. In this chapter I provide a detailed postcolonial queer analysis of Aboriginal queer participants' experiences accessing health care services. This chapter is divided according to salient themes present in interview and seminar data: being Aboriginal in St. John's, cultural insensitivity and holistic health care, delivery of health care services, and structural issues. My analysis focuses on how client experiences illustrate a different picture of health care services than what is portrayed in institutional data. I demonstrate that there are significant discrepancies between available services and experiences of use that negatively impacts the ability of Aboriginal queer clients to achieve and maintain good health in St. John's.

This chapter helps to answer my third research question: what are the experiences of Aboriginal queer individuals when accessing health care? I detail the experiences of Mariah, Lucy, and Billie using a variety of health care services in St. John's. I discuss salient themes in relation to how historical contexts of invisibility and marginalization are reflected in participants' experiences. A postcolonial queer approach to my analysis helps

make sense of these themes by providing a lens with which to show how clients' health care experiences are shaped.

This chapter is divided into five main sections. The first section of this chapter discusses how Aboriginal identities and cultures are experienced in St. John's. This section situates participants' health care experiences within a social context particular to St. John's. I present data from the Aboriginal Talks: Empowerment Status and Identity seminar, interviews with Aboriginal queer participants - Billy, Lucy, and Mariah, as well as the interview I conducted with Riley, a senior staff member at SJNFC who identifies as Inuit and queer. This data illustrates some of the struggles and tensions associated with claiming an Aboriginal identity, stigmatization and marginalization in health care settings, and Aboriginal queerness in St. John's.

The second section of this chapter deals with cultural insensitivity and holistic health care. In the context of interview and seminar data this theme was expressed primarily by the perception that existing health care services undermine Aboriginal holistic understandings of good health. In order to examine how health care systems exclude Aboriginal conceptions of health, I discuss how the segmented delivery of services is problematic for Aboriginal and queer clients.

The third section of this chapter discusses the delivery of health care services, in particular the delivery of therapy services and heterosexist attitudes and practices. In the fourth section I discuss structural issues in the form of available human resources and transportation options. I end this chapter with a discussion that links the previous sections in a postcolonial queer analysis of participant experiences.

Being Aboriginal in St. John's

A prominent theme from the Aboriginal Talks: Empowerment, Status, and Identity discussion circle and interviews was that people felt they were not entitled to claim an Aboriginal identity or that they would be judged harshly for doing so by some Aboriginal communities and health care providers. Issues associated with being Aboriginal or Aboriginal and queer are more thoroughly analyzed in chapter eight. The tension caused by struggling to affirm one's identity was a source of mental stress. Feeling as though one looked visibly non-Aboriginal, defined by most people at the Aboriginal Talks seminar as having light skin, was framed as a source of tension and stigmatization when trying to legitimize access to an Aboriginal identity and culture. Robinson (2014) notes that Aboriginal people trying to affirm their heritage are sometimes viewed as opportunists. At the Aboriginal Talks discussion circle there was some debate about the best way to enact Aboriginal culture in order to legitimize one's Aboriginal identity. Blood quantum measures, how the federal government confirms or denies 'Indian' status based on the percentage of Aboriginal blood a person has by linking blood relations, are problematic in St. John's. Historically many Aboriginal people sought to erase their Aboriginal roots (Bartels & Bartels, 2005) and official status was denied to Aboriginal people in Newfoundland and Labrador for decades (Tanner, 1998). Therefore, individuals may not have access to records that would 'prove' their Aboriginal identity.

At Aboriginal Talks the general consensus was that being taught Aboriginal ways and thinking, being, and doing Aboriginal identities was more important than blood percentage. However, if one did not enact Aboriginal traditions and follow Aboriginal ways they may be viewed as an opportunist. Billie, an Aboriginal queer Chippewa Ojibwa participant who has darker skin, is much more comfortable asserting an Aboriginal identity without debating how to do it correctly; being Aboriginal is about how they feel rather than a set of prescribed actions. Billie said, “I think people get this idea that you need to go to the Friendship Center every week and you need to do all these things to be an Indian and it’s more about actions than who you are as a person. I am Native and I feel that every day” (interview, February 26, 2015). Affirming an Aboriginal identity is potentially problematic in Newfoundland due to a unique colonial history of invisibility. This is further complicated by the current climate of decision-making about band membership and debating the legitimacy of Aboriginal roots and socially prescribed actions.

Lucy, an Aboriginal queer participant between the ages of 36 and 40, spoke about the tension between blood quantum measures and self-determination as a measure of identity:

The tribe I come from is really wedded to blood quantum and being able to prove your lineage, which I could not do... Lots of other tribes, lots of other people will say yes you are [Native] and that it’s not actually a problem... Chances are excellent that you do have a lineage, and it’s part of oppression is that sometimes you don’t get to know that (interview, February 6, 2015).

I think this excerpt is especially poignant for those in St. John's struggling to affirm an Aboriginal identity. The invisibility and stigmatization of Aboriginal peoples in Newfoundland has historically been associated with people distancing themselves from being Aboriginal by claiming more acceptable identities (Bartels & Bartels, 2005); appearing light skinned would aid in this goal. However, Aboriginal culture is now seeing resurgence in St. John's, but due to years of invisibility, affirming an Aboriginal identity is potentially problematic (Robinson, 2014).

It took me a long time to come to terms with that and I'm still dealing with that. You know because I feel guilty, it's super complicated... there's a reason that the band I'm from is extremely wedded to blood quantum and colonial paperwork. There are concrete reasons and it has to do with resources and livelihood and survival and those are valid reasons. There are also excellent reasons that self-determination and cultural knowledge and being and doing and living Native is what matters for Native identity. Right, not who your great, great, great was and whether he was there to sign a paper when the White man came, and that's right. So try to maneuver that, especially when you pass for White. It's been super tricky my whole life (Lucy interview, February 6, 2015).

Lucy defines exactly the type of issue health care providers in St. John's need to be aware of and have some sense about how to address in order for health care spaces to be safe and increase access to appropriate health care for Aboriginal clients.

Mariah, who identifies as Métis and bisexual or two-spirit, spoke about having to 'break in' her new doctor in relation to the stigma she faces when accessing health care,

I'm breaking her in slowly; yesterday she got to go through the shock of me talking about a tribal Elder. I haven't tried talking to her about having female partners yet. It is a process to know that anybody who doesn't fit in the standard box is going to be a shock to the system for these doctors, and for the system in general...you feel like you got to disappoint them when you say 'no I don't have a husband', you know you're letting them down. They're holding you up here and unfortunately everything you tell 'em

makes you feel like you go down a rung in standing for being stigmatized you know? You're becoming more and more stigmatized with every bit of honesty (interview, January 27, 2015).

Aboriginal clients can feel as though their Aboriginal identities are a burden for health care providers. Feeling shame for deviating from what is considered the norm can cause clients not to disclose information so they do not have to feel like they are disappointing health care providers. The shame and stigma Mariah refers to reflect a lack of cultural sensitivity in health care that has a negative effect on Aboriginal clients' well-being.

The categories of Aboriginal status are sometimes perceived to be narrow in St. John's which adds to the stigmatization of those who do not fit into the dominant categories of Inuit, Innu, Mi'kmaq, or Qalipu. Mariah spoke about being an Aboriginal person from out of province and how Newfoundland-specific ideas of what an Aboriginal identity is affect her.

I'm not Inuit, I'm not Mi'kmaq, I'm not even one of the throngs of people who claim to be part Beothuk. I don't have any of that because I'm not from here. It's interesting in some respects and because I'm not visibly Aboriginal that I'm always kind of finding do I put my foot out there? Kind of like coming out; if you can't tell by looking at me should I tell you? How many people when I come out and say I'm Aboriginal...people say 'geez you don't look it, what culture are you from?'...So many things are easier to keep inside, keep to yourself rather than let other people go and stomp on them. Once you put it out there you put it out there for people to judge and sometimes things are too precious to let that out (interview, January 27, 2015).

Although affirming an Aboriginal identity is difficult at times Mariah finds some comfort in the fact that Aboriginal cultures are being recovered in Newfoundland. She states that, "It has changed. There was a point in my life where I was so light skinned I didn't think I

had the right to claim my Aboriginal background whereas here, especially with Qalipu...they can claim it so can I. Some people are even lighter than me and they're claiming it" (Mariah interview, January 27, 2015).

Societal and structural barriers to affirming an Aboriginal identity have an impact on one's sense of belonging and well-being. The need to have an Aboriginal identity affirmed by a community is important to accessing culture.

Everyone thinks they're a bad Indian like everyone I've met is like 'well I'm not exactly native' and I'm like if that's the universal condition then I've nailed it...once you start practicing, you know and having fry bread Fridays with your community and having Native thanksgivings and you do that every year for many years and people and the community starts interpreting you as Native, that becomes very normal. Then you can be like 'oh I will drum' and 'oh I do want to learn to dance' or you know we should take up language...then you can start doing the things that are more usually associated with Nateness even if already the whole time you've had values or thinking or whatever that might be called Native or Métis or something (Lucy interview, February 6, 2015).

This excerpt demonstrates how community acceptance, actions, and connections to Aboriginal culture are linked to a process of legitimizing an Aboriginal identity.

Aboriginal queer people in St. John's may experience many of the struggles outlined in this section in addition to stigmatization associated with being queer. Riley indicated that there are layers of stigma associated with being both Aboriginal and queer by saying "many Aboriginal queer people are not open about their sexuality and experiences because they are stigmatized. Aboriginal-specific contexts for queerness, including two-spiritness, have little to no meaning for the people of St. John's" (interview, May 22, 2015). Thus, queerness is mostly mediated by non-Aboriginal conceptualizations of sexuality in St. John's. Being an Aboriginal queer person, working

with Aboriginal people, and promoting Aboriginal culture has provided Riley with a great deal of insight into how Aboriginal representations of queerness take shape in St. John's.

Cultural insensitivity and holistic health care

I begin this section by discussing how the self is constructed in some Aboriginal contexts. In the current study, a holistic sense of self was indicated as central to an Aboriginal identity and well-being several times in interviews and seminars. At the Tuned In: Intercultural and Interdisciplinary Roundtable on Health, Dr. Fern Brunger described the construction of the self for Inuit people in Nunatukavut in southern Labrador as being linked to understandings of health. Good health is dependent on maintaining balance through “respect for the environment, caring for each other, traditions that resonate with the ways of Elders, and a connection with all living things, including the environment” (Dr. Brunger presentation, February 10, 2015). How the self is socially constructed guides culturally specific ways of thinking, being and doing; an imbalance would be a source of poor health in some Aboriginal contexts. This holistic understanding of the self in relation to health supports a negation of mind-body dualism, a separation that is supported in practice by many health care providers and organizations. Lucy indicated that mind-body dualism is promoted in St. John's, saying, “I think the mental health part seemed better than the physical health part even though they shouldn't be divided, but they are” (interview, February 6, 2015). Because health

care systems in St. John's value a segmented version of what represents good health care, Aboriginal clients may feel alienated.

Demarcating health care services as being either for physical or mental health makes it difficult to examine how physical, mental, and social health are connected to overall health outcomes. Integrating health care services to promote a more holistic picture of health and well-being would benefit Aboriginal and queer clients. Taylor, a transgender activist, mentioned that "better integration of mental and physical health services is the most important step to providing better queer health care in St. John's because family doctors do not connect mental and physical symptoms when treating clients" (interview, February 27, 2015). Because poor health is connected with social factors such as colonialism and heterosexism that disproportionately affect queer and Aboriginal clients (Browne, & Smye, 2002; Spurlin, 2001) promoting a holistic interpretation of health that is defined by clients, rather than institutions, can help to address health disparities for Aboriginal and queer people.

Aboriginal and Aboriginal queer clients are further excluded from participating in health care in St. John's by not having access to Aboriginal health care providers. Seeking care in the context of speaking with an Elder was important to both Lucy and Mariah. Speaking with tribal Elders gives Lucy and Mariah access to a type of care they are unable to get from services provided in St. John's. Mariah notes that talking with her Elder is important to her health it would be nice to have access to this type of care in St. John's.

It's not somebody right here on hand that I can actually sit down with. It's all by distance you know? Luckily my Elder has learned how to text and

he checks on me almost every day which is sweet. I need someone I can talk to about being an Aboriginal...and I can talk with him about being two-spirited because that's an open and safe situation to do that (Mariah interview, January 27, 2015).

Mariah said that her Elder provides care for her in ways that clinics in the city would not even consider: "he's the one I can talk to about my meds, I can talk to him about how I'm doing with all these things plus when I have ...a dream...he came back and told me what ceremony I needed to look into and things for spiritual health" (interview, January 27, 2015). In this experience with the dream Mariah felt that she could not share this information with health care providers in St. John's as part of her health care: "if I went to Eastern Health and said oh I had a dream...I mean that's not a conversation I am able to have with Eastern Health. Let alone getting someone to spend the time to sit down with you and even tell you you're cracked or not" (Mariah interview, January 27, 2015). Mariah expressed that traditional care from her Elder is entirely different than westernized care by saying, "I've got a tribal Elder who understands and respects me, and we talk the same language about that. I mean we are communicating in English but it's a whole different language of terms and thought patterns and belief systems" (Mariah interview, January 27, 2015). Even with her new doctor Mariah is cautious: "I said I'm part Aboriginal and so I have a tribal Elder that I talk to. She says oh it must be nice to have someone to talk to...even mentioning my Elder to a GP and they're like 'what?'...I'm talking about such a foreign concept" (interview, January 27, 2015). Cultivating cultural competency through an appreciation for client-driven conceptualizations of health and consulting with Aboriginal health care providers would

lessen the marginalization of Aboriginal cultures within health care in St. John's. Cultural insensitivity negatively impacts participation in health care, thus negatively impacting client health.

Delivery of health care services

Accessing health services was a significant theme for participants. This is not surprising given that Aboriginal and queer people are at elevated risk of poor health and experience a disproportionate amount of mental and physical illnesses (*Eastern Health*, n.d.; *Respect Women*, n.d.; Tjepkema, 2008; MacMillan, MacMillan, Offord, & Dingle, 1996). Although some participants had positive experiences with particular health care providers, the bureaucracy of the system made accessing services difficult.

Intake forms are often the first communication between clients and health care institutions and they are a powerful mediator of accessing services. Lucy spoke about her experience at an out-of-province clinic and the power of intake forms to signal to a client the types of interactions they are able to have within a given health care system,

They had this amazing form, they were clearly on the up and up with the queer, LBGTQLMNOP sort of business because there were like a million boxes for me to check...things that I'd never seen before and I was just like this is awesome, clearly I can let anything drop and they've seen it all before. There's no possibility of the taboo. I don't know if this is true or not but the impression I was given was that I can come with anything here and they've got it because they've already anticipated it in their forms. And I hadn't even spoken to a human at this point, the receptionist gave me a form and said, 'please fill this out, be as honest as you can thank you' (interview, February 6, 2015).

Lucy's experience demonstrates how effective a thorough intake form can be for setting up a safe environment where clients can feel more at ease. Conversely, when Lucy was given an intake form at a different health care institution that did not account for her ethnicity she left without receiving care which further illustrates the role that holistic health care awareness plays in Aboriginal and queer access of health care services.

Aboriginal and queer populations are at increased risk of poor mental health in Newfoundland and Labrador (*Eastern Health*, n.d.). Therefore, the processes guiding the delivery of these services are particularly important. When Lucy arranged to see a therapist through Eastern Health the institution imposed an end date to their sessions without consulting Lucy or their health care provider. This is an issue that is not unique to Aboriginal and queer clients accessing therapy services; the delivery of services that includes an imposed end date negatively impacts all clients. Lucy describes how this practice affected them, by saying

Putting into this system the termination of something means that you lose people out of the system and they have to work to get back in and it's super unethical for serious mental health issues...it's systematic falling through the crack-ness, you talk about people falling through the cracks but you can *make* people fall through the cracks by that practice...it's extremely exclusionary especially around mental health, it has so many stigmas attached to it that calling someone up that I don't know ... and I'm supposed to tell them that I'm still suicidal, that's not cool (interview, February 6, 2015).

Eastern Health's intake form for mental health services does not disclose that it is within the institutions' purview to impose an end date to therapy sessions (see Appendix I). Talking about mental health is difficult. Forcing clients to continually deal with arranging services puts detrimental strain on them and can serve to further stigmatize

mental health issues. Lucy goes on to say “you have to be both depressed and assertive to maneuver in that system...well that doesn’t usually go along” (interview, February 6, 2015). The manner in which therapy services are delivered by Eastern Health masks oppressive power relations that negatively impact clients’ ability to achieve and maintain good health (Browne, & Smye, 2002; Spurlin, 2001).

Heterosexist practices and attitudes that assume heterosexuality marginalize queer clients and contribute to these clients avoiding health care spaces (Tjepkema, 2008; Goldberg, Harbin, & Campbell, 2011). Heterosexism in health care settings caused Aboriginal queer participants to feel unwelcome and stigmatized. When heterosexuality is considered to be the norm those who deviate from this norm can feel like they are disappointing. Mariah indicated that heterosexism and misogyny are barriers to feeling accepted in health care settings, saying,

When I was done with my surgery they said ‘oh is your husband waiting for you out there?’ I’m like, I don’t have a husband...I could have only imagined their response if I said ‘no my wife is out there for me’. If I don’t have a husband there’s something wrong ...I’m sure I wouldn’t even feel comfortable telling them if I had a wife or a female partner either...when you’re marginalized as a woman...you add on your sexual orientation on top of that and you’d be marginalized even further (interview, January 27, 2015).

This excerpt illustrates how Mariah feels marginalized as a woman and every further deviation from the perceived norm makes her feel more marginalized. Thus, even though official health care policy does not exclude particular representations of self, systemic practices can make health care spaces feel unwelcoming for queer people. A client is

unlikely to access services or disclose important health information when they feel as though they are shamed or excluded (Brotman, & Ryan, 2001).

Heterosexist practices are not unique to visiting a general practitioner. Taylor described how health care providers can exacerbate health issues by recommending heterosexist treatments: “I was placed in a women’s body image workshop when I wanted to talk to someone about gender issues which was completely inappropriate” (interview, February 27, 2015). This heterosexist lens assumes all female-bodied individuals seek to meet an aesthetic based on heteronormativity; such assumptions can make health care spaces unsafe for all individuals who do not subscribe to normative gender notions. When health care providers discuss sexuality in an inclusive way it can dramatically improve clients’ experiences. Billie describes their most memorable health care interaction as one where the doctor made them feel at ease about their sexuality,

I had an appointment with the doctor I was telling you about, the doctor at Blackmarsh clinic; she’s very cool with everything. One time I went in there I had got my pap with her and she asked me right point blank if I use dildos so that made me feel good. She didn’t even, it didn’t even faze her. She was so professional about it. She asked me if I’m a lesbian, I said yes, she said ‘are you sexually active?’ I said yes (interview, February 26, 2015).

Billie said that unless their sexual practices are pertinent to a medical situation they normally would not disclose this information. However, having a doctor ask about their sexuality made Billie feel cared for and accepted.

Homophobic or racist practices and attitudes may not always be the cause of poor delivery of services. In the case of Lucy’s doctor, “she’s a cold brick wall. I’m not going to venture more data especially if it’s sensitive data about sexuality, mental health, or

about what I get up to that might put me at risk” (interview, February 6, 2015). Lucy’s experience could mirror that of any client because it is not linked to her Native or queer identities, however this type of experience ensures that their doctor will not be made of aware of those identities. Therefore, Lucy’s doctor will not be aware of important risk and social factors that impact their health.

Mariah saw her previous doctor for five years before finally getting a new one and in those five years she never told her doctor she is bisexual, “I didn’t feel comfortable saying that I’m bi and talking about the ideas of stable relationships where I would like to have STI screenings going on as well” (interview, January 27, 2015). Going five years without screenings for STIs meant that Mariah’s non-disclosure was a detriment to her sexual and physical health; the stress she felt about not feeling safe to disclose sexual health information also had a negative effect on her mental health. Mariah said she saw her previous doctor “as little as possible” because he was insensitive and “did not have any interest in giving medical assistance” (interview, January 27, 2015). Mariah has seen her new doctor four times in the last four months whereas she saw her old doctor once a year.

Structural issues that act as barriers to accessing services

This section discusses the poor availability of doctors in St. John’s and a lack of appropriate transportation options as structural issues that act as barriers to accessing health care services. I provide a further discussion of these issues in chapter eight where I analyze gaps between available services and Aboriginal queer participants’ experiences.

Two Aboriginal queer participants cited a lack of doctors accepting new patients as a barrier to accessing care, “that was a serious problem, I had to hunt” (Lucy interview, February 6, 2015). When Lucy was looking for a new general practitioner there were three doctors taking new clients in the entire St. John’s area and only one female doctor available in their area. When Lucy visited this doctor the level of care was not satisfactory. She said “it was super-fast, super impersonal; she didn’t ask a lot of questions coming in and out like on an assembly line. Which means afterwards I was like ‘wait a minute what if things didn’t get caught’ ...there was no context for my medical care...she’s a crappy doctor, I want a different one, there are no other ones” (Lucy interview, February 6, 2015).

Mariah said “nobody’s ever taking any new patients and so there are very few choices for a family doctor. And the one and only that was taking new patients at the time when I had moved here, he ended up being very inappropriate for me” (interview, January 27, 2015). Among other examples of inappropriate behavior, when Mariah was dealing with suicidal feelings and told her previous doctor she wanted to “jump off a cliff” her doctor replied, “There’s no shortage of them in Newfoundland” (interview, January 27, 2015). It took Mariah years to find a new doctor and she had to “get strings pulled and go through a back door” (interview, January 27, 2015).

Those doctors who do practice medicine in St. John’s may experience burn out because they are overloaded with work. This speaks to a lack of human resources that is likely due to low doctor retention rates within the province (Basky, Mathews, Edwards, & Rouke, 2007). At the Tuned In: Intercultural and Interdisciplinary Roundtable on

Health Dr. Aaron McKim spoke about the effect that increased demand has had on the elder care health care system in St. John's (presentation, February 10, 2015). A lack of human resources, combined with increased demand, has led to overcrowding, health care provider burnout, and health care professionals experiencing low engagement levels with their work and clients. Thus, a sheer lack of human resources is likely one of the causes of insufficient care and poor doctor-client relationships.

Participants indicated that existing transportation services in St. John's are a significant barrier to accessing health care. If one does not own a vehicle public bus services are problematic due to the time involved. Lucy noted that, "I have to make an appointment and I haven't yet because I can't figure out what I want to schedule, when I can take the two and a half hours it takes to go and re-fill my prescription. It takes so long to get there" (interview, February 6, 2015). Billie specifically mentioned that buses run at inconvenient times, saying that "buses run every hour and at a certain point between 7 and 9 o'clock they stop...I've worked at places before where I would take the bus to work and I've had to walk home for 40 minutes because I couldn't take the bus and that place closed at 11" (interview, February 26, 2015).

Problematic transportation services can cause clients to avoid seeking care. When offered mental health care services that were not in their area Lucy said, "I can't spend all day on the bus getting to you [a therapist] because it is not going to help my mental health" (interview, February 6, 2015). In this instance Lucy had to choose between accessing mental health care in a manner that would exacerbate health issues and not using the service at all. Lucy said that not having a vehicle is fine for "everything except

health care...I can get everything I need except for to the doctors...for that I use a cab but it's incredibly expensive" (interview, February 6, 2015). Taxis in the city are not a suitable option for those who cannot afford to purchase this service. Receiving a ride from friends is not always available or appropriate due to privacy concerns and one may not know friends who own vehicles. Problematic public transportation and expensive taxi services may impact Aboriginal and queer clients more than most because they are at an elevated risk of experiencing poverty (Barnes, et al., 2006; Taylor, Clow, & Jantzen, 2013; Monette, Albert, & Waalen, 2001).

In the event that the participant owned a vehicle they found it difficult to access particular services where they were required to secure alternate transport. Mariah describes a situation after receiving day surgery at an Eastern Health facility,

I had to have someone come and get me, sign me out as a responsible adult. And I said 'well I don't have anybody like that in my life'... I said 'can I just take a cab home' and they said no...So I had to start reaching out to people who are only acquaintances, not friends because I didn't have. I've got no family here other than my sons. I didn't have any friends; my friends who are close enough, none of them drive... Transportation is a huge problem in this city you know? And there are so few resources. So I mean if I relied on the bus for transportation I couldn't have used that. I couldn't go for that surgery, couldn't use the taxi...you know they all assume (interview, January 27, 2015).

This excerpt demonstrates that health care providers are not necessarily aware of or attentive to the issues their clients may face. Because Eastern Health's community health needs assessment for the St. John's area excludes Aboriginal and queer clients (*Eastern Health*, 2010) this institution is unlikely to provide transportation services for urban Aboriginal residents the same way they do for rural Aboriginal clients through the APN

program. The lack of accessible transportation services is a significant barrier to accessing health care and it disproportionately affects those who are economically disadvantaged.

Discussion

Culturally insensitive interactions with health care providers can be a barrier to accessing health services, especially for those who value non-Western approaches and traditions. However, the differences between talking to an Elder and talking to a health care provider in St. John's are not insurmountable. Doctors do not necessarily have to be dream interpreters, but they can be aware of the importance of holistic medicine and speak openly about seeking advice from an Elder or participating in a ceremony rather than taking medications if that aligns with how the client interprets their well-being.

The foreignness of important cultural relationships marginalizes Aboriginal interpretations of health and is problematic to accessing health care that addresses clients in ways that are relevant to them. Mariah's experiences problematize institutional claims that health care is being made more culturally relevant to Aboriginal clients through such measures as the Aboriginal Patient Navigator (APN) Program. The APN program is not designed with St. John's residents in mind, however Aboriginal queer participants' experiences indicate that access to this type of program would communicate that their cultural knowledge is valued and respected.

Communicating that cultural knowledge is respected matters to client health because subjective beliefs based on factors such as gender, class and ethnicities are

central to making sense of experiences and finding meaning in the face of suffering (Bendelow & Williams, 1995). When accessing health care services there are a range of social, cultural, and biological factors that mediate how clients interpret their health and experiences of care. Bendelow and Williams note that “pain is never the sole creation of our anatomy and physiology...it emerges only at intersection of bodies, minds and cultures” (1995, p. 83). For queer clients, mind-body dualism in health care severs the link between social, mental, and physical health which affects the accuracy of diagnosis and the effectiveness of treatments. Therefore, segmented services and a lack of cultural sensitivity means that health care providers are not necessarily generating a complete picture of illness, and treatment is limited by their understandings of circumstances that are important to their client. The expression of ailments varies according to social factors such as class, gender, and ethnicity. This affects how illness is “perceived, experienced, reacted to, and expressed physically, mentally, and emotionally” (Bendelow & Williams, 1995, p. 98). Health care that is not relevant to Aboriginal and queer clients may actually cause a decline in health due to ineffective treatments. Adjusting current health care services to be more holistic in nature would make them more culturally sensitive to Aboriginal clients and provide better, more comprehensive care to queer clients. Taking social factors and self-defined measures of health and well-being into account in health care discourse and practices decolonizes health care by addressing how hegemonic power impacts clients’ well-being (Spurlin, 2001).

Although health care discourse in Newfoundland and Labrador advocates for participation in health care systems (*Eastern Health*, 2012; *Eastern Health*, 2010) this

advocacy masks hegemonic power structures that marginalize Aboriginal and queer clients (Browne, & Smye, 2002; Spurlin, 2001). This discourse does not acknowledge exclusionary factors present in health care practices. In this model social inequality and health disparities are reduced to products of individual choice (Browne, & Smye, 2002). However, marginalization and social exclusion are largely the cause of a lack of participation in health care within my sample. Heterosexist experiences can cause queer clients to mistrust health care providers and therefore avoid or delay seeking care (Brotman, & Ryan, 2001). Thus, social exclusion in the form of heterosexism and cultural insensitivity has a negative impact on health and well-being for queer and Aboriginal queer clients.

Providing accurate, detailed information to health care providers is essential to receiving appropriate care. The doctor-client relationship needs to be supported with a welcoming, non-judgmental atmosphere because experiences that stigmatize clients can lead to avoiding care and limiting disclosure (Brotman, & Ryan, 2001). When a client does not feel comfortable or safe enough to share health related information it has a negative impact on their health. Thus, experiences that have the effect of censoring clients' disclosure negatively affect their ability to achieve and maintain good health.

Marginalization is linked to how much a client discloses to health care providers, for Mariah the marginalization of Aboriginal traditions in health care settings limits the types of information she tells her doctor. Mariah does not share the same information with her doctor in St. John's that she shares with her Elder, however she does share her westernized health experiences with her Elder. This speaks to multiple issues within how

Eastern Health delivers services. Aboriginal knowledge and language is not represented as an acceptable part of discussion or treatment, therefore Aboriginal clients may not disclose information that they feel is important to their well-being. Mariah also illustrates the difficulty involved in getting a health care provider to spend time discussing a clients' needs and thoughts. As Lucy mentioned, there is a cold efficiency governing some health care interactions in St. John's that can leave clients feeling isolated from managing their own care.

Client disclosure is impacted by experiences that communicate that their personal information is not welcome or appreciated by health care providers. The relationships between experiences, disclosure, and health go unaddressed in health care discourse that dictates how to increase client participation without examining institutional practices (*Eastern Health*, 2012; *Eastern Health* 2010). Thus, there is a difference between health care discourse and Aboriginal queer experiences that perpetuates marginalization (Browne, & Smye, 2002). The amount of information a client feels they can disclose to health care providers affects clients' opportunities to achieve and maintain good health.

Conclusion

In conclusion, this chapter provides a detailed postcolonial queer analysis of Aboriginal queer participants' experiences in relation to accessing health care services according to themes of being Aboriginal in St. John's, cultural insensitivity and holistic health care, delivery of health care services, and structural issues. In the discussion section I focus on how experiences illustrate a different picture of health care than what is

stated in institutional data. Aboriginal queer participants' experiences demonstrate that colonial marginalization is reflected by institutional practices which negatively impacts their ability to achieve and maintain good health.

The next chapter links information from the two previous chapters on health care discourse and Aboriginal queer client experiences. I focus on gaps between available services and experiences of use that negatively impact health such as struggles related to affirming an Aboriginal identity, a lack of transportation services and health care providers, and structural issues in society that mitigate institutional efforts. After detailing discrepancies between services and Aboriginal clients' experiences I discuss ways to address Aboriginal queerness in St. John's that promote health, well-being, and social inclusion. This discussion is grounded in previous research with Aboriginal queer people as well as participant interviews from this research project.

Chapter 8: Discrepancies between Health Care Services and Experiences of Use

Introduction

In the two previous chapters I have demonstrated that there are significant gaps between available services and what people want and need based on their experiences of using health care services. In this chapter I briefly restate the types of services available and what Aboriginal queer participants have said they want from health care in St. John's. I then discuss discrepancies between the two in the form of barriers to accessing services and structural factors that negatively impact Aboriginal queer clients' capability to achieve and maintain good health. The gaps that prevent clients from using existing services include a lack of health care providers and transportation options, a lack of culturally appropriate services, insensitive delivery of services, and conditions that stem from being Aboriginal and queer. I analyze these discrepancies using a postcolonial queer framework that illustrates how historical marginalization is recreated for Aboriginal queer clients who are already at an elevated risk of poor health. I then discuss how cultural insensitivity and heterosexism in health care can be addressed to improve Aboriginal queer clients' experiences.

Available services and participants' experiences

In chapter five I described and analyzed health care discourse and available services at Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee of Newfoundland and Labrador (ACNL), and St. John's Native

Friendship Center (SJNFC). I showed that Eastern Health does not have any programs that are specifically aimed at queer clients and the only program designed for Aboriginal clients, the Aboriginal Patient Navigator Program, excludes clients that live in St. John's. In addition, Eastern Health does not seek out feedback from at risk Aboriginal and queer clients when conducting community health needs assessments which is a significant barrier to acting on any concerns these clients may have. PPNL offers a range of social and medical services that especially focus on queer clients, including Camp Eclipse which provides a safe place for queer youth that is geared toward acceptance, support, and affecting social change. While PPNL strives to be welcoming and accessible to marginalized clients, including Aboriginal clients, they rely heavily on client feedback to do so. This is problematic in St. John's where Aboriginal clients may not possess the cultural knowledge or the comfort level to ask for more culturally sensitive health care services.

ACNL mainly works with Aboriginal clients through SWAP, a clean needle program for intravenous drug users, and by working with incarcerated people. They do not have many Aboriginal clients that use their other services such as housing and health care assistance. This is likely due to Aboriginal populations seeking support through SJNFC or the Atlantic Aboriginal AIDS Network as well as being at increased risk of problematic substance use and structural conditions that criminalize Aboriginal peoples. SJNFC promotes Aboriginal cultures and offers social support services to all clients, regardless of their Aboriginal status. SJNFC'S decision to be 'status blind' when offering

services allows the Center to be more inclusive due to the ongoing difficulties associated with uncovering and affirming Aboriginal identities.

Aboriginal queer participants' experiences with accessing and using health care services speak to a lack of culturally sensitive services and poor delivery of services which negatively impacts health. A lack of culturally appropriate services is illustrated by clients feeling as though their cultural relationships, interpretations of health, and knowledge was not respected or welcomed in health care settings which can alienate Aboriginal clients. In addition, a lack of holistic health care services fails to link mental, social, and physical health which can lead to ineffective diagnoses and treatments. Poor delivery of services is characterized by practices that put undue stress on clients and made them feel unwelcome which negatively affected how much important health-related information they disclosed, and in turn negatively affected their health. Specifically, the problematic practices discussed were Eastern Health imposing an end date to therapy sessions without consulting the client or health care provider, heterosexist practices and attitudes that assume heterosexuality and marginalize queerness, and rushed or unfriendly interactions with health care providers.

Health care providers

One of the significant gaps between available health care services and experiences of use is that there is a lack of health care provider options in St. John's. This section discusses health care providers in St. John's in order to illustrate how human resources impact access to health care services for Aboriginal, queer, and Aboriginal queer clients.

General practitioners are not a part of Eastern Health but they do work together to address clients' health care needs. Because non-specialized health matters, physical exams, and referrals for specialized services are the purview of general practitioners, these doctors make up a substantial proportion of the health care providers clients visit.

Gaining access to appropriate services through general practitioners is important for many health care clients. Aboriginal and queer clients may avoid seeing a doctor because of how health care services are perceived and past negative experiences, both of which have a negative impact on health status (Tjepkema, 2008; Goldberg, Harbin, & Campbell, 2011). Clients may fear being judged or perceive that physicians may not be knowledgeable about particular issues which are barriers to accessing services (*Eastern Health*, 2010). In the Northeast Avalon Community Health Needs Assessment from June, 2010 the first issue addressed in the summary notes is that of barriers to accessing family doctors. Significant barriers include: doctor availability; length of wait; and not having a family doctor due to relocation or retirement of doctors (*Eastern Health*, 2010, p. 70). Thus, gaining access to a general practitioner can be difficult in St. John's and this issue disproportionately affects clients who avoid seeking care due to past negative experiences.

I provide a richer discussion on how a lack of human resources affects the delivery of services later in this chapter. In terms of the development of services, there needs to be health care providers available to implement new services and programs. If the appropriate human resources do not exist it is difficult for any institution to create programming that caters to marginalized clients.

Being Aboriginal and queer in St. John's

Many of the discrepancies between available health care services, the delivery of those services, and Aboriginal queer clients' experiences of using services stems from the conditions of being Aboriginal in St. John's. Historical invisibility due to a lack of federal government recognition (Tanner, 1998) and racism that has stigmatized and marginalized Aboriginal identities and cultures (Bartels & Bartels, 2005) has had far reaching consequences that affect institutional efforts and clients' ability to provide feedback. Specifically, there is currently a struggle among some Aboriginal people to effectively affirm or legitimize their Aboriginal identities. This struggle is related to how forthcoming people feel they can be about their heritage and what they feel entitled to in terms of culturally sensitive health care. The debate in larger society about the legitimacy of Aboriginal identities in Newfoundland and Labrador serve to stigmatize Aboriginal people and delegitimize their health care needs. Due in large part to the formation of the Qalipu Band, a new Aboriginal affiliation recognized by the federal government, Aboriginal culture is experiencing a reawakening, especially on the island of Newfoundland (Robinson, 2014). While there is renewed interest in Aboriginal traditions, Aboriginal contexts of queerness have not been reclaimed to the same degree as other cultural elements.

Discussion

Access to a general practitioner who made clients feel safe and comfortable was mentioned as a barrier to accessing health care in St. John's. Combined with the issue of transportation, participants said having access to an appropriate physician is further limited. Inappropriate care leads to clients avoiding their doctor or not disclosing important information that affects their health (Brotman & Ryan, 2001).

Availability of doctors and insensitive, impersonal care are factors that have a negative impact on the ability of Aboriginal queer clients to access appropriate care. A lack of human resources to meet clients' health care needs may be partially explained by doctor retention rates in Newfoundland and Labrador. Basky, Mathews, Edwards, and Rouke (2007) note that few physicians who are trained in Newfoundland and Labrador stay in the province to practice medicine long term. This is also true for physicians trained at other institutions that immigrate to the province. Low doctor retention rates, combined with low training numbers, means there are not many general practitioners accepting new clients in the province.

Due to a lack of doctors in the province health care providers can experience burnout because they have a large workload. Doctor availability and health care provider exhaustion are serious structural issues that make providing culturally sensitive health care services difficult, if not impossible, because the human resources needed are significantly depleted. Thus, the marginalization of Aboriginal and queer clients is not solely the result of failures to challenge colonial influences. Doctor retention rates and high demands on health care systems in St. John's likely contribute to a lack of culturally

sensitive services and the ability of health care providers to engage with social issues, such as the needs of queer and Aboriginal clients.

For Aboriginal queer participants stigma as a barrier to accessing health care services was largely linked to affirming their Aboriginal identity and having it recognized as a contributing factor to good health and well-being. In St. John's this can be particularly difficult due to a history of invisibility and marginalization (Tanner, 1998; Bartels & Bartels, 2005). Multiple, intersecting forms of stigma signify a need for practices and training in health care that take client experiences into account when developing ways of reducing stigma and educating health care providers. Reducing stigma and providing health care that is sensitive to social issues yields services that are better for clients (Brotman & Ryan, 2001).

Culturally insensitive health care services make accessing services an exercise in navigating an arena where one's identity may feel unwelcome and stigmatized. Mariah and Lucy illustrate how some Aboriginal individuals may not share their Aboriginal identity because they feel as if they have no right to claim it, which limits how health care interactions take shape. If health care providers cultivate cultural sensitivity it would encourage clients to share more about themselves which allows for better care (Brotman & Ryan, 2001). This sensitivity has to be reflective of Newfoundland and Labrador's colonial history and contemporary conditions of being Aboriginal in this province in order for it to be effective.

It is important to take into account that queerness is a part of Aboriginal culture when reducing stigma for Aboriginal queer clients. Part of recognizing culturally-specific

forms of queerness is creating space for it in its own right rather than allowing these expressions to become absorbed by processes that do not recognize this intersection (Spurlin, 2001). Greensmith and Giwa suggest that colonialism informs Western-Aboriginal relations to “sustain White-normed same-sex politics and practices within lesbian, gay, bisexual, transgender, transsexual, intersex, Queer, questioning, and Two-Spirited (LGBTTIQQ2S) communities in North America” (2013, p. 129). They argue that assuming Aboriginal queerness mirrors western conceptualizations of sexuality is a colonizing act that limits Aboriginal autonomy. Sexuality is shaped by culture and traditions, therefore Aboriginal queerness may be different from dominant conceptualizations. Often, however, “homosexualities in non-Western societies are, at best, imagined or invented through the imperialist gaze of Euroamerican queer identity politics...or, at worst, altogether ignored” (Spurlin, 2001, p.185). Increasing access to Aboriginal cultural representations of queerness is a decolonizing act that can facilitate the creation of culturally appropriate services and social supports that empower Aboriginal queer people in St. John’s. Health care should be an important part of addressing Aboriginal and queer intersections in order to provide services that cater to the needs of marginalized Aboriginal queer clients.

Addressing cultural insensitivity and heterosexism

Health care is hard no matter who you are, but especially as a female. Then other aspects of being Aboriginal and queer on top of it makes it even harder. Like I said though, for me I don’t feel comfortable about coming out about any of those things to my health care providers (Mariah, interview, January 27, 2015).

In order to understand how to think of and incorporate approaches that address Aboriginal queerness in institutions it can be helpful to contextualize Aboriginal queerness in contrast to Western concepts of queerness. Before contact with European culture many Aboriginal societies established multiple genders; four, five, six, or even seven different gender categories were common (Urban Native Youth Association, 2004, p.6). Therefore, our modern concept of homosexuality could not exist in an Aboriginal context because two-spirit was considered to be an entirely different gender than man or woman.

Research from the McGill School of Social Work uncovered some of the cultural meanings of the term ‘two-spirit’. It appears that the majority of Aboriginal languages have a term to designate individuals considered to be neither men nor women (Brotman, & Ryan, 2001). The terms “two-spirit” or “two-spirit people” may be more acceptable to many Aboriginals than Western terms such as gay or lesbian because of their cultural context. Thus, non-heterosexist approaches to health care are linked with cultural sensitivity that acknowledges Aboriginal representations of queerness (Spurlin, 2001).

Colonization and Christianity appear to be responsible for the exclusion of Two-Spirit people from certain Aboriginal communities by importing homophobic notions and effacing a non-binary gender system (Brotman, & Ryan, 2001). Two-Spirit people struggle against discrimination, homophobia, stigmatization and rejection by their own communities but also by the White-normed queer community (Ristock, Zoccole, & Passante, 2010). Brotman and Ryan offer an explanation for some of the social inequalities faced by Aboriginal queer people,

The risks of coming out in hostile or intolerant environments, thereby being exposed to homophobia and heterosexism, causes significant stress on glbt-s people and often forces them to focus more on assessing the safety of environments rather than on developmental achievements (such as education, employment, family, social networks, etc.), this contributes to lower life satisfaction and self-esteem among glbt-s people (2001, p. 16).

Homophobia and heterosexist experiences can cause LBGTQ clients to mistrust health care providers and therefore avoid or delay seeking care (Brotman, & Ryan, 2001, p. 32). When care is sought LBGTQ people may not disclose important sexual health information due to fear of being discriminated against or homophobic/heterosexist attitudes projected by health care providers. Aboriginal queer participants in this study and Taylor, a transgender activist, indicated that health care providers' attitudes and practices negatively impact disclosure and safe, welcoming spaces are difficult to find in St. John's.

Brotman and Ryan's (2001) research demonstrated how a non-heterosexist approach to providing health care manifests through validating all relationship models, resisting assumptions of sexual orientation, and being aware that sexual identity of any kind does not guarantee a particular level of happiness or sadness. The authors advised that health care providers should seek to find causes of ill health without assuming it lies in non-heterosexual relations, not dismiss homophobia as a cause of ill health, understand that sexual experiences do not necessarily align with an individual's sexual identity, resist the temptation to diagnose, and know the difference between tolerance and acceptance (Brotman, & Ryan, 2001, p. 19).

Institutional approaches can be made more accommodating and accepting, “being able to come out to one’s health care provider in an atmosphere of safety and trust significantly improves health care interactions between glbt-s patients/clients and their health care providers as well as increasing satisfaction with care” (Brotman, & Ryan, 2001, p. 32). Support, openness, knowledge about LBGTQ health, cultural sensitivity, and respecting confidentiality also increase client satisfaction when seeking care (Ristock, Zoccole, & Passante, 2010; Urban Native Youth Association, 2004). Health care providers can adopt signals that let LBGTQ clients know that they are in a safe, accepting space by advertising in LBGTQ media, leaving posters or pamphlets about LBGTQ issues in offices and institutions, identifying and advertising LBGTQ resources, and not taking these steps until they are ready to provide appropriate knowledge and services (Brotman, & Ryan, 2001, p. 33; *Newfoundland and Labrador Medical Association*, 2007).

Access and experiences of using health care approaches are improved by increasing knowledge and expertise, as well as using effective communication. Providing clients with a choice to have their orientation or ethnicity recorded in their medical records can be effective for increasing client satisfaction because documenting it could amount to discrimination from other health care professionals (Brotman, & Ryan, 2001). Health care providers also need to be informed about the positions their colleagues hold on LBGTQ health care in order to make wiser referrals by identifying other health care providers who are sensitive to the needs of LBGTQ people and advocacy (Brotman, &

Ryan, 2001, p. 36). These approaches will benefit LGBTQ clients by providing a safe, accepting and welcoming health care environment.

In a St. John's-specific context, the ability for a client to have control over what is disclosed in their medical record may be especially important. The Newfoundland and Labrador Medical Association newsletter for spring 2007 notes that although the number of LGBT people coming out in Newfoundland and Labrador is increasing, real or perceived discrimination still keeps some people from visiting a doctor. Because one of the prominent themes discussed by participants in the current research is stigma, it may be important to only disclose gender, sexual or ethnicity information to health care providers one feels they can trust and in conditions that support anonymity between service organizations. It may be encouraging and comforting for clients to know that disclosing information to one health care provider does not necessarily mean they are coming out to all future health care providers who view their record.

Health care providers need to be aware of how hegemonic power structures in health care marginalize Aboriginal, queer, and Aboriginal queer clients in order to understand continuing health disparities (Spurlin, 2001). It is important to recognize that queerness is not homogeneous and that non-heterosexist approaches to health care must also be mindful of representations of queerness in Aboriginal cultures (Greensmith & Giwa, 2013). Health care training that incorporates cultural competency while challenging homophobia and heterosexism improves access and experiences of using health care for Aboriginal, queer, and Aboriginal queer clients (Spurlin, 2001; Browne, & Smye, 2002; Brotman & Ryan, 2001).

In the next chapter I conclude the current study by briefly restating key points from each chapter and reflecting on the research processes. I end this thesis with a review of Canadian research done with Aboriginal queer people and a discussion of areas for future research.

Chapter 9: Conclusion

In conclusion, the current research examined discrepancies between available health care services and Aboriginal queer clients' health care needs and experiences. I began this study with three research questions: what kinds of programs and services designed for Aboriginal queer people, if any, does Eastern Health, Planned Parenthood Newfoundland and Labrador (PPNL), the AIDS Committee of Newfoundland and Labrador (ACNL), and St. John's Native Friendship Center (SJNFC) provide? How are these institutions in St. John's addressing Aboriginal, queer, and Aboriginal queer health needs? What are the experiences of Aboriginal queer individuals when accessing health care?

To answer these questions, I used a multi-method approach that included semi-structured interviews and demographic surveys, unobtrusive observation, and qualitative content analysis. I conducted semi-structured interviews with institutional representatives from selected community health related organizations – Eastern Health, PPNL, the ACNL, and SJNFC; as well as a transgender activist and three people who identify as Aboriginal and queer. I observed two public seminars on Aboriginal people and health; on March 18, 2014 I attended a discussion circle sponsored by Memorial University's Aboriginal Resource Office called Aboriginal Talks: Empowerment, Status, and Identity which consisted of a presentation about smudging and an opening prayer led by Inuk Elder Emma Reelis followed by an open discussion about Aboriginal identities and empowerment. The second seminar I attended was the Tuned In: Intercultural and

Interdisciplinary Roundtable on Health on February 10, 2015 sponsored by the Music, Media, and Place (MMaP) where speakers discussed challenges faced by Eastern Health, Aboriginal conceptualizations of health, and the benefits of music therapy. In addition, I carried out qualitative content analysis of Eastern Health's reports and webpages of the largest local health authority, Eastern Health, and the selected community organizations.

I situated the current study within a colonial history and social context unique to Newfoundland and Labrador as well as previous research that demonstrates that Aboriginal queer people are rarely the subject of academic inquiry and they suffer a disproportionate amount of mental and physical illness in Canada. Previous land settlements and self-governing agreements with the federal government have granted official status to the Conne River Mi'kmaq, the Innu Nation in Labrador with the communities of Natuashish and Sheshatshiu, and the Inuit in Nunatsiavut. Changes within the federal government have recently allowed Aboriginal peoples in Newfoundland and Labrador a new path to gaining official status through the formation of the Qalipu Band. Queerness has taken shape in Newfoundland and Labrador under strong religious and rural influences; combined with geographic isolation on both the island of Newfoundland and the mainland portion of Labrador the social contexts in which queerness develops are unique. A detailed literature review revealed the need for a postcolonial queer approach that values the experiences of Aboriginal queer people and links historical influences to current health care realities. Thus, the postcolonial queer framework I used shows how historical marginalization and Western cultural domination is reflected in a lack of appropriate services, insensitive delivery of existing services, and

structural factors that criminalize and marginalize Aboriginal queer peoples in St. John's. Organizational efforts to include Aboriginal queer clients, when they exist, are constrained by structural factors that mediate the effectiveness of such efforts. For example, PPNL would like to cater more to Aboriginal and Aboriginal queer clients but they require direction from these clients. However, due to historical invisibility (Tanner, 1998) and racism (Bartels & Bartels, 2005) Aboriginal clients may not possess the cultural knowledge or feel comfortable enough to direct more culturally sensitive health care. People are hesitant to learn about Aboriginal cultures or publicly self-identify as Aboriginal, and they are especially resistant to discussing Aboriginal forms of queerness. The ACNL works with Aboriginal peoples mainly through SWAP, a clean needle program, and by working with prisoners. The criminalization of Aboriginal peoples (Barsh, 1994) and increased risk of problematic substance use prevent the ACNL from having more long-term Aboriginal clients. Thus, historical marginalization is reflected by social exclusion and structural factors such as invisibility, criminalization, and problematic substance use that negatively impact institutional efforts to better serve Aboriginal clients.

Aboriginal queer participants' experiences indicated that there is a lack of culturally sensitive services and poor delivery of existing services which negatively impacted their ability to live healthful lives. Participants felt as though their cultural relationships, interpretations of health, and knowledge were not respected or welcomed in health care settings. In addition, a lack of holistic health care services failed to link mental, social, and physical health which can lead to ineffective diagnoses and

treatments. Poor delivery of services was characterized by practices that put undue stress on clients, such as Eastern Health imposing an end date to therapy sessions without consulting the client or health care provider, heterosexist practices and attitudes that assume heterosexuality and marginalize queerness, and rushed or unfriendly interactions with health care providers.

Gaps between available services and health care needs act as barriers to seeking care. High demand on health care and a lack of health care providers puts stress on the health care system making it difficult to provide culturally sensitive care because human resources are severely depleted. There is a lack of affordable transportation options in St. John's which disproportionately affects those who are economically disadvantaged, such as Aboriginal and queer clients (*Eastern Health*, n.d.). Aboriginal queer participants' experiences suggested that the most pressing issue for them was cultural insensitivity and heterosexism in health care. These discrepancies between available services and Aboriginal queer clients' health care needs negatively impacted participation in health care and the capability of these clients to achieve and maintain good health in St. John's. Institutions and health care providers must be educated about Newfoundland and Labrador's social and historical contexts for Aboriginal and queer clients and be committed to creating safe, welcoming spaces that encourage participation in health care in order to address the disproportionate health risks these clients face.

Reflections on research

In this section I reflect on how using the specific methods I discussed earlier took shape in the field. In particular, there were unexpected issues associated with recruitment which led to a smaller than hoped for sample. I outline my experiences with recruiting key informants from Eastern Health and Aboriginal queer participants with a focus on what approaches might have increased the number of participants. I end this section with a discussion on limitations of the current research and what can be done to address these limitations in future studies.

As noted earlier in the methods chapter I did not interview any key informants from Eastern Health who would go on the record. However, I did have an informal conversation with a contact at Eastern Health who politely informed me that I would not likely receive any replies to my request for participants. This contact informed me that Eastern Health employees likely would not have any information to share with me because there are currently no policies related to Aboriginal queer health at Eastern Health and none are in development, and they do not monitor or collect data related to race or sexuality of clients. If I had interviewed Eastern Health employees and Aboriginal Patient Navigators I likely would have been able to gather much more nuanced data that would demonstrate the depths of Eastern Health's efforts to address marginalized clients.

Two other people affiliated with Eastern Health expressed interest in being interviewed but they indicated that they needed my consent form approved by Eastern Health's Communications Department. After two and a half weeks one person told me they would need a revised consent form designed for services providers before it could be

forwarded to the Communications Department. The other person forwarded my consent form in its original form; no progress had been made in over two weeks. Rather than create a new consent form I contacted the Communications Department directly for an update on the approval process of the consent form they already had. I was not given any information about the approval process or which stage my consent form was in, but the manager I spoke with forwarded a copy of my consent form to a second manager for follow up. There was no follow up information provided in time to be included in this thesis. I was informed after submitting my thesis that the Communications Department is not responsible for approving consent forms, it is the job of the Research Proposals Approval Committee at Eastern Health. This miscommunication in the approval process is likely the reason I was unable to interview these two Eastern Health employees.

For the current study there were three Aboriginal queer participants although I had thought I could recruit a sample of at least six people from this population. I did receive some indication as to why I had limited success enlisting Aboriginal queer participants. A few weeks into the recruitment phase of this study I received a racist and homophobic voice mail message where I could hear a number of voices in the background belonging to a mix of genders. The main speaker used an exaggerated Aboriginal accent studded with Newfoundland lexicon and referenced explicit sexual acts which everyone in the room he was in seemed to find humorous. The phone message left me with the impression that I had witnessed only a small part of the racism and homophobia Aboriginal and queer people have to deal with in St. John's. Faced with this

type of social reality I imagine Aboriginal queer people would be reluctant to speak about their experiences.

Another reason I may not have had many Aboriginal queer participants is due to a lack of means to offer monetary compensation. I chose not to offer compensation for participation in the current study but an honorarium may have increased the number of volunteers. In my initial assessment of the risks and benefits involved in the current research I did not feel compensation was necessary. Because I wanted to interview a marginalized population I was concerned about the power dynamic involved between myself and participants. I felt that compensation would be considered coercive and volunteers may have felt as though their compliance had been ‘bought’.

However, through personal communication I was informed of one person who indicated that they would not participate in an interview because I was not offering compensation. At the time that this was brought to my attention I had already conducted two interviews and applying for an amendment to begin offering remuneration would not have been fair to the people who participated without being given an honorarium. During my interview with Taylor Stocks, a transgender activist and writer, I was made aware that being an LGBTQ activist in St. John’s comes with challenges associated with personal and monetary resources. Taylor reported that those who engage in activist work in St. John’s are taking on multiple roles without funding. This can lead to fatigue and stress regarding finances. Some LGBTQ activists feel as though they have reached a limit as to what they can offer without being compensated and thus are unlikely to participate in research where they are not paid for their time. All of the Aboriginal queer interviewees

in the current study were employed full-time which suggests that compensation may not have been a large draw to participating in this study for them.

The small number of participants in the current study as well as how the topic of compensation was brought to my attention leads me to believe that the risks associated with sharing Aboriginal queer experiences are more significant to participants than I had anticipated. This issue also speaks to the level of stigmatization associated with Aboriginal queerness in St. John's; these identities are more marginalized than I had imagined and an incentive may be required to generate more participant data in future studies. If I had the means to do so when conducting interviews I would have offered a small honorarium to those willing to share their health care experiences with me.

After reflecting on my data set and my recruitment experiences I think those conducting research with Aboriginal queer participants in the St. John's area should consider offering participants a small payment for their contributions. Due to the amount of stigmatization associated with Aboriginal and queer populations in St. John's it can be difficult for individuals to share their experiences which poses a risk to participants. Offering remuneration would most likely increase the number of participants (Bentley, & Thacker, 2004) but it may be at the cost of introducing an unwanted power dynamic into the researcher-participant relationship. Future researchers should carefully consider the amount of compensation offered; it should not be enough that it could be considered coercive, however to be successful it must communicate that participant experiences are valuable to the research.

The data guiding my analysis for Eastern Health was gathered from public reports; however PPNL, SJNFC and ACNL do not have similar reports available for public use. This is likely due to budget concerns and limited resources, the Executive Director of PPNL pointed out that “to keep the center running, money is a constant source of stress” (interview, May 8, 2015). The ACNL also has to cope with a limited budget, noting that “we only get \$200,000.00 from the federal government to run a province-wide organization and our budget was cut by \$25,000.00 in 2011” (Ex. Director ACNL interview, May 8, 2015). One indicator of the amount of resources PPNL may be able to devote to research is that there is no advertising budget; PPNL relies on “word of mouth and free advertising from radio stations and Twitter” (Ex. Director PPNL interview, May 8, 2015). In addition, qualitative content analysis of PPNL websites is limited because their website is out of date and the organization has no way of changing it, “the contractor who created the site left no information on how to change it and now we cannot reach him” (Ex. Director PPNL interview, May 8, 2015). Thus, PPNL relies on Facebook, Twitter, and a separate Camp Eclipse website to have a presence on the internet. Therefore, I rely mostly on interview data to analyze health care discourse and services at PPNL, SJNFC, and ACNL.

In regards to my research methodology for the current study there are some issues to consider. The first is that the study focuses on St. John’s, meaning that the findings and data are not generalizable to other urban centers or alternative parts of Newfoundland and Labrador. All three of the Aboriginal queer participants in this study had been in St. John’s for less than four years and so they are reacting to utilizing health care as people

who are from out of province. Health care access and use may be interpreted entirely differently by those who have spent more time in St. John's or who were originally from the province. The public seminars I attended attracted like-minded people which provided specific views on issues such as Aboriginal identities and Aboriginal health care. Overall, the interview and seminar data gathered for this project is a snapshot of particular experiences and perspectives that do not necessarily apply beyond the individuals who provided data for this project.

The intent of this study was for the findings to be primarily driven by participant interviews, however I had a dearth of transcript data to draw from. This means I had to change the parameters of the study to focus more on institutions rather than Aboriginal queer client experiences. However, many of the themes present in interview transcripts and seminars share similarities with previous studies that aim to measure Aboriginal queer health care needs in other parts of Canada (Ristock, Zoccole, & Passante, 2010; Urban Native Youth Association, 2004; Brotman, & Ryan, 2001). Therefore, some of the suggestions made by other investigators for effective Aboriginal queer health care may also be practical in St. John's.

In regards to my recruitment methods, it is possible that if I had generated more of a presence in the queer and Aboriginal communities prior to seeking participants I would have had more interviewees. To prepare for trying to access a marginalized population I attended queer-focused events including the St. John's Pride Parade and an auction for St. John's Pride; I had also attended a seminar about Aboriginal identities and spoke with two people who self-identify as Aboriginal and queer who expressed excitement about

my research. Regardless, I needed more time to generate the comfort and familiarity required to generate more participants for this study. Alternatively, online surveys may have increased participation due to their ability to increase anonymity. However, interviews allow for more in-depth responses to questions and this raises the quality of the data collected. I would recommend that further research addressing Aboriginal queer issues in St. John's be collaborative with members of the queer and Aboriginal communities to ensure that their perspectives and experiences make up a larger part of future studies.

Research with Aboriginal queer people

Until recently Aboriginal queer peoples have not been a significant target population for academic inquiry. This section outlines other studies done with Aboriginal queer people in Canada as a basis for conducting future research with this population. Canadian research initiatives that address the needs of Aboriginal queer peoples tend to be limited in scope and qualitative in nature.

Research conducted by Ristock, Zoccole, and Passante (2010) in Manitoba examined the health concerns of Aboriginal two-spirit and LGBTQ peoples in the province. Recommendations made for the city of Winnipeg included creating more social supports related to child welfare, education, health, and housing that are culture and sex/gender sensitive (Ristock, Zoccole, & Passante, 2010). The authors also stressed the need for a safe transitioning space for those who first move to the city where they can connect with their culture, sexuality, and access available resources. Some of the main

concerns for participants were the creation of two-spirit housing services and the presence of Aboriginal staff at LGBTTTQ organizations (Ristock, Zoccole, & Passante, 2010, pp. 35-36). In order to improve the quality of life for Aboriginal two-spirit and LGBTQ people this study concluded that Aboriginal two-spirit and LGBTQ participation in city services is a significant factor for raising awareness and making Aboriginal queerness more visible. Institutions should implement sensitivity and awareness training for community agency staff, school employees, and child welfare workers. The authors also recommend that further research on the needs of Aboriginal two-spirit and LGBTQ people be conducted (Ristock, Zoccole, & Passante, 2010, p. 37).

Many of the recommendations made for the city of Winnipeg would also make sense in St. John's. In particular, sensitivity and awareness training for health care providers would increase the visibility of Aboriginal queer peoples and help to address cultural insensitivity in the delivery of health care services. Creating more social supports that are aimed at Aboriginal queer clients would also be beneficial in St. John's because Aboriginal queer participants cited a lack of appropriate services as a significant issue.

A report from the Urban Native Youth Association (2004) that focused on the Vancouver area found that Aboriginal queer respondents said that there were a number of community and health care settings that were unsafe spaces where they felt stigmatized. In order to address these concerns Aboriginal queer participants stressed the need for more education about GLBT issues, particularly in school settings and in Aboriginal communities (Urban Native Youth Association, 2004). Participants expressed the need for two-spirit role models that could provide guidance and increase the visibility and

acceptance of Aboriginal queer people in the area (Urban Native Youth Association, 2004). Because Aboriginal cultures and representations of queerness are relatively new to the public sphere in St. John's cultural sensitivity training that does not exclusively focus on queerness may be a more appropriate place to start educating health care providers about Aboriginal queer issues. It may also be the case that once institutions demonstrate an interest in learning about Aboriginal issues and cultivating practices to address these issues that Aboriginal queer role models will become more visible in the community.

These studies from Manitoba and Vancouver demonstrated some commonalities in regards to interactions with institutions and barriers to accessing services.

Heterosexism, racism, discrimination, and invisibility have dramatic effects on Aboriginal queer individual's lives. While Ristock, Zoccole, and Passante (2010) recommended a holistic approach to social change by encouraging Aboriginal queer people to become more active in their communities and make themselves more visible in concert with policy changes to create better services, it is not the responsibility of marginalized individuals to educate a system that has a history of being hostile towards them (Browne, & Smye, 2002). However, Aboriginal, queer, and Aboriginal queer peoples who are comfortable being educators are appropriate collaborators.

It can be difficult for people who feel stigmatized to continually make themselves vulnerable to privileged members of dominate groups who experience less risk when engaging with marginalized peoples. Further education is needed to better understand the issues faced by Aboriginal queer individuals which can be applicable to Aboriginal communities, heterosexual people, health care providers, and institutional representatives

(Urban Native Youth Association, 2004). Those who are in positions of power need to create safer spaces and better services directed at improving the quality of life of Aboriginal queer peoples without shifting responsibility onto this marginalized group.

Areas for future research

Aboriginal queerness is largely invisible in St. John's even though this population exists. This is indicative of a high level of stigma associated with these identities. I would recommend that future research be conducted in partnership with the SJNFC, LBGT MUN, Eastern Health and other community institutions to raise awareness and lessen stigmatization. Institutions should be the focus of future research in relation to Aboriginal queerness so as not to make it the responsibility of marginalized individuals to educate a system that has been unwelcoming or hostile to them. Aboriginal queer educators who are willing to share their experiences and expertise that are already present in St. John's should be made a part of future research with an aim to create safe spaces and educate health care providers as well as the larger public.

Eastern Health's APN program is evidence of their efforts to cultivate cultural sensitivity. However, this program characterizes Aboriginal clients as foreign to St. John's. Institutional efforts could be improved by taking into account a substantial urban Aboriginal population in the development and delivery of health care services.

I think social change will happen, although it is a slow process, and further research is an important step to improving the quality of life for individuals. In order to legitimize the design and implementation of new health care services and approaches

there needs to be research and experts to support it. Research is needed to perpetuate the idea that Aboriginal queer experiences matter and that marginalized populations deserve to be included in the social landscape and institutional health care structures of St. John's.

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Appendix A: Map of Newfoundland and Labrador (greenwichmeantime.com, 2015)



Appendix B: Letter of Initial Contact

Dear madam or Sir,

My name is Sylvia Grills, and I am a masters student of Sociology at Memorial University.

I am currently researching a project titled “**Access and Use of Health Care Services by Aboriginal Queer People in Newfoundland’s Avalon Region**”.

The aims of this study are to illustrate the health care needs of Aboriginal queer people in the Avalon area as well as how and why Aboriginal queer individuals in Newfoundland access health care services. Past research in Aboriginal and queer health care suggests that Aboriginal queer identities intersect with health care in unique ways that should be a focus of academic research in order to draw attention to this populations’ health care needs.

I wish to compare the use, access and experiences of Aboriginal queer individuals in health care with the services offered by Eastern Health, in order to demonstrate what is working and what is not for Aboriginal queer participants. I would like to demonstrate the impact of mobility, service availability, awareness of services, and experiences of use on accessing health care in the future.

I would like to recruit potential participants through your organization via posters that invite interested individuals to contact me for further information, with your permission. I am seeking individuals who self-identify as Aboriginal and queer in any capacity, meaning they experience desire or perform gender in ways that are not strictly cis-gendered, heterosexual. Although understanding health care use, access and experiences of the general population is important, this study will focus on the needs of Aboriginal queer people.

I will be asking participants questions about their access, use and experiences of use when accessing health care, including how often they see a health care professional and what happens during those visits. I will also be asking questions about their Aboriginal and queer identities and how they intersect. Participants will be asked to take part in one interview and demographic survey, lasting approximately 20-45 minutes. The interview will be audio recorded, if consent is granted. Participation in this project is entirely voluntary. The research process will consist of one interview and each participant will be offered a report of the research findings.

The benefits of participating in this study include furthering the knowledge of Aboriginal queer health care needs in Avalon region, especially in relation to Eastern Health services. There are no costs associated with this study. Participants will be asked to speak about their experiences as Aboriginal queer individuals, including access to health

services and health care interactions, which may result in feeling uncomfortable due to the potentially sensitive nature of the topic. If participants are distressed or uncomfortable we will stop the interview and they will decide if they would like to continue. The interview can be finished in one meeting or in multiple meetings if the participant prefers and they may withdraw from the study any time before March 1, 2015. If a participant wishes to speak to a counsellor I recommend Comprehensive Counselling Chelsea Building 10 Forbes Street, St John's, NL A1E 3L5 709-330-3679 who specialize in stress and anxiety; Gentle Path 282 Lemarchant Rd, St John's, NL A1E 1P7 709-701-3120 who are a non-profit charitable organization that provides counselling and support group services to individuals and families regardless of financial means; or Atlantic Consulting & Counselling Associates 112 Elizabeth Towers North Entrance, St John's, NL A1B 1S1 709-579-2276 who specialize in stress, addiction, and relationship issues.

Confidentiality will be strictly maintained for those who choose to participate: once the research is translated into written data, names as well as any personal identifying features will be omitted; individual answers will not be shared with the other participants of the study, or presented in any way that would identify the participant as the source. By participating individuals do not waive any rights to legal recourse in the event that this research causes harm.

This project is not designed to protect anonymity. By recruiting and interviewing in public spaces there is a chance that participants may be associated with this project and its findings. Due to the specificity of this study and the target sample of Aboriginal queer people living in the Avalon region participants may be known to or identified by Eastern Health staff. Data will not be shared with health care providers prior to being stripped of participant identifiers; answers and experiences will be void of identifying markers that would reveal the source when results are publicly shared.

Data will only be accessible by myself and my supervisors. At the conclusion of this study, the information collected will be stored in a locked cabinet of which only I possess a key, and a password protected computer, to which only I know the password. The data will not be used by any third parties. Five years after the project is complete I will destroy all raw data (recorded interviews and questionnaires), as well as all fieldwork journals.

The results of this study will be used to produce sociological scholarly research, which will take the form of presentations, texts, and articles. The findings will be presented at Universities, Sociological conferences, and other institutions of higher learning in Canada and the world. My thesis will be publicly available at the Queen Elizabeth II Library located at the Memorial University campus.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have

been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

If you have any questions or concerns about the project itself or the methods used, please contact myself, Dr. Cullum, Dr. Power, or the Interdisciplinary Committee on Ethics in Human Research.

Sylvia Grills
Phone: (709) 749-4543
Email: sd385@mun.ca

Dr. Cullum
Email: lcullum@mun.ca

Dr. Power
Email: npower@mun.ca

Thank you for your consideration.

Sincerely,
Sylvia Grills
Masters student

Appendix C: Interview Schedule for Eastern Health Employees

Interview #:

Respondent's Pseudonym:

Date interview conducted:

Time:

Consent form used:

Are there any existing Eastern Health policies, programs or services directed at Aboriginal queer or Aboriginal and queer individuals?

How were these policies and services developed?

Are there any policies, programs or services in development that would be directed at Aboriginal queer individuals?

Is there any current training aimed at meeting Aboriginal or queer health care needs?

Can you describe this training and its goals?

What are your experiences implementing these policies and programs?

Can you describe a typical health care based interaction with an Aboriginal queer individual?

Do you have any memorable moments related to these policies and programs when meeting with patients?

Appendix D: Recruitment Poster

Are you Aboriginal and queer?

If you are Aboriginal and queer (gay, lesbian, two-spirit, trans, gender non-conforming, have same-sex partners, or not heterosexual) and over the age of 19, please email me for information on how to participate in a research project about health care use and experiences

Name: Sylvia Grills, masters student in the Memorial University Sociology Department

Email: sdk385@mun.ca Phone: 709-749-4543

Supervisors: Dr. Cullum and Dr. Power

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills	Sylvia Grills
Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543	Email: sdk385@mun.ca Phone: 709-749-4543

Appendix E: Interview Schedule for Aboriginal Queer Participants

Interview #:

Respondent's Pseudonym:

Date interview conducted:

Time:

Consent form used:

Participant's response to request for consent:

Section I: Location and Mobility

Where are you living?

Follow up: How long have you lived there?

Have you moved in the last 12 months?

Follow up: From where? How long did you live there?

Do you own a vehicle?

What forms of transportation do you use?

Section II: Health Care

Do you have a family doctor?

How often have you seen a doctor in the past 5 years?

Can you describe your last visit?

Have you ever used Eastern Health's services? (list all) (such as the Aboriginal Patient Navigator program)

What did you like and dislike?

What were your experiences when accessing these services?

In the past 5 years have you visited an alternative or traditional health care provider?

What was your most memorable health care experience?

What was your best health care experience?

What was your worst health care experience?

Do you have any unmet health care needs?

Follow up: What are they?

Section III: Identity

How does being (use appropriate band) affect your views on relationships?

What does being Aboriginal (use appropriate band) mean to you?

Follow up: Has being Aboriginal (use appropriate band) changed for you over time?

Prompt: In what ways?

Section V: Conclusion

That is the end of my questions. Thank you again for your participation.

Is there anything I haven't addressed that you would like us to talk about?

Would you like to receive a copy of the research results when the project is finished?

E-mail [if applicable]:

Mailing address [if applicable]:

Appendix F: Informed Consent Document

Title: *Access and Use of Health Care Services by Aboriginal Queer People in Newfoundland's Avalon Region*

Researcher(s): Sylvia Grills, *Sociology department Memorial University*,
SDK385@mun.ca (709)749-4543

Supervisor(s): Dr. Linda Cullum and Dr. Nicole Power, *Sociology department Memorial University*, Lcullum@mun.ca Npower@mun.ca

You are invited to take part in a research project entitled “*Access and Use of Health Care Services by Aboriginal Queer People in Newfoundland's Avalon Region* ”

This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, Sylvia Grills, if you have any questions about the study or for more information not included here before you consent.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Introduction

My name is Sylvia Grills and I am a masters student in the Sociology Department at Memorial University. As part of my masters thesis I am conducting research under the supervision of Dr. Cullum and Dr. Power.

Purpose of study:

This project documents the access, use and experiences of Aboriginal queer people seeking health care in the Avalon region. The aims of this study are to illustrate the health care needs of Aboriginal queer people in the Avalon area as well as how and why Aboriginal queer individuals in Newfoundland access health care services. Past research in Aboriginal and queer health care suggests that Aboriginal queer identities intersect with health care in unique ways that should be a focus of academic research in order to draw attention to this populations' health care needs. I wish to compare the use, access and experiences of Aboriginal queer individuals in health care with the services offered by Eastern Health, in order to demonstrate what is working and what is not for Aboriginal queer participants. I would like to demonstrate the impact of mobility, service

availability, awareness of services, and experiences of use on accessing health care in the future.

What you will do in this study:

If you choose to participate, I will interview you once for approximately 20-45 minutes about your access, use and experiences with health care in the Avalon region. As part of this process I will ask that you fill out a short demographic survey. The interview will be audio recorded, with your permission. I will be asking questions about your access, use and experiences of use when accessing health care, including how often they see a health care professional and what happens during those visits. I will also be asking questions about your Aboriginal and queer identities and how they intersect.

Length of time:

Your interview will take between 20 and 45 minutes. We can meet multiple times to complete the interview if that is what you prefer but you are under no obligation to meet with me again.

Withdrawal from the study:

You have the right to withdraw from this study at any time prior March 1st, 2015. After data collection is finished and data analysis begins it will be impossible to separate and remove your data because it will not be distinguishable from responses given by others.

If you would like to withdraw from this study:

- *Indicate to me during the interview that you would like to withdraw or you can call or email me after you have completed the interview.*
- *If your data has not been aggregated I will destroy your interview transcript. If your data has been aggregated but not published I will remove quotes from your interview transcript that appear in unfinished written reports.*
- *Data cannot be removed after March 1, 2015.*
- *There are no consequences for choosing to withdraw from this study.*

Possible benefits:

The benefits of participating in this study include furthering the knowledge of Aboriginal queer health care needs in Avalon region, especially in relation to Eastern Health services. The results of this study will be used to produce sociological scholarly research, which will take the form of presentations, texts, and articles. The findings will be presented at Universities, Sociological conferences, and other institutions of higher learning in Canada and the world.

Possible risks:

Participants will be asked to speak about their experiences as Aboriginal queer individuals, including access to health services and health care interactions, which may result in feeling uncomfortable due to the potentially sensitive nature of the topic. If you are distressed or uncomfortable we will stop the interview and you will decide if you would like to continue. The interview can be finished in one meeting or in multiple meetings if you prefer and you may withdraw from the study any time before March 1, 2015. If you wish to speak to a counsellor I recommend Comprehensive Counselling Chelsea Building 10 Forbes Street, St John's, NL A1E 3L5 709-330-3679 who specialize in stress and anxiety; Gentle Path 282 Lemarchant Rd, St John's, NL A1E 1P7 709-701-3120 who are a non-profit charitable organization that provides counselling and support group services to individuals and families regardless of financial means; or Atlantic Consulting & Counselling Associates 112 Elizabeth Towers North Entrance, St John's, NL A1B 1S1 709-579-2276 who specialize in stress, addiction, and relationship issues.

Confidentiality:

Confidentiality will be strictly maintained: once the research is translated into written data, names as well as any personal identifying features will be omitted; individual answers will not be shared with the other participants of the study, or presented in any way that would identify you as the source. My supervisors, Dr. Linda Cullum and Dr. Nicole Power, will have access to data after personal identifiers have been removed.

Anonymity:

This project is not designed to protect anonymity. By recruiting and interviewing in public spaces there is a chance that you may be associated with this project and its findings. Due to the specificity of this study and the target sample of Aboriginal queer people living in the Avalon region you may be known to or identified by Eastern Health staff. Your data will not be shared with health care providers and your answers and experiences will be void of identifying markers that would reveal you as the source when results are publicly shared.

Recording of Data:

You have the option to have your interview audio recorded. Having your interview recorded ensures that there is a reliable record of your interview that I can refer to when analyzing data. A digital recording increases the accuracy of data analysis. Please refer to the check-boxes below.

Storage of Data:

Data will be stored in a password protected computer that only I have access to and all textual materials will be kept in my private, locked files to which only I have access to. Data will be kept for a minimum of five years, as required by Memorial University policy on Integrity in Scholarly Research, after such time all data will be deleted or disposed of via paper shredder.

Reporting of Results:

Knowledge mobilization plans include: lay reports for participants; publications in local newspapers, and speaking at local events and meetings. I will publish articles and speak at conferences, such as The Annual Algonquian Conference, the Canadian Sociological Association's Annual Congress and the International Sociological Association's World Congress of Sociology to disseminate my findings to academic audiences. My thesis will be publicly available at the Queen Elizabeth II Library located at the Memorial University campus. Quotes from interview transcripts will be used to communicate findings. None of the quotes used will contain personally identifying information.

Sharing of Results with Participants:

All participants will be offered a lay report with general findings. Results can also be accessed by reading my publications in local newspapers, such as *The Telegram*; as well as hearing me speaking at local events and meetings.

Questions:

You are welcome to ask questions at any time during your participation in this research. If you would like more information about this study, please contact: Sylvia Grills, Sociology department Memorial University, SDK385@mun.ca (709)749-4543 or my supervisors: Dr. Linda Cullum and Dr. Nicole Power, Sociology department Memorial University, Lcullum@mun.ca Npower@mun.ca.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at ICEHR@mun.ca or by telephone at 709-864-2861.

Consent:

Your signature on this form means that:

- You have read the information about the research.
- You have been able to ask questions about this study.
- You are satisfied with the answers to all your questions.

- You understand what the study is about and what you will be doing.
- You understand that you are free to withdraw from the study without having to give a reason and that doing so will not affect you now or in the future.
- You understand that any data collected from you up to the point of your withdrawal will be destroyed

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your signature:

I have read what this study is about and understood the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

I agree to participate in the research project understanding the risks and contributions of my participation, that my participation is voluntary, and that I may end my participation.

I agree to be audio-recorded during the interview Yes No

I agree to the use of quotations Yes No

A copy of this Informed Consent Form has been given to me for my records.

Signature of participant Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Principal Investigator Date

Appendix G: Demographic Survey, All Interviewees

8. Please indicate which age range (in years) you fall into:
- ☐ 21-25
 - ☐ 26-30
 - ☐ 31-35
 - ☐ 36-40
 - ☐ 41-45
 - ☐ 46-50
 - ☐ 51-55
 - ☐ 56-60
 - ☐ 61-65
 - ☐ 66-70
 - ☐ 71 and over
2. Sex assigned at birth:
- ☐ Male
 - ☐ Female
3. Ethnicity:
- ☐ Innu
 - ☐ Inuit
 - ☐ Mi'Kmaq
 - ☐ Qalipu Mi'kmaq
4. How would you describe your relationship status?
- ☐ Single
 - ☐ In a relationship and living apart
 - ☐ In a relationship and co-habiting
 - ☐ Legally married
 - ☐ Married and separated
 - ☐ Divorced
 - ☐ Widowed
 - ☐ Other (please describe)
5. Level of Education:
- ☐ Less than high school
 - ☐ High school diploma
 - ☐ Trade/university certificate
 - ☐ Bachelors degree
 - ☐ Masters degree
 - ☐ Doctoral degree
6. Employment Status:

- ☐ Retired
- ☐ Full-time
- ☐ Part-time
- ☐ Unemployed

7. Can you describe, in general terms, the duties involved in your job?
3.1 How long have you held this position?

8. Can you please provide a pseudonym (a fake name) for yourself for this study?

Appendix H: Planned Parenthood Newfoundland and Labrador Intake Form

Registration Form - Planned Parenthood NL Sexual Health Centre
Completely Confidential

Full Name: _____ Date of Birth: ____/____/____
(As it appears on MCP card) Day Month Year

Preferred Name: _____ Gender: _____

Full Address: _____ Permanent Address:
(If different than address already provided)

Phone: Home - _____
Cell - _____

Email: _____ Family Physician: _____
(used to contact if we are unable to contact by phone)

Alternative contact: _____ Medications: _____
(used to contact if we cannot reach you)

Name: _____
Relation: ☐ Parent ☐ Partner ☐ Friend Allergies: _____
Phone: _____

Health Care Insurance Information

MCP: _____ Expiry date: ____/____/____
Day Month Year

Have you been out of the province for more than 3 months in the past year? ☐ Yes ☐ No

If you do not have MCP coverage, please see the following:

- ☐ Canadian Resident: Province: _____
Health Card #: _____ Expiry date: ____/____/____
Day Month Year
- *Note: There is a cash fee for Quebec Residents; receipt will be provided for reimbursement through your provincial healthcare
- ☐ Canadian Military: Insured healthcare for military personnel is provided at the military base. If you would like to be seen by our physician there will be a cash fee payable prior to seeing the physician.
- ☐ Immigrant/Refugee Claimant: If you do not qualify for MCP coverage, please contact the Association for New Canadians for information regarding your healthcare and access to a physician. If your concern is of an urgent nature, please see the staff to discuss seeing a physician at the centre.
- ☐ Foreign Resident: Please be advised that due to Canadian regulations, you must complete a Waiver Form prior to seeing the physician and that the physician may not consent to provide treatment to you. There will be a cash fee for your visit, payable prior to seeing the physician. There may also be fees from the Health Care Corp, in order to process any laboratory tests.

Office Use Only: Visit Dates				

Contact Instruction Agreement

It is very important that we are able to contact you. It is your responsibility to provide complete, current and accurate contact information.

We will first attempt to contact you through phone. Our telephone number will not appear on call display, and it is blocked against the use of *69. If we leave a voicemail message, it will state that the clinic is trying to contact you and you are requested to call us at 579-1009.

~~If we are unable to reach you by phone, we will attempt to contact you through email. Further information or results will not be provided through email.~~

~~If we are unable to reach you through phone/email, we will attempt to reach your alternative contact provided and leave a message with them that you should contact the clinic at 579-1009. Further information or results will not be provided to your alternative contact.~~

Once contact has been made, it is **YOUR RESPONSIBILITY TO CONTACT US.**

If you have testing done, please allow 2-3 weeks for test results. We do not take the responsibility for delay in notifying you of your results.

I understand and agree to the contact agreement as outlined above.

Signature

Date

Confidentiality Agreement

Planned Parenthood has a strict confidentiality policy. Information obtained through discussions between you and a health practitioner, counsellor, office staff or volunteer will be kept confidential. We will not release any information regarding your visit here, unless we have your written consent to do so.

However, there are exceptions to this policy that are mandated by law:

In Canada, the age of consent refers to the age at which people are legally able to make their own decisions about sexual activity. The age of consent in Canada is currently 16, with some exceptions that still stand:

- Unmarried persons under the age of 18 cannot consent to anal sex.
- Someone under the age of 18 cannot legally consent to have sex with a person in a position of authority such as a teacher, health care provider, coach, lawyer, or family member.
- 12 and 13 year-olds can consent to have sex with other youth who are not more than 2 years older than themselves.
- There is also a provision called the *5 year peer group provision*, which means that youth aged 14 or 15 will be able to consent to sex with partners who are no more than 5 years older than themselves.

If you disclose to a member of Planned Parenthood that you have been involved in any way with the above four exceptions, we must report it to Child, Youth and Family Services.

We are also obligated to report any disclosure of the following acts to the Royal Newfoundland Constabulary:

- 1) If you are under the age of 16 and have been assaulted.
- 2) If you report that you have abused a child.
- 3) If you are threatening suicide or threatening to hurt someone else.

As well, keep in mind that drug and alcohol use can affect your ability to give consent to sexual activity. If you are concerned that something may have happened to you while under the influence, a Planned Parenthood staff member can provide you with more information and support.

If you have any questions or concerns regarding this confidentiality policy, please ask to speak with a staff member **PRIOR** to providing any further information.

I have Read and Understood the terms of Planned Parenthood's Confidentiality Policy.

Client Signature

Date

FPNLSHC Clinic Notes

[illegible]

Appendix I: Eastern Health's Central Adult Intake Form for Mental Health and Addictions Services



INCOMPLETE FORMS WILL BE RETURNED

Referral Form



(Please complete and return both sides)

Date of Referral: DD/MONTH/YYYY

Service requested: _____

Reason for referral (please be as specific as possible and include diagnosis if appropriate)? _____

Current or past mental health & addictions services used? _____

List current medications: _____

Current community supports/involvement with other services? _____

Problems with Aggressive Behaviour? ☐ Yes ☐ No

If yes, explain: _____

Is this a mandated referral? ☐ Yes ☐ No

Is this for consultation only? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

Has this person served in military or RCMP ☐ Yes ☐ No

If child, is there a risk of child going into the care of Child, Youth & Family Services (CYFS)? ☐ Yes ☐ No

Please include any additional information/special considerations: _____

Is the person being referred aware of this referral? ☐ Yes ☐ No

Self Referral: ☐ Yes ☐ No

If client is a minor:

Name of Parent/Guardian: _____

Tel: _____

If not self referral, please complete the following:

Form completed by (please print):

Name: _____

Agency/Service: _____

Address: _____

Tel: _____ Fax: _____

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act*, and will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025.

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**Mental Health and Addictions Services
Referral Form (Part II)**

Name: _____

HCN: _____

Date of Birth: _____

Please check most relevant:

- Suicidal/Homicidal Ideation
 - ☐ Plan with clear intent to die/kill (**refer immediately to emergency department**)
 - ☐ Plan with vague and/or undetermined plan
 - ☐ Recurring thoughts of suicide/homicide –no plan
 - ☐ Vague fleeting thoughts of suicide/homicide
 - ☐ No thoughts of suicide / homicide
- Acuteness / Chronicity of symptomatology /presenting issues
 - ☐ Severe acute symptoms with impaired reality testing (e.g. Delusions, hallucinations)
 - ☐ Acute Symptoms/circumstances with significant distress
 - ☐ Acute symptoms/ circumstances with some distress
 - ☐ Ongoing symptoms /circumstances
 - ☐ Mild symptoms/circumstances with minimal distress
- Impairment in Activities of Daily Living, Social, Occupational, or School Functioning
 - ☐ Unable to maintain minimal activities of daily living
 - ☐ Not attending/functioning in social, occupational or school environment
 - ☐ Attending but having difficulty functioning at work, school, family or social situations
 - ☐ Some difficulty with day to day functioning but still participating
 - ☐ Mild difficulties but has skills to function pretty well
- Formal Supports available
 - ☐ No supports appropriate to current level of functioning
 - ☐ For continuity of care this current service is essential (next logical step)
 - ☐ Supports available - not being utilized/effective
 - ☐ Some supports
 - ☐ Adequate supports

PLEASE COMPLETE AND RETURN BOTH SIDES OF FORM

Name: _____

Date: DD/MONTH/YYYY

Signature: _____

For Office Use Only:

Date Received: DD/MONTH/YYYY

Date of Intake Commencement: _____

Urgency Classification: P1 ☐ P2 ☐ P3 ☐

Program Assigned: _____

Date Seen by Program _____

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act*, and will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025.

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Appendix J: Eastern Health Interview Guides for Key Informants

1. Who does your organization represent? (demographics of clientele, geographic region, scope, etc.)
2. From your organization's perspective, what are the challenges related to:
 - a. Emergency Room use?
 - b. Access to Diagnostic Imaging?
 - c. Access to Specialists?
3. In your opinion, how can these concerns be reduced or eliminated?
4. Of all the concerns we discussed here today, how would you prioritize the issues that are most important to address?
5. Have we missed anything that you would like to comment on regarding the health and community services-related needs of this region?
6. Is there a particular person or group that you feel I should consult during the needs assessment?

1. Who does your organization represent? (demographics of clientele, geographic region, scope, etc.)
2. From your organization's perspective, what are the challenges to the health and community services system?
3. What are the challenges to *accessing* the health and community services system?
4. Overall, what do you consider to be the main health and community services concern(s) of the Northeast Avalon Region?
5. In your opinion, how can these health concerns be reduced or eliminated?
6. In your opinion, what would need to happen in order for the people of the region to achieve an optimal state of health?
7. Of all the concerns we discussed here today, how would you prioritize the issues that are most important to address?
8. Have we missed anything that you would like to comment on regarding the health and community services-related needs of this region?
9. Is there a particular person or group that you feel I should consult during the needs assessment?

Appendix K: St. John's Native Friendship Center's Logo with Rainbow



**Written and Oral Submission for Trinity-Conception Community Health Needs
Assessments**