VERS DES SOINS
POUR TOUSTES

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Toward Care for All:

Access to Health Care for Francoqueer Patients in Manitoba

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The English version of this report was translated by Gaston Murdock.

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Land acknowledgment and positionality

This research project took place on land that is part of the traditional territory of the Anishinaabe, Cree, Oji-Cree, Dakota, and Dene peoples, and the Homeland of the Red River Métis Nation—land shaped by our parents, our ancestors, and Louis Riel.[1]

Positionality statement: The lead researcher identifies as 2SLGBTQI+, has been socialized and is perceived as a man, is a first-generation academic, and is a Francophone from Québec. These lived identities and social positions influence how they approach this research.

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[1] This land recognition was written by the Union nationale métisse Saint-Joseph du Manitoba for the purposes of the *From and for our own* [*Des nôtres*] report.

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POUR TOUSTES

Highlights

Toward Care for All: Access to Health Care for Francoqueer Patients in Manitoba

Background

French-speaking 2SLGBTQI+ people experience generally poorer health outcomes. Paradoxically, they also face more barriers to accessing social and health services. Access to care at the intersection of minority language status and 2SLGBTQI+ realities remains largely undocumented.

This study is the first phase of the *Toward Care for All* [*Vers des soins pour toustes*] program, a five-year research initiative aimed at improving access to care for Francoqueer people in Manitoba. Its objective was to document Francoqueer patients' experiences of accessing care and to deepen understanding of care trajectories at the intersection of minority language status and 2SLGBTQI+ realities.

Key findings of the study

In total, 37 episodes of care were explored through seven interviews conducted between November 2025 and February 2026. The participants represented diverse 2SLGBTQI+ identities and care pathways and a variety of areas of care; overall, they were relatively highly educated, predominantly urban, and often turned to services in English.

1. CONSISTENCY WITH EXISTING LITERATURE

Participants reported a number of barriers that have already been documented in research on 2SLGBTQI+ people and Francophone minority communities. These include predominantly English and minimally inclusive communication, a lack of an active offer of French-language and inclusive care, experiences of discrimination, and limited information about available resources.

2. RECONFIGURATION OF ACCESS TO CARE FROM AN INTERSECTIONAL PERSPECTIVE

The study highlights a dynamic of constant trade-offs between various forms accessibility: linguistic, inclusive, geographic, and financial. Speaking English becomes a mechanism for accessing resources, vocabulary, or spaces seen as more affirming of 2SLGBTQI+ people.

3. IMPLICATIONS FOR THE DELIVERY OF CARE

The findings reveal strong support for intersectional measures. Many actions, such as hiring diverse staff, modernizing services, and reducing financial barriers, are perceived as helping the population as a whole, while also improving access to care for 2SLGBTQI+ and/or French-speaking people.

Recommendations

FOR HEALTH CARE AND SOCIAL SERVICES ORGANIZATIONS

- Implement known facilitators of access to care for French-speaking and 2SLGBTQI+ people
- Adopt tailored accessibility strategies for Francoqueer communities
- Implement accessibility measures that benefit the population as a whole

FOR POLICYMAKERS

- Support the development of Francoqueer-specific services
- Review legal and policy frameworks that hinder access to care

FOR RESEARCHERS

- Document the blind spots in Francoqueer care
- Routinely apply an intersectional lens in research
- Improve the production of population-level data

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This initiative was made possible thanks to financial support from Health Canada.
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VERS DES SOINS
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Executive summary

Toward Care for All: Access to Health Care for Francoqueer Patients in Manitoba

Study background and objectives

The health inequities affecting 2SLGBTQI+ and French-speaking people are well documented. However, very few studies examine how these realities intersect. Health care systems, population data, and research tend to treat linguistic and 2SLGBTQI+ dimensions separately, which limits understanding of lived experiences at their intersection.

This study explores the factors that influence access to social and health care services for Francoqueer people in Manitoba. It represents the first phase of the *Toward Care for All* [*Vers des soins pour toustes*] initiative, a five-year research program aimed at improving access to care for Francoqueer people, including through the development of professional training and the Comfortable in Our Own Skin diagnostic tool. Its goal was to document how Francoqueer people experience access to care in Manitoba.

Methodology

In total, 37 episodes of care were explored through semi-structured interviews conducted between November 2025 and February 2026 with seven Francoqueer participants. The participants reflected a diversity of ages, gender identities, sexual orientations, and life experiences, and their care trajectories spanned several categories of care (primary care, mental health care, specialized care, paramedical care, and 2SLGBTQI+ care).

The data were analyzed deductively, drawing on factors previously documented for 2SLGBTQI+ and French-speaking populations, and then inductively to identify patterns specific to their intersection.

Key findings

1. CONSISTENCY WITH EXISTING LITERATURE

Participants reported a number of barriers that have already been documented in research on 2SLGBTQI+ people and Francophone minority communities. These include:

- Experiences of discrimination and denial of care
- A lack of services and information in French or in inclusive settings/formats
- An inconsistent active offer, with communication primarily in English and lacking inclusivity
- Administrative procedures and forms that are insufficiently inclusive or linguistically inadequate
- A general lack of training for service providers
- Costs that limit access to certain services, particularly in mental health and paramedical care

These findings confirm that inequities observed elsewhere in Canada are also present in Manitoba.

However, the study shows that these barriers are not simply cumulative; they interact and profoundly shape how Francoqueer people experience access to care. It highlights several distinctly intersectional dynamics that have received little attention in the scientific literature, largely because research on 2SLGBTQI+ people and French-speaking communities tends to take place in silos.

The analysis nonetheless reveals that these two fields of research share several conceptually similar factors. For instance, the active offer of French-language services echoes inclusion strategies aimed at 2SLGBTQI+ people, challenges around French-language communication mirror those related to inclusive language, and the processes of disclosing one's linguistic or 2SLGBTQI+ identity are driven by similar dynamics. Despite the parallels, these phenomena are rarely analyzed together.

These conceptual silos are also reflected in the way health care services are organized: Francophone and 2SLGBTQI+ resources often operate separately rather than synergistically. This structural separation forces Francoqueer people to navigate between two weakly aligned systems.

Similarly, the small size of Francophone communities and their symbolic associations with religious institutions lead many to fear discrimination or breaches of confidentiality related to their 2SLGBTQI+ identity. These concerns can lead people to avoid these spaces, even when they would prefer to receive services in French.

Finally, when it comes to providers, participants place great importance on identity-based affinities and shared life experiences, which they perceive as fostering trust, understanding, and safety. This relational dimension has received relatively little attention in the literature, which generally focuses on training or technical skills.

2. RECONFIGURATION OF ACCESS TO CARE FROM AN INTERSECTIONAL PERSPECTIVE

The study's main contribution lies in highlighting a dynamic of constant trade-offs between various forms of accessibility: linguistic, inclusive, geographic, and financial.

While policies governing French-language services often assume that Francophone people will naturally prioritize receiving care in French, the patterns observed suggest that needs are prioritized based on the given context. When forced to choose, many Francoqueer people prioritize care they perceive as inclusive—even when it is offered in English—over services in French that they view as less safe or less suited to their realities.

Speaking English becomes a mechanism for accessing resources, vocabulary, or spaces perceived as more affirming of 2SLGBTQI+ people. This individual adaptation compensates for a lack of structural alignment between Francophone networks and 2SLGBTQI+ services.

The emphasis placed on providers' experiential knowledge highlights a tension between an approach grounded in lived experience and a more technical approach that relies primarily on training or language skills as markers of expertise in inclusive care.

3. IMPLICATIONS FOR THE DELIVERY OF CARE

Francoqueer people express a strong interest in intersectional measures. Actions such as hiring diverse staff, modernizing services, and reducing financial barriers are perceived as benefiting the population as a whole, while also improving access to care for 2SLGBTQI+ and/or French-speaking people.

Their needs manifest differently depending on the category of care.

- **Primary care and mental health care:** These are the areas where the combination of language and inclusivity matters most, yet is also the hardest to find. Identifying inclusive providers remains challenging, and mental health services are rarely available in French. The lack of government coverage for mental health care leads Francoqueer people to make additional compromises.
- **Specialized and emergency care:** The technical or urgent nature of these services means that speed and clinical expertise take precedence over linguistic or inclusivity considerations. Care in these settings is almost always provided in English, even in bilingual organizations, and inclusivity is rarely prioritized, which makes the active offer of inclusive, French-language services all the more important.
- **Paramedical care:** Access depends more heavily on peoples' financial resources and their ability to navigate a predominantly English-speaking system that is not subject to French-language health care policies.
- **2SLGBTQI+ care:** These services are mostly offered in English and are never designated as bilingual or Francophone. Patients must go through a primary care provider to receive certain types of care, which results in additional delays and exposes them to the risk of being denied care. The availability of services, even in English, remains very limited and may require people to travel outside the province.

Overall, access to care depends more on people's ability to adapt than on a structurally inclusive and bilingual health system.

Recommendations

For health and social service organizations:

1. Implement known facilitators of access to care for Frenchspeaking and 2SLGBTQI+ people:
    a. Frenchlanguage care: include Frenchlanguage skills as a hiring criterion; identify Frenchspeaking providers with visual cues (e.g., badges); ensure that the active offer is consistently and effectively practised; develop training on language needs in a linguistic minority context.
    b. Inclusive care: adopt inclusive language in all verbal and written communications; display visible markers of inclusion (e.g., posters); train providers on 2SLGBTQI+ health care; review and revise policies and procedures that have implicit discriminatory effects; develop recruitment strategies that support the hiring and retention of 2SLGBTQI+ staff;
2. Adopt tailored accessibility strategies for Francoqueer communities:
    c. 2SLGBTQI+ organizations: make resources available in French (e.g., websites, forms); clearly identify services that are accessible in French; embed the active offer of Frenchlanguage care.
    d. Francophone organizations: explicitly integrate 2SLGBTQI+ realities into resource directories, forms, and communications; minimize the display of religious symbols; actively offer inclusive care.
3. Implement accessibility measures that benefit the population as a whole: build a more diverse workforce that represents the communities being served; reduce financial barriers to care; streamline administrative processes by modernizing access to services and information (e.g., telehealth, patient access to health records).

For policymakers:

4. Support the development of Francoqueerspecific services, for example by funding clinical and community initiatives that combine Frenchlanguage and 2SLGBTQI+ expertise, and by strengthening support for existing programs that provide care in French or explicitly inclusive care.
5. Review legal and policy frameworks that hinder access to care, such as those that fail to recognize certain 2SLGBTQI+ family structures and those that require patients to have a primary care provider in order to access 2SLGBTQI+ care.

For researchers:

6. Document the blind spots in Francoqueer care, including home care, palliative care, sexual health, and denial of care, and explore emerging intersectional phenomena such as Francoqueer bilingualism;
7. Routinely apply an intersectional lens in research by systematically including variables that capture linguistic identities and 2SLGBTQI+ identities at the same time;
8. Improve the production of populationlevel data on access to care by incorporating linguistic and 2SLGBTQI+ variables into clinical data systems and by automating the collection of patientreported measures.

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COLLECTIF LGBTQ* DU MANITOBA

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1. Introduction

Since its creation in January 2019, the Collectif LGBTQ* du Manitoba has been dedicated to promoting the health and well-being of the province's French-speaking 2SLGBTQI+ communities.

Its work is inspired by community-based research aimed at providing an objective assessment of needs. Among its initiatives, the *From and for Our Own* [*Des nôtres*] study revealed that health care constitutes a priority sector (Prada et al., 2021) and led to two scientific articles on service use and mental health (de Moissac et al., 2024; Prada et al., 2023). The Collectif also developed the *Comfortable in Our Own Skin* [*Bien dans notre peau*] diagnostic tool to assess the safety and inclusiveness of services and conducted a complementary study to *From and for Our Own* targeting young people (Avanthay Strus et al., 2024; Courcelles et al., 2023).

Recognizing the discrimination experienced by 2SLGBTQI+ people, Francophones, and those at the intersection of these identities, the Government of Canada adopted the Federal 2SLGBTQI+ Action Plan to improve health outcomes and well-being, with support for community organizations (Government of Canada, 2022). At the same time, the Action Plan for Official Languages 2023–2028 aims to strengthen access to services in French (Government of Canada, 2023b).

This is the context that gave rise to the *Toward Care for All* [*Vers des soins pour toustes*] (VST) program, a five-year (2023–2028) research program aimed at improving access to care for French-speaking 2SLGBTQI+ people in Manitoba. The study is being carried out in collaboration with a scientific committee, a community advisory board composed of members of Manitoba's Francoqueer communities, and a committee of partners made up of Manitoba-based organizations. This three-phase program aims to improve access to care for French-speaking 2SLGBTQI+ people in Manitoba. The three phases are:

- A qualitative study based on interviews on patient experiences to identify barriers and facilitators to accessing care
- Consultations with providers and managers to identify training needs and validate the phase 1 data
- An assessment of complementary professional training (quasi-experimental design) for providers, informed by the two previous phases

This report presents the results of phase 1. The theories and concepts relevant to the study are presented in section 2, followed by a literature review on access to care for French-speaking 2SLGBTQI+ people in section 3. This is followed by a presentation of the study objectives (section 4) and methodology (section 5), then the results (section 6) and a discussion section (section 7).

2. Theoretical and conceptual framework

This section presents the theoretical foundations underpinning the research and the study's central concepts.

2.1. Theoretical framework

Intersectionality and the ecological systems model of health guided the development of this study.

2.1.1. Intersectionality

Intersectionality is a theoretical approach for understanding how social identities (gender, age, ethnicity, etc.) interact to create unique experiences of discrimination or privilege. It explains how systems of oppression (sexism, racism, etc.) are interconnected and cannot be understood in isolation. This concept, formulated by Crenshaw (1991), posits that studying groups in isolation is insufficient to capture the complexity of intersecting identities.

This framework is useful for the study of Francoqueer people, whose lived experience cannot be reduced to the sum of discrimination linked to language and 2SLGBTQI+ identity. This framework also invites us to recognize the internal diversity within this intersection, particularly in terms of age, ethnicity, disability, social class, and gender. This approach has guided the Collectif's research to date (Avanthay Strus et al., 2024; Prada et al., 2021).

2.1.2. The ecological systems model

The ecological systems model developed by Bronfenbrenner (1977) posits that humans are best understood by examining their interactions with the environment. It is structured around nested systems, including the microsystem (family, school), the mesosystem (relationships between players in the microsystem), the exosystem (immediate social structures), and the macrosystem (social norms, laws). Initially developed in the field of psychology, it is now applied to health, where it is used to analyze the individual and contextual factors influencing access to care (Bronfenbrenner, 1977; McLeroy et al., 1988; Stokols, 1992); it is also regularly used in 2SLGBTQI+ health research (Haviland et al., 2020; Matsick et al., 2024; Mink et al., 2014; Mottier, 2024). This approach highlights the limits of interventions focused solely on the individual and encourages the development of tailored, multilevel actions (Colpitts & Gahagan, 2016; Renaud & Lafontaine, 2011). It is therefore well suited to Toward Care for All, an intersectional study that includes a phase 3 intervention.

2.2. Conceptual framework

The PICOS model (Richardson et al., 1995) was used to structure the research question and guide the literature review (see Annex A). This model helped clarify the key components of the study to make the process more systematic and reproducible. This research focuses on the factors (barriers and facilitators) affecting access to care for Francoqueer people in Manitoba during the postCOVID period.

2.2.1. Population: Francoqueer people

Francoqueer people are individuals living at the intersection of two marginalized identities: gender identity/sexual orientation and language. The acronym 2SLGBTQI+ refers to gender identities and sexual orientations (TwoSpirit, lesbian, gay, bisexual, trans, queer, intersex, and more) *and was chosen to align with the terminology* in the Federal 2SLGBTQI+ Action Plan (Government of Canada, 2022).[2] The study population was determined based on self-identification, and the concepts related to gender and sexual orientation were described in the first report (Prada et al., 2021).

With regard to linguistic identity, the term "French-speaking people" refers to people who speak French in a minority language setting in Canada (i.e., outside of Québec). This wording is preferred by Francophonie organizations and public institutions because, unlike the term "Francophone," which often refers to a cultural or historic identity, it encompasses a variety of linguistic trajectories, notably in migration contexts.

The term "Francoqueer" is used in this report specifically to refer to people with both of these identity characteristics. Although not all French-speaking 2SLGBTQI+ people use this term, it provides a clear distinction from the terms "French-speaking" or "2SLGBTQI+", which describe people who share only one of these identity characteristics, and who are also discussed in this report.

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[2] The research team recognizes that other terms, such as "GSD" or "queer," are also used to refer to 2SLGBTQI+ communities. It also recognizes that it would have been possible to define gender identity, sexual orientation, and gender separately, as other teams and organizations have done (Lee & Kanji, 2017; Waite & Denier, 2019). Finally, the research team acknowledges that the choice of an acronym is politically loaded and subject to debate even within the communities themselves—debates that this report does not aim to resolve.

2.2.2. Intervention: Factors influencing access (barriers and facilitators)

Various factors can facilitate or limit access to care. They may be observed concretely or proposed theoretically, depending on whether they arise from lived experiences or from recommendations. Since each barrier generally has an equivalent facilitator, this study uses the blanket term “factor” without distinguishing between these modalities. Four systems from the ecological model are used to classify these factors:

- **Individual:** Factors related to patients (characteristics, behaviours, perceptions)
- **Interpersonal:** Factors related to the patient-provider relationship
- **Organizational:** Factors related to organizations, whether simple organizations (e.g., a private clinic) or multilevel organizations (e.g., a clinic affiliated with a provincial organization), which oversee access to care (environment, procedures, tools)
- **Structural:** Macrosocial constraints and conditions (e.g., regulatory frameworks, overall availability of care and tools, social phenomena, etc.)

2.2.3. Outcomes: Accessibility of care

Accessibility refers to the real possibility of having one’s health needs met; it also encompasses the quality, safety, and inclusiveness of care. According to Levesque et al. (2013), accessibility is based on five interdependent dimensions: approachability, acceptability, availability, affordability, and appropriateness. This concept can be measured with various tools, including the diagnostic tool Comfortable in Our Own Skin (Courcelles et al., 2023), and has been used to study health care for French-speaking populations (Éthier & Carrier, 2022).

While there is no universally accepted classification of types of care, this study uses six categories:

- **Primary care:** Front-line care focused on continuity and provided by primary care providers, including physicians or nurse practitioners.
- **Emergency and specialized (secondary) care:** Short-term care for a specific temporary condition, such as surgery, often following a referral from a primary care provider.
- **Mental health care:** Care intended to support emotional and psychological well-being, usually not covered by public insurance, provided by specific specialists (therapists, psychologists, etc.) and comprising prevention, diagnosis, treatment, and emergency care.
- **Paramedical care:** Short-term ancillary care essential to health, such as dental care, pharmacy services, and physiotherapy, usually not covered or only partially covered.
- **2SLGBTQI+ care:** Care (primary or secondary) aimed more specifically at 2SLGBTQI+ people, such as certain sexual and reproductive health care services and trans-affirming care.
- **Home care, long-term care, end-of-life care, and palliative care:** Specialized care most often directed toward older adults, involving both primary and secondary care providers and combining features of primary and secondary care.

Certain categories of care may overlap. For instance, there are emergency mental health services, and many 2SLGBTQI+ services are considered part of primary care.

This study uses an episodes of care classification, defined as the set of interventions related to a single health problem, from initial consultation to resolution. A single episode may therefore involve several providers and clinical settings.

Finally, the linguistic dimension remains central: Each episode is classified as (1) entirely French, (2) entirely English, or (3) hybrid when interactions, tools, and communications alternate between French and English, depending on the stage of care.

2.2.4. Setting: Manitoba post-COVID

This study took place within the specific context of post-pandemic Manitoba. Although the World Health Organization lifted the state of emergency in May 2023, the temporal boundaries of the "post-COVID period" remain blurred and vary by sector and region. In Canada, this context is marked by recent social and legislative changes related to 2SLGBTQI+ health, a post-pandemic restructuring of health services, and a distinct provincial reality. Focusing on Manitoba makes it possible to take into account the province's unique geographic, linguistic, and organizational characteristics.

3. Literature review

A literature review drawing on academic and grey literature helped situate the research project within its broader context. The review examined four key dimensions:

1. The profile of French-speaking 2SLGBTQI+ people in Manitoba
2. Their health status
3. Their care needs
4. The factors influencing their access to services

Given the very small number of studies focusing specifically on Francoqueer people, the literature review draws mainly on work concerning 2SLGBTQI+ and French-speaking people, carried out mostly in Canada. International studies were consulted to deepen the analysis, and any existing research specific to Manitoba is noted.

3.1. Profile of French-speaking 2SLGBTQI+ people in Manitoba

Linguistic data indicate that 8.4% of Manitoba's population is French-speaking (2.8% by mother tongue) (Statistics Canada, 2022), with an increase in unilingual Francophones linked to immigration (Société de la francophonie manitobaine (SFM), 2022). On average, French-speaking people are older, more socially isolated, and predominantly located in rural settings (de Moissac et al., 2015; Muray et al., 2022).

Data on 2SLGBTQI+ people remain limited: The Census does not collect information on sexual orientation and continues to operate on a binary logic, despite the addition in 2021 of an open category allowing for identification of other genders (Statistics Canada, 2021b, 2024b). Canadian surveys that collect data on 2SLGBTQI+ identities recorded 100,815 trans or nonbinary people in 2018, and 1.3 million 2SLGBTQI+ people in 2021 (Government of Canada, 2024b; Statistics Canada, 2022). These numbers are likely underestimated due to reporting bias (de Vries et al., 2019; Horner et al., 2012; Lee & Kanji, 2017; Waite & Denier, 2019).

It is difficult to discern the profile of Francoqueer people, since surveys do not collect or publish intersectional data (e.g., in the Canadian Community Health Survey) (Statistics Canada, 2024a). Only the study by Prada et al. (2021) provides a descriptive portrait of the Francoqueer population of Manitoba. An estimate based on available data suggests that there are approximately 4,510 Francoqueer people in Manitoba; this figure was calculated by multiplying the proportion of 2SLGBTQI+ people by the proportion of Frenchspeaking individuals and Manitoba's share of the Canadian population.

In Manitoba, health care is organized as a universal, publicly funded system administered by the provincial government through Manitoba Health, which is responsible for the planning, funding, and regulation of services. Medically necessary care (physicians, hospitals) is covered by the public plan, while service delivery is largely decentralized to regional health authorities (RHAs) responsible for hospitals, long-term care facilities, community services, and public health services. Family physicians and specialists mostly practise independently and are paid on a fee-for-service basis. Some paramedical services, such as out-of-hospital medications, physiotherapy, mental health, or vision care, are partially covered or provided under targeted programs. Clinical sites, programs, and RHAs are designated as bilingual or francophone (Shared Health, 2024), but the majority of care is provided in English. The provincial organization Shared Health operates above the RHAs: While it does not provide most front-line care, it coordinates and manages clinical and support services across Manitoba, such as laboratory and diagnostic services, tertiary specialized care, medical transport, digital health, and select provincial programs. Community organizations in the field of Francophone health and 2SLGBTQI+ health also provide care to the public and are primarily funded by Manitoba Health, Shared Health, the RHAs, or Health Canada, depending on the program.

A distinctive feature of Manitoba is the strong concentration of its population in Winnipeg: According to the 2021 Census, nearly 56% of Manitoba's population resided in Winnipeg, where population density was 650 times higher than the provincial average (Statistics Canada, 2021a). More than two thirds of Manitoba's Frenchspeaking population also live in Winnipeg, primarily in the Francophone neighbourhoods of St. Vital, St. Boniface, and St. Norbert (de Moissac et al., 2012).

3.2. Health of French-speaking 2SLGBTQI+ people

Frenchspeaking 2SLGBTQI+ people experience generally poorer health outcomes than heterosexual, cisgender, and Anglophone populations in Canada. Among 2SLGBTQI+ people, studies show higher rates of chronic illnesses (cancer, obesity, asthma, and cardiovascular diseases) and specific risks, including HIV and anal cancer among gay and bisexual men, and arthritis among lesbian and bisexual women (Casey, 2019; Egale Canada, 2020; Jeffries IV et al., 2021; Matsuzaka et al., 2021; McNeill et al., 2023; Romanelli & Hudson, 2017). Their mental health is particularly vulnerable, with higher rates of anxiety and depressive disorders, suicidal ideation, substance use, and social isolation; however, community belonging serves as an important protective factor (Alencar Albuquerque et al., 2016; Bize et al., 2011; Brubaker, 2020; Casey, 2019; Garcia et al., 2020; Haviland et al., 2020; Lee & Kanji, 2017; McGlynn et al., 2020; Prada et al., 2023; Richard et al., 2011; Wilson & Liss, 2022). Within the 2SLGBTQI+ community, certain subgroups face additional challenges. Trans people experience significantly higher risks of suicide and homicide (Government of Canada, 2022; Grant et al., 2011; Hughto et al., 2015; Silverman & Baril, 2023), while intersex individuals show elevated rates of asthma and depression and are often subjected to nonconsensual "corrective" surgeries (Government of Canada, 2022; Rosenwohl-Mack et al., 2020).

French-speaking people also have poorer physical and mental health, with higher prevalence of chronic diseases, obesity, mood disorders, psychological distress, substance use, and depressive or anxiety symptoms (Bouchard & Desmeules, 2013; Bouchard et al., 2009; Chartier et al., 2012; de Moissac et al., 2015; Reaume et al., 2024; van Kemenade et al., 2024).

Individuals who belong to multiple minority groups tend to experience even poorer health outcomes. Older 2SLGBTQI+ adults are particularly vulnerable to isolation, financial barriers, and uncomfortable interactions with health care staff, and their specific needs remain insufficiently studied (de Vries et al., 2019; Horner et al., 2012). Migrant 2SLGBTQI+ people may come to Canada seeking refuge from hostile environments; they are more likely to conceal their 2SLGBTQI+ identity, underuse available programs, and face dual discrimination—within their own cultural communities due to their gender identity or sexual orientation, and within the 2SLGBTQI+ community due to their ethnicity (Chbat et al., 2023; Gates-Gasse & Lassonde, 2015; Saleh et al., 2011).

The poorer health observed among both 2SLGBTQI+ and Frenchspeaking populations can be partly explained by social, economic, and environmental inequities that undermine their health and access to care—factors linked to Canada's 12 recognized social determinants of health (Government of Canada, 2024a). In Canada, 2SLGBTQI+ people more frequently experience employment discrimination and insecurity, housing instability, homelessness, and higher poverty rates (Egale Canada, 2020), while French-speaking people are statistically poorer and less educated (Bouchard & Desmeules, 2013; Bouchard et al., 2022). These social conditions contribute to the health inequities experienced by 2SLGBTQI+ and Frenchspeaking people.

3.3. Limited access to care for French-speaking 2SLGBTQI+ people

Despite experiencing greater health problems, French-speaking 2SLGBTQI+ people, paradoxically, have less access to care than heterosexual and Anglophone populations. This limited access to care is reflected across multiple measures of accessibility: unmet expectations (de Moissac et al., 2015; Meyer et al., 2020), low utilization of services (Chartier et al., 2012); unmet care needs (Cleland et al., 2014; Dupuis-Blanchard, 2022; Meyer et al., 2020; Statistics Canada, 2023); limited access to a primary care provider (Statistics Canada, 2023); longer wait times (Statistics Canada, 2023), and instances of denial of care by providers (Casey, 2019; Egale Canada, 2020).

Frenchspeaking older adults are more likely to experience unmet health needs and to forgo essential home care services (Bouchard et al., 2022; Dupuis-Blanchard, 2024). Across Canada, 35% of Frenchspeaking people report difficulty obtaining services in French (40% in Manitoba), and only 41% used French when communicating with their primary care provider (16% in Manitoba) (Bouchard & Desmeules, 2013). More than three quarters (76.8%) believe that access to care in French is poor or nonexistent (de Moissac & Bowen, 2017). These access challenges also extend to mental health services, caregiving, and long-term care facilities for older adults (Éthier & Carrier, 2022; Muray et al., 2022). Overall, French-speaking people face limited access to health care services (Muray et al., 2022), resulting in longer hospital stays and higher readmission rates (Reaume et al., 2024).

Across Canada, 2SLGBTQI+ people also report reduced access to a primary care provider (77.4% of bisexual or pansexual people, compared to 85.6% of heterosexual people) (Statistics Canada, 2023), and they are also more likely to rely on emergency services (Leeies et al., 2024). Onethird report having had a negative experience in the health care system in the past year, with rates even higher among trans and racialized 2SLGBTQI+ people (Meyer et al., 2020). Nationwide, only 15% of people report having access to inclusive mental health services, while 44% have access to gender-affirming care (Government of Canada, 2022, 2023a)avec fierté. Unmet health needs remain significant: 45% of trans individuals report unmet needs, including 42.3% of trans men and 36.4% of trans women over a oneyear period in Ontario (Egale Canada, 2020; Government of Canada, 2022).

3.4. Barriers and facilitators of health care accessibility for French-speaking 2SLGBTQI+ people

Several known factors help explain disparities in access to care experienced by 2SLGBTQI+ and French-speaking people in Canada. Appendix A illustrates how these factors interact.

3.4.1. Individual factors

3.4.1.1. Behaviours

CARE AVOIDANCE

Care avoidance refers to the decision to postpone or forgo the use of social or health services, most often in the area of preventive care (e.g., breast and cervical cancer screening among lesbian and bisexual women) (Alencar Albuquerque et al., 2016; Bize et al., 2011; Heer et al., 2023). It may also manifest as reluctance to use certain types of care (e.g., care in French) or to assert one's health-related rights or needs (Éthier & Carrier, 2022). In Canada, 12% of trans people report avoiding emergency departments when needed (21% in Ontario) (Egale Canada, 2020; Government of Canada, 2022), and 21.2% of French-speaking patients avoid seeking care when it is not available in French (de Moissac & Bowen, 2017). 2SLGBTQI+ people in Canada are also more likely to avoid dental care when it is not covered (Gupta et al., 2023). In Manitoba, the main reasons for care avoidance among Francoqueer people are the lack of Frenchlanguage services of comparable quality to English services (59.1%) (or poor quality of French services: 33.3%), lack of awareness of available services (37.9%), and fear of discrimination (31.8%) (Prada et al., 2021).

Among 2SLGBTQI+ people, care avoidance is often shaped by previous experiences of discrimination (or dissatisfaction), or by providers' lack of knowledge regarding 2SLGBTQI+ health (Ayhan et al., 2020; Conyers et al., 2023; Lee & Kanji, 2017; Leeies et al., 2024; McNeill et al., 2023; Romanelli & Hudson, 2017; Silverman & Baril, 2023). This effect is particularly evident among older adults, who have had extensive lifelong interactions with the health care system (Alencar Albuquerque et al., 2016; Bize et al., 2011; Heer et al., 2023). For Frenchspeaking people, care avoidance may stem from the absence of Frenchlanguage services, the unavailability of interpreters, difficulty communicating in English, or lack of knowledge about which services are covered (de Moissac & Bowen, 2017; Éthier & Carrier, 2022; Muray et al., 2022).

REQUESTING CARE IN FRENCH

French-speaking people can proactively request to receive care in French. In Canada, only 11.8% ask for services from a bilingual provider (de Moissac & Bowen, 2017), and on average, 53.3% request care in French in Manitoba (de Moissac et al., 2015). Among Francoqueer people in Manitoba, only 9.8% report often being offered care in French without having to request it (Prada et al., 2021).

In theory, requesting French-language services could help improve accessibility of care by enabling people to receive linguistically concordant care. However, in practice, the availability of services in French remains insufficient to meet demand (de Moissac & Bowen, 2017; de Moissac et al., 2015; Éthier & Carrier, 2022). Moreover, requesting care in French exposes people to the risk of being labelled as "difficult" and of facing negative attitudes from providers (Forgues & Maillet, 2024; Lévesque, 2022; Schrewe et al., 2023).

3.1.4.2. Feelings

FEAR OF EXPERIENCING DISCRIMINATION

Fear of experiencing discrimination refers to the anticipation of negative treatment based on one's sexual identity, gender, or language, which can discourage individuals from seeking care. This concern is a recurring theme across most articles on access to care for 2SLGBTQI+ people (Mottier, 2024), arising from a broader historical context of stigma and the pathologization of 2SLGBTQI+ identities (Government of Canada, 2022; Mottier, 2024). This fear is reduced when providers are themselves members of the 2SLGBTQI+ community, an effect even more pronounced among older 2SLGBTQI+ adults (Conyers et al., 2023).

3.1.4.3. Individual characteristics and preferences

PRESENCE OF PEERS

For French-speaking 2SLGBTQI+ people, peer support is a factor that improves access to care services. Friends and family can provide various forms of support, including logistical assistance, transportation, and help with navigating information. For French-speaking people, the presence of bilingual peers can also ease communication with care providers, particularly when services are offered in English. Friends and family play a key support role for older adults, and often act as caregivers.

IDENTITY DISCLOSURE

The disclosure of one's 2SLGBTQI+ identity can act both as a facilitator and as a barrier to accessing care, with disclosure rates ranging from 17% to 75% depending on the fear of discrimination and the personal significance ascribed to identity by patients (Ayhan et al., 2020; McNeill et al., 2023). In Manitoba, 50.8% of Francoqueer people rarely or never disclose their identity, mainly because they believe (in 48.1% of cases) that their 2SLGBTQI+ identity does not influence the care they receive (Prada et al., 2021). These nearly equal proportions point to a persistent tension within 2SLGBTQI+ communities: For some, disclosure is viewed as essential to recognition, safety, and appropriate care; for others, it is a strictly context-dependent choice, deemed necessary only when it has a concrete impact on care.

Some researchers argue that 2SLGBTQI+ identity constitutes clinically relevant information, comparable to age or ethnocultural background, and should be integrated into comprehensive patient assessment (Comeau et al., 2023; McNeill et al., 2023), in a context where assuming the incorrect information may lead to inadequate care (Neville & Henrickson, 2006; Romanelli & Hudson, 2017). However, disclosure can also produce negative consequences, such as stigmatization or changes in providers' attitudes (Ayhan et al., 2020; Comeau et al., 2023; Kuzma et al., 2019; Rufino et al., 2018). Older adults may stop disclosing their sexual identity after having lived openly, a phenomenon referred to as "going back into the closet" (Ayhan et al., 2020; Government of Canada, 2022; Silverman & Baril, 2023).

Several factors encourage identity disclosure: the presence of 2SLGBTQI+ providers, physical environments that visibly demonstrate inclusivity (Brooks et al., 2018), and systematic practices for collecting 2SLGBTQI+ identity data (McNeill et al., 2023). Providerinitiated opportunities for disclosure are particularly important, as the absence of such opportunities is cited by 59.3% of Francoqueer people in Manitoba as a reason for concealing their identity (Prada et al., 2021).

3.4.2. Interpersonal factors

According to Mottier (2024), interpersonal factors remain relatively underexplored in research on 2SLGBTQI+ people.

3.4.2.1. Provider behaviours and attitudes

2SLGBTQI+ people—in particular trans, Two-Spirit, racialized, and older individuals—report discriminatory behaviours that undermine their access to care (Alencar Albuquerque et al., 2016; Ayhan et al., 2020; Silverman & Baril, 2023). In Canada, 39% of 2SLGBTQI+ people report having experienced discrimination (Government of Canada, 2022).

Discrimination can take the form of harassment (intrusive questions, denial of identity, or aggressive physical examinations) (Grant et al., 2011; Meyer et al., 2020; National LGBT Health Education Center, 2016; Rufino et al., 2018), or negative attitudes, such as non-verbal cues or disparaging comments about a patient's language (de Moissac & Bowen, 2017; de Moissac et al., 2015; Éthier & Carrier, 2022; Forgues & Maillet, 2024; Lévesque, 2022; Schrewe et al., 2023). These behaviours damage the therapeutic relationship and reinforce feelings of stigma (Lee & Kanji, 2017; McNeill et al., 2023; Romanelli & Hudson, 2017). Discrimination can also extend to a patient's family and friends, decreasing their capacity to provide support and adding to their burden, factors that may exacerbate isolation among older 2SLGBTQI+ adults, for example (Silverman & Baril, 2023). In Manitoba, 65.3% of 2SLGBTQI+ men report having experienced discrimination in health care settings (Souleymanov et al., 2022), while Francoqueer people report discrimination related to sexual orientation (42.6%) and to speaking French (39.3%) (Prada et al., 2021).

Denial of care represents a severe form of discrimination, affecting between 19% and 27% of trans people, 8% of LGB people, and 5% of men who have sex with men (Ayhan et al., 2020; Egale Canada, 2020; Grant et al., 2011). Denial of care may be motivated by personal or religious objections, particularly in the areas of sexual and reproductive health, or by a lack of knowledge, especially concerning genderaffirming care (Casey, 2019; Collège des médecins du Québec (CMQ), 2021; Comeau et al., 2023).

3.4.2.2. Adapted communication

INCLUSIVE LANGUAGE

The use of neutral terms (e.g., "partner" rather than "girlfriend"), openness to discussing 2SLGBTQI+ identities, and respect for chosen pronouns all help foster trust and identity disclosure among 2SLGBTQI+ people (Brooks et al., 2018; Comeau et al., 2023; Klein et al., 2018; Kuzma et al., 2019; McGlynn et al., 2020; McNeill et al., 2023; National LGBT Health Education Center, 2016; Neville & Henrickson, 2006; Reynolds, 2020; Rufino et al., 2018; von der Warth et al., 2024; Willis et al., 2020). It is equally important for providers to actively create opportunities to discuss 2SLGBTQI+ identities, consistent with the preferences expressed by most patients (Ayhan et al., 2020; Brooks et al., 2018; Rufino et al., 2018; Schmitz & Tabler, 2021). Inclusive communication fosters a safe environment and helps prevent clinical interventions based on incorrect information. Using the correct terminology, in particular chosen names and pronouns, helps avoid uncomfortable situations that can lead to care avoidance. For example, a trans person who is addressed by their deadname may prefer to leave a health care setting rather than disclose their trans identity (Colpitts & Gahagan, 2016; Menkin et al., 2022; Tam, 2019).

PREFERRED LANGUAGE

Language-concordant care improves patient satisfaction and care continuity, and reduces risks associated with languagediscordant services (Bernier et al., 2013; Drolet et al., 2014; Muray et al., 2022; Reaume et al., 2024). This is particularly crucial for older adults, who are more vulnerable to language barriers that can accompany aging (de Moissac & Bowen, 2017; Drolet et al., 2014; Muray et al., 2022). Despite this, many providers assume that Francophones are proficient in English, which limits access to linguistically appropriate care (Bouchard et al., 2022; Muray et al., 2022). The active offer of services in French serves as a facilitator for access to language-concordant care.

3.4.2.3. Identity-based affinities

Shared sociodemographic characteristics between providers and patients can influence access to care. Certain sociodemographic characteristics of providers (older age, masculinity, non-white ethnicity, heterosexuality, or religiosity) have been associated with more negative attitudes toward 2SLGBTQI+ people (Alencar Albuquerque et al., 2016; Aleshire et al., 2019; McNeill et al., 2023; Nowaskie & Najam, 2022; Yang, 2021). Conversely, Frenchspeaking providers tend to place greater importance on ensuring the satisfaction of Frenchspeaking patients (Forgues & Maillet, 2024), and the 2SLGBTQI+ identity of providers helps facilitate identity disclosure and reduce fear of discrimination, especially among older adults (Brooks et al., 2018; Conyers et al., 2023). However, structural barriers such as employment and educational discrimination can hinder the hiring of 2SLGBTQI+ or Frenchspeaking providers, limiting their representation within the health care system (Beagan et al., 2022; Bizzeth & Beagan, 2023; Morgenroth et al., 2024; Savard et al., 2024).

3.4.3. Organizational factors

3.4.3.1. Operations and procedures

ACTIVE OFFER

An active offer of Frenchlanguage care and services facilitates access to language-concordant care. It involves inviting patients to communicate in the official language of their choice before they make a request to do so (Bouchard, Beaulieu, et al., 2012; de Moissac et al., 2015). In the absence of an active offer, access to linguistically concordant services depends on the patient's own willingness to request them, thereby creating an additional barrier (de Moissac et al., 2015). The existence of laws governing active offer can encourage this practice, although the effectiveness of such laws depends on organizational factors (Forgues & Maillet, 2024). In Manitoba, the active offer of health care services is enshrined in law, and certain clinics, RHAs, and programs are designated as bilingual or francophone (Shared Health, 2024).

INTERPRETATION SERVICES

Hiring qualified interpreters can improve the quality of care and reduce missed appointments (Bernier et al., 2013; Bouchard, Chomienne, et al., 2012; de Moissac & Bowen, 2017). These services are particularly important for French-speaking older adults, whose second-language proficiency may decline over time (Bouchard, Chomienne, et al., 2012). Conversely, interpretation services may compromise the confidentiality of French-speaking patients' medical information (de Moissac et al., 2015; Drolet et al., 2014). The use of untrained interpreters remains a problematic practice in Manitoba (de Moissac et al., 2020).

COLLECTION OF PERSONAL INFORMATION

Recording information such as gender, chosen name, pronouns, and sexual orientation in medical records enables providers to deliver care better tailored to 2SLGBTQI+ people (Bize et al., 2011; Brooks et al., 2018; Comeau et al., 2023), while documenting language preference facilitates continuity of care and referrals to linguistically concordant services (de Moissac et al., 2020). These practices spare patients from having to disclose their identity unnecessarily and encourage providers to adopt inclusive communication and use a patient's chosen language. Standardized datacollection policies, such as those implemented in British Columbia, help ensure that identity data are compiled respectfully and in line with interoperability considerations (British Columbia Ministry of Health, 2025; HL7®, 2024). In Manitoba, since 2023, some organizations have begun collecting data on ethnicity; however, this initiative remains limited and does not include information on 2SLGBTQI+ identity or language (Sawatzky, 2023). However, self-declaration of official language has been added to Manitoba's new health card (Government of Manitoba, 2025).

CONFIDENTIALITY

Clear policies on data access and confidentiality are essential to foster transparency and reduce fears of unauthorized disclosure (Brooks et al., 2018; Klein et al., 2018; McNeill et al., 2023). When clearly communicated to 2SLGBTQI+ patients, confidentiality policies can contribute to greater comfort with identity disclosure (Klein et al., 2018).

PATIENT FEEDBACK

Complaint mechanisms can provide valuable insights into the accessibility of care, but they remain underused: Only 13% of French-speaking people in Manitoba consistently or often file a complaint when care is not available in French (de Moissac et al., 2015). In Canada, the absence of complaints is often assumed to mean a lack of problems (Muray et al., 2022). The systematic collection of patientreported experience measures (PREMs), most often through questionnaires that do not place the burden of action on patients, provides a key indicator of quality of care (Kingsley & Patel, 2017).

3.4.3.2. Signage and documentation

Appropriate signage and documentation help create welcoming environments for French-speaking 2SLGBTQI+ people. Inclusive posters, pamphlets, and symbols (e.g., rainbows, pronoun options, gender-neutral washrooms) foster trust and signal openness (Bize et al., 2011; Comeau et al., 2023; Conyers et al., 2023; Klein et al., 2018; Lee & Kanji, 2017; McNeill et al., 2023; Menkin et al., 2022; Meyer et al., 2020; Quinn et al., 2015; Reynolds, 2020; Romanelli & Hudson, 2017; Rufino et al., 2018), whereas religious imagery can signal the opposite (Brooks et al., 2018; Kalmar & Mariano, 2024). Clinics that explicitly identify as being operated by and for 2SLGBTQI+ communities reinforce these signals of inclusivity, although they may be less accessible to individuals who are not open about their identity (Comeau et al., 2023; Romanelli & Hudson, 2017). Inclusive forms that include options other than "male" and "female," that recognize diverse family structures, and that do not address only heterosexual people can further strengthen this sense of inclusion (Fish & Williamson, 2018; Quinn et al., 2015). Inclusive signage and documentation enhance trust among 2SLGBTQI+ people and promote identity disclosure.

Bilingual signage and French language documentation are essential for Frenchspeaking individuals, particularly older adults and Francophone immigrants (Bouchard, Chomienne, et al., 2012; de Moissac & Bowen, 2017; de Moissac et al., 2015; Gates-Gasse & Lassonde, 2015). However, these materials must also be clear and avoid overly complex translations (Bouchard et al., 2022). Such practices can encourage Francophones to request services in French and to access language-concordant care. Conversely, signage that is inclusive in appearance but unsupported by effective inclusive or linguistic practices may be perceived as discriminatory (Bouchard et al., 2022; Comeau et al., 2023).

3.4.4. Structural factors

3.4.4.1. Availability of care and information

The availability of care and information reflects the system's capacity to meet demand, to ensure alignment between the service offer and population needs.

AVAILABILITY OF INFORMATION

Access to clear information about services enables patients to understand what is available and to access services at the appropriate time. Service characteristics, such as language, inclusivity, and physical or financial accessibility, must also be clearly indicated. In the absence of such information, patients may use emergency services inappropriately for nonurgent issues, particularly among immigrant populations, or avoid seeking care altogether (Bernier et al., 2013; de Moissac et al., 2015). French-speaking people have consistently reported a strong need for a centralized information directory due to a chronic lack of available resources (de Moissac & Bowen, 2017; Muray et al., 2022).

In Manitoba, Francoqueer people report difficulty finding information about health services (53%), finding a family physician (39%), or obtaining reliable information about available resources (33.3%) (Prada et al., 2021). Currently, the Family Doctor Finder tool (Province of Manitoba, 2025) allows people to find a provider in French or according to certain accessibility criteria, but it does not allow identification of inclusive providers. While Frenchlanguage health directories exist (Santé en Français Inc., 2025a, 2025b) and Englishlanguage lists of 2SLGBTQI+ resources are available (Canadian Queer Medical Students Association, 2023; Rainbow Resource Centre, 2026), there is currently no directory dedicated to 2SLGBTQI+ services in French. On the other hand, several informational documents on 2SLGBTQI+ care and organizations are available only in English (Klinic Community Health, 2024; Rainbow Resource Centre, 2026; Sexuality Education Resource Centre MB (SERC), 2018). The From and for Our Own project had proposed promoting the Société de la francophonie manitobaine's Annuaire des services en français (Frenchlanguage service directory) and adding information on accessibility for 2SLGBTQI+ people (Prada et al., 2021; Société de la francophonie manitobaine (SFM), 2026), but this addition has not yet been implemented.

AVAILABILITY OF 2SLGBTQI+ AND INCLUSIVE CARE

The availability of health care programs specific to 2SLGBTQI+ people is a key determinant for improving access to services among these populations. In Manitoba, several clinics and programs offer tailored services, such as the Gender Diversity and Affirming Action for Youth, Trans Health Klinic, Sexuality Education Resource Centre and Rainbow Resource Centre; however, none of these sites are designated bilingual (Canadian Queer Medical Students Association, 2023; Community-Based Research Centre, 2026; Sexuality Education Resource Centre MB (SERC), 2018; Shared Health, 2024). Access to certain specialized care, such as gender-affirming surgeries or hormone therapy, may require a referral from a primary care provider or travel outside Manitoba (Klinic Community Health, 2024).

The availability of inclusive care ensures that 2SLGBTQI+ people have access to general health care services, including those requiring a primary care provider, without having to rely exclusively on specialized programs. This inclusivity depends heavily on provider training, as a lack of knowledge about 2SLGBTQI+ needs and inclusive practices undermines both care quality and provider-patient communication (Ayhan et al., 2020; Kalmar & Mariano, 2024; Lee & Kanji, 2017; Matsuzaka et al., 2021; Reynolds, 2020; Tam, 2019). This training gap is also linked to the persistence of conversion therapies, despite their being banned (Comeau et al., 2023; Egale Canada, 2023; Pearce & Di Lorito, 2023; Tam, 2019).

Finally, the availability of care adapted to 2SLGBTQI+ communities also depends on the inclusion of these populations in reference materials. When such documentation is absent, providers and patients alike remain unaware of clinical guidelines, resulting in a lack of tailored programs (Comeau et al., 2023; Haviland et al., 2020).

AVAILABILITY OF CARE IN FRENCH

The availability of care in French is essential to meeting the needs of Frenchspeaking people, particularly those who are unilingual. In general, limited availability of Frenchlanguage services constitutes a significant barrier to access, forcing patients to choose between care in their preferred language and services with other forms of accessibility such as shorter wait times or closer geographic proximity (de Moissac & Bowen, 2017; Muray et al., 2022). This limited availability is primarily attributed to a shortage of bilingual providers and the small size of the minority-language population (de Moissac & Bowen, 2017; Éthier & Carrier, 2022). The shortage contributes to difficulties in delivering services in French (de Moissac & Bowen, 2017; Dupuis-Blanchard, 2024; Éthier & Carrier, 2022) and is compounded by hiring practices that prioritize unilingual Anglophone providers over Francophones, the additional workload placed on bilingual providers due to their language skills, and unstable funding for Frenchlanguage services (de Moissac et al., 2020; Drolet et al., 2014).

In Manitoba, 90% of French-speaking people consider receiving services in French to be important. However, although 53.3% actively request services in French, only 24.7% actually receive care in this language, attesting to insufficient availability (de Moissac et al., 2015). Services in French are more common in urban settings than in rural settings and are more concentrated in St. Boniface than in anglophone areas of Winnipeg (Bouchard et al., 2022; de Moissac et al., 2012). Even designated bilingual organizations do not always provide services in French (Drolet et al., 2014). Finally, most Francoqueer people report primarily using health services in English (Prada et al., 2021), suggesting insufficient availability of inclusive or 2SLGBTQI+ services in French.

GEOGRAPHIC AVAILABILITY OF CARE

Geographic availability refers to the system's capacity to provide services that are accessible based on patients' physical location. Overall, health care services are heavily concentrated in urban settings, which constitutes a barrier for patients living in rural areas, across all categories of care. This barrier is amplified for French-speaking people, who face greater challenges accessing linguistically appropriate care outside urban centres (Carr et al., 2024; de Moissac & Bowen, 2017; de Moissac et al., 2015; Muray et al., 2022), and for 2SLGBTQI+ people, who sometimes must travel long distances to obtain inclusive care (de Moissac et al., 2024; Reynolds, 2020; Romanelli & Hudson, 2017; Souleymanov et al., 2022; Willis et al., 2020). The concentration of bilingual or Francophone providers in urban settings helps explain the limited availability of French-language services outside major cities (Carr et al., 2024; Muray et al., 2022). Similarly, 2SGBQ+ men in rural settings also report lower access to services (Souleymanov et al., 2022).3.4.4.2. Formation et documentation

3.4.4.2. Training and documentation

TRAINING

Training providers on the needs of 2SLGBTQI+ and French-speaking communities is crucial to improving access to care. However, training on 2SLGBTQI+ health remains insufficient (Alencar Albuquerque et al., 2016; Carabez et al., 2015; Klein et al., 2018; Kortes-Miller et al., 2019; Leeies et al., 2024; Reynolds, 2020; Tam, 2019; Yu, Bauermeister, et al., 2023). Only one third of Canadian and American medical faculties offer training specific to trans health (Comeau et al., 2023), and 50% of 2SLGBTQI+ people report that their providers lack adequate knowledge (Ayhan et al., 2020; Government of Canada, 2023a; Willis et al., 2020). A lack of training also affects comfort levels: 33% of providers report feeling uncomfortable working with 2SLGBTQI+ people, a phenomenon attributed to historical biases (Gisondi & Bigham, 2021; Romanelli & Hudson, 2017). This deficit can foster misconceptions, such as the belief that discrimination against 2SLGBTQI+ people no longer exists (McGlynn et al., 2020), and contributes to diminished confidence and competence among providers (Gahagan & Subirana-Malaret, 2018; Gisondi & Bigham, 2021).

Few training programs focus specifically on Frenchspeaking communities (Drolet et al., 2014). The lack of Frenchlanguage training programs leads Francophone providers to pursue their studies in English, hindering their ability to work and master medical terminology in French (de Moissac et al., 2017; Schrewe et al., 2023). Medical training in French is not available in Manitoba (although a bilingual stream is offered at the University of Manitoba), and professional training programs are costly (de Moissac et al., 2017; University of Manitoba, 2023).

Moreover, the lack of training on linguistic and cultural minorities limits understanding of the importance of language-concordant care and the active offer of services (Bouchard, Chomienne, et al., 2012; de Moissac & Bowen, 2017; Savard et al., 2024). Although cultural competency training programs exist (Drolet et al., 2014), including some designed for linguistic minority communities, none specifically target the French-speaking minority (Deliz et al., 2020). Promoting French-language health training among Francoqueer people represents a promising approach to improving accessibility (Prada et al., 2021).

Some training resources are nonetheless available. For example, both Klinic and the Sexuality Education Resource Centre offer 2SLGBTQI+ health training for providers (albeit only in English) (Klinic Community Health, 2026; Sexuality Education Resource Centre MB (SERC), 2018). Shared Health also provides mandatory training for its staff on the active offer of Frenchlanguage services (Winnipeg Regional Health Authority, 2024); and numerous training resources on French-language services have been developed by the Société Santé en français (SSF) (2025).

STANDARDS AND PROCEDURES

Reference standards for care providers published by governments and universities present a major challenge with regard to their erasure of 2SLGBTQI+ and Frenchspeaking people. Yet, the publication of standards and procedures is a key lever for improving access to care, particularly for older 2SLGBTQI+ people (Horner et al., 2012). The absence of standards—whether related to French-language services or services for 2SLGBTQI+ populations—means that service delivery largely depends on organizational culture and the goodwill of providers (Bouchard et al., 2022; Comeau et al., 2023; de Moissac et al., 2020; Éthier & Carrier, 2022). To ensure equitable access and continuity of services for French-speaking people, it is essential that their health needs be integrated into national standards and procedures, as well as training programs.

3.4.4.3. Society

Care, situated within a broader social context, is influenced by social markers that shape accessibility. Cisnormativity and heteronormativity, which are deeply embedded in society, contribute to the barriers faced by 2SLGBTQI+ people (Comeau et al., 2023; McGlynn et al., 2020). These biases are even more entrenched within health care settings, where sexual orientations and gender identities were long considered mental disorders (Giguère, 2022; Hughto et al., 2015; Robles et al., 2021). This social and historical context reinforces fears of experiencing discrimination in the health care system among 2SLGBTQI+ people (Government of Canada, 2022) and perpetuates misconceptions among some providers, such as the belief that homosexuality and trans identity are still mental disorders, or that sexual orientation is a topic relevant only to psychiatry (Comeau et al., 2023; Lee & Kanji, 2017; McGlynn et al., 2020; Rufino et al., 2018; Saleh et al., 2011).

Anglonormativity, shaped by Canada's history of English dominance, also limits the availability of services for Frenchspeaking people (Forgues & Maillet, 2024). It undermines the effectiveness of legislation, meaning that language provisions do not always translate into access in practice (Muray et al., 2022), as illustrated by the fact that some designated bilingual organizations do not systematically provide care in French (Drolet et al., 2014). Anglonormativity also fuels negative attitudes; Francophobia has been described as the "last acceptable prejudice" (Nadeau, 2016), and even officially bilingual federal commissions have displayed unfavourable attitudes toward the French language (Lévesque, 2022).

3.4.4.4. Policies

CARE POLICIES

Provincial and federal policies govern care and influence access to care. Policies on French-language services determine the availability of care in French. The Official Languages Act of 1969 recognizes French and English as having equal status and, in Manitoba, services must be actively offered in French and be of comparable quality to those provided in English (Government of Manitoba, 2017). However, this equality is not evident across all services, as access to care remains unequal (Muray et al., 2022). The implementation of the Official Languages Health Program aims to address these disparities (Government of Canada, 2023b).

Government policies formally protect 2SLGBTQI+ people from discrimination, and gender identity was added to the list of protected grounds in Manitoba in 2025 (Hunter, 2025). More broadly, the lack of legal recognition of chosen families and 2SLGBTQI+ partners remains a barrier that limits 2SLGBTQI+ caregiving (Fish & Williamson, 2018; Horner et al., 2012; Kalmar & Mariano, 2024; McNeill et al., 2023; Silverman & Baril, 2023). This barrier is present in Manitoba, where legislation adopted in 2022 provides that a child may have no more than two parents, unlike in other Canadian provinces (LCM Attorneys, 2025; Sprout Family, 2024; Wong, 2024).

Care policies can also affect access. For example, home care is not included under the Canada Health Act, meaning its provision depends on provincial priorities (Dupuis-Blanchard, 2024). In Manitoba, as of 2024, a mental health referral is no longer required to access trans-affirming care, which facilitates access to gender-affirming care (Beaucamp, 2024). However, accessing this care still requires registering with a primary care provider (Klinic Community Health, 2024), which may lengthen wait times for individuals who do not have a provider or whose provider lacks expertise in trans-affirming care.

FINANCIAL COVERAGE OF CARE

Universal health care coverage is a major driver of improved access to care. When coverage for PrEP, a medication that reduces HIV transmission, was introduced in British Columbia in 2018, it led to a decline in infections as early as the following year (Casey, 2019). Conversely, the absence or partial coverage of certain medications remains a significant barrier, particularly for 2SLGBTQI+ people facing economic precarity and lacking private insurance (Kalmar & Mariano, 2024; Matsuzaka et al., 2021; Mottier, 2024; Romanelli & Hudson, 2017; Schmitz & Tabler, 2021). Trans people are particularly affected: Some insurance plans explicitly exclude them from gender-related care, such as cervical or prostate cancer screening (Haviland et al., 2020; National LGBT Health Education Center, 2016; Romanelli & Hudson, 2017). Financial barriers also include the requirement to obtain a mental health referral to initiate hormone therapy, often at the patient's own expense (Comeau et al., 2023), which leads some people to turn to unregulated hormones (Hughto et al., 2015; Romanelli & Hudson, 2017). For French-speaking people, high health care costs may be associated with care avoidance

(Éthier & Carrier, 2022).

In Manitoba, primary care services are generally covered; however, certain administrative procedures, such as accessing one's medical record or requesting a transfer to a different primary care provider, may incur fees for patients (Government of Manitoba, 2023). In the context of 2SLGBTQI+ care, PrEP has been offered free of charge since 2024 under certain conditions (Government of Manitoba, 2024), but most trans-affirming care and services (hormone therapy, legal documentation) involve costs (Canadian Queer Medical Students Association, 2023; Klinic Community Health, 2024). Some paramedical care, such as dental care and physiotherapy, is covered under certain conditions by federal and Manitoba plans (Government of Canada, 2025; Manitoba Public Insurance, 2025). These services, offered by private companies, are most commonly provided in English, thereby reducing access to care for French-speaking individuals (Éthier & Carrier, 2022). Mental health services are not universally covered but may be reimbursed through private insurance or specific programs (Canadian Medical Association, 2026).

3.5. Limitations of current knowledge

Although many factors affecting access to care for 2SLGBTQI+ or French-speaking people are known, the Franco/queer intersection remains underdocumented. On this topic, the literature review identified only two scientific articles (de Moissac et al., 2024; Prada et al., 2023), one thesis (Avanthay Strus, 2026), and seven pieces of grey literature—three from Manitoba (Avanthay Strus et al., 2024; Courcelles et al., 2023; Prada et al., 2021) and four from Ontario (Charles & Ngoumou, 2024; Collins et al., 2024; Gates-Gasse & Lassonde, 2015; Ngoumou et al., 2022). There may therefore be interactions and factors that the current literature does not capture. It is also possible that the identified factors operate differently in an intersectional context than they do for 2SLGBTQI+ or French-speaking people considered separately. Studies specifically targeting the Francoqueer population are therefore needed to assess the relevance and applicability of these factors to this intersectional identity.

The two scientific articles identified use a quantitative methodology and rely on the same dataset from a study conducted by the Collectif LGBTQ* du Manitoba, whose sample remains homogeneous (white, urban, educated people under the age of 55) (Prada et al., 2021). As these studies did not focus specifically on health care, they do not allow for the identification of new factors or the exploration of interactions between factors— tasks for which a qualitative approach is better suited.

Several of these publications focus on specific subgroups, such as youth (Avanthay Strus et al., 2024), parents (Avanthay Strus, 2026), racialized people (Charles & Ngoumou, 2024; Collins et al., 2024; Ngoumou et al., 2022), or immigrants (Gates-Gasse & Lassonde, 2015). While useful, these studies describe realities specific to these groups and cannot be generalized to all Francoqueer people.

Finally, several studies conducted in Manitoba among French-speaking populations (Bernier et al., 2013; Chartier et al., 2012; de Moissac et al., 2015; Levesque et al., 2022) or 2SLGBTQI+ people (Souleymanov et al., 2022) do not adopt an intersectional lens. In this context, knowledge about the Franco/queer intersection remains limited, in particular in Manitoba and within qualitative research designs.

4. Research objectives and significance

4.1. Objectives

This research aims to identify the main factors influencing access to care for Francoqueer people in Manitoba. More specifically, it pursues three objectives:

1. Document the lived experience of access to care at the Francoqueer intersection
2. Identify the most effective practices for improving access to care for Francoqueer people
3. Support the development of a diagnostic tool and complementary training for care providers particularly in four priority areas (mental health, home care, primary care, and palliative care)

Achieving these objectives will lay the groundwork for transformative actions to sustainably improve access to care for Francoqueer people in Manitoba and, potentially, elsewhere in the Canadian Francophonie.

4.2. Significance of the study

This study fills a significant gap, as no previous research has specifically examined Francoqueer people's access to care using a qualitative methodology. It therefore provides new insights into their lived realities and needs.

From a practical standpoint, the study provides essential data to:

- Design a diagnostic tool capable of assessing the actual accessibility of services
- Support the development of professional training for providers focused on Francoqueer needs
- Develop interventions tailored to this population

In this sense, this research constitutes a key contribution to improving the quality, safety, and inclusiveness of care provided to Francoqueer people.

5. Methodology

A case study design was chosen to examine the health care experiences of Francoqueer people in Manitoba in depth (Creswell, 2013). The methodology and data collection tools were validated by the scientific committee and the community advisory board before the project was submitted to the ethics committee or approval. The project received ethics approval under certificate ETH 2025 3 juin (Université de SaintBoniface). In November 2025, Université de SaintBoniface and the Collectif LGBTQ* du Manitoba entered into a collaboration agreement to clarify each organization's respective roles in recruitment, data collection, and data management.

5.1. Sampling

Between four and 25 participants were sought. Participants were eligible if they: (1) selfidentified as Frenchspeaking and 2SLGBTQI+; (2) were at least 16 years old and able to provide consent; (3) had sufficient French-language proficiency to take part in 90minute one-on-one interviews in French; and (4) had received health care or social services in Manitoba in the postCOVID period.

Purposive (nonprobability) sampling was used to maximize the diversity of participant profiles (Campbell et al., 2020; Palinkas et al., 2015). A sociodemographic questionnaire enabled the selection of participants with diverse identities and health care experiences, to avoid overrepresentation of white, cisgender, or urban participants (Casey, 2019; Prada et al., 2021; Prada et al., 2023).

5.2. Recruitment

Recruitment took place from November 3, 2025, to February 6, 2026, and was guided by three strategies:

- Direct outreach through the Collectif's social media accounts and newsletter, supplemented by print and radio advertisements (December 2025), and a Facebook and Instagram digital campaign (January 2026)
- Community partnerships: Twenty-one organizations were approached, including Francophone organizations, 2SLGBTQI+ organizations, and organizations serving subgroups that are typically underrepresented in research (e.g., older adults and immigrants). Six organizations disseminated the recruitment materials; two of them delayed distribution to the end of the recruitment period
- Snowball sampling through referrals from participants

5.3. Data collection

Participants completed two questionnaires on the LimeSurvey online platform (sociodemographic and contact forms). The questionnaire drew on instruments used in 2SLGBTQI+ research (Prada et al., 2021; von der Warth et al., 2024) and included a question about categories of care.

The virtual interviews (each lasting approximately 90 minutes) were divided into three parts:

1. 2SLGBTQI+ and French-speaking identity;
2. episodes of care (iterative section);
3. overall assessment of the care received.

5.4. Data transcription, analysis, and validation

All interviews were audio-recorded, then transcribed and anonymized. Two transcripts were independently annotated to validate the codes and categories, informing the development of a codebook. The full dataset was coded using QualCoder (Curtain, 2025). The categories were defined deductively, based on the theoretical framework and existing literature, while codes and inclusion criteria were developed inductively.

6. Results

6.1. Sample description

6.1.1. Recruited participants

Of the 11 people who filled out the consent form, nine provided their contact information and were contacted, eight responded to our attempts to reach them, and seven were interviewed (loss to followup: 36.3%). The sample comprises seven participants whose ages were distributed as follows: one person aged 16 to 24, three aged 25 to 34, two aged 35 to 44, and one aged 65 or older. Several participants belonged to minority groups: one participant was from a visible minority, and two lived with disabilities. Participants reported a diversity of gender identities: three identified as nonbinary/agender/neutrois, two as trans, and one each as a woman, a man, bigender or genderqueer, TwoSpirit, questioning, and "other" gender identity. Sexual orientations were also highly diverse, with three lesbian participants, two bisexual participants, and one participant each identifying as gay, polysexual, questioning, or "other." In terms of language, six participants described themselves as Francophone, three as bilingual (FrenchEnglish), and one as multilingual. Educational attainment was high: four participants held a bachelor's degree and three held a master's degree. Lastly, participants resided mainly in urban settings: four lived east of the Red River, two lived west of it, and one reported another residential situation.

6.1.2. Episodes of care received

Participants reported a total of 37 episodes of care. Emergency and specialized care represented the most frequent category, with 13 episodes, followed by primary care (12), paramedical care (8), mental health care (6), and 2SLGBTQI+ care (4). In terms of financial coverage, most care was fully covered (27 episodes), while six episodes were not covered, two were partially covered, and two had indeterminate coverage. Linguistically, participants received care mainly in English (24 episodes), followed by hybrid care (9), while three episodes took place in French. The geographic distribution shows a high concentration of care in urban settings: 16 episodes occurred west of the Red River and 17 to the east, while a few episodes were reported outside Manitoba (2), in rural Manitoba (1) or by telephone (1).[3]

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[3] Voir annexe C pour les tableaux sociodémographiques complets

6.2. Factors influencing accessibility of care

This section presents the deductive analysis; interview findings are organized according to the main categories identified in the scientific literature, illustrating how these factors play out in the Manitoban context. Because links between factors sometimes emerged only indirectly from the interviews (and because they have already been discussed in the literature review), this section focuses primarily on the factors themselves.

6.2.1. Individual factors

Three dimensions emerged at the individual level. First, behaviours refer to the strategies participants used to access care, such as actively seeking out services perceived as safe, making specific requests (e.g., language requests), or avoiding certain consultations. Second, participants' feelings—especially trust or distrust toward providers and institutions—influenced their decision to seek care and the extent of their identity disclosure in clinical settings. Lastly, individual characteristics and preferences, including socioeconomic situation, linguistic security, disability, and reliance on peer support, shaped the practical resources available to participants as they navigated the health care system.

6.2.2.1. Feelings

FEAR OF EXPERIENCING DISCRIMINATION

Participants expressed strong fears of discrimination related to their 2SLGBTQI+ identity. These concerns stemmed from past experiences of mistreatment and broader societal factors, including the religiosity associated with Francophone contexts. These fears were heightened in situations of real or anticipated vulnerability, such as emergency care, postoperative care, genderaffirming care, or care for older adults. Participants who had experienced more openly hostile social situations for 2SLGBTQI+ people (e.g., older adults or immigrants) continued to hold fears rooted in these experiences.

- **With all the Catholic influence in our Francophone hospitals, things often feel aligned with a sort of Catholic society that operates a bit on the sidelines. It's all a bit worrying if we ever find ourselves in a complicated situation, you know.**

These fears shaped participants' willingness to disclose their 2SLGBTQI+ identity. They anticipated breaches of confidentiality, discrimination, and a decline in the quality of care if they came out.

- **If I let them know [about my 2SLGBTQI+ identity], I might end up being the last patient they see, and maybe they wouldn't really take good care of me.**

6.2.2.1. Individual preferences

PRESENCE OF PEERS

Having assistance from caregivers, friends, and family in navigating the health care system served as a protective factor. Participants reported calling on peers for support with tasks such as booking appointments and interpreting in Englishlanguage clinics.

- **I pushed for it, and I had a friend who spoke English. I gave her the number so she could call them and say it was really urgent.**

IDENTITY DISCLOSURE

Participants expressed a range of preferences regarding identity disclosure. Some felt it was important for providers to know everything, including their 2SLGBTQI+ identity, while others preferred to share this information only when it was medically necessary.

- **I'll start by telling him about my orientation, so he knows that's who I am. […] Since he's my [specialist], he needs to know everything about me, including my orientation.**

LANGUAGE PREFERENCES

Participants also reported varying degrees of preference for receiving care in French, even when they had a good command of English. They described Frenchlanguage care as preferable, comfortable, and friendly, but also as an additional barrier and a secondary criterion. These preferences were shaped by the practical impossibility of receiving care in French and by the importance participants place on language.

- **It's more comfortable, for example, to receive services in French. I was talking about it with friends who said, "I don't get it, your English is better than mine, but you insist on getting services in French." And I said, "Well yes, because I would rather my doctor speak to me in French than in English, because I want to be sure I've really understood everything.**

OTHER CHARACTERISTICS

Participants also reported a variety of individual characteristics, such as age, disability, financial situation, or linguistic insecurity, which limited the range of care they could access. These characteristics hindered access to health care when English proficiency, economic resources, or functional abilities were required to obtain services. Some participants also recognized characteristics such as being white as a facilitator of access to care, whereas other characteristics, such as disability, made them more vulnerable to discriminatory situations.

- **For someone like me who needs followups quite regularly, I can't just leave this doctor and go looking for another one.**

6.2.1.3. Behaviours

CARE AVOIDANCE

Participants occasionally reported careavoidance behaviours, avoiding care because of past experiences of discrimination or because services were not covered financially.

- **I didn't go see her even though I was supposed to book an appointment. I booked it more or less to appease the [specialist]. But I didn't go back to her for a followup to make sure everything was okay […]. I didn't go see her because I was so afraid of being judged, that she would say something about my body, about who I am. And now, looking back, I see how dangerous that was.**

REQUESTS FOR FRENCH LANGUAGE SERVICES

Participants rarely requested services in French, and when they did, such requests were rarely successful. They attributed this to organizations' ongoing difficulty in providing Frenchlanguage health care, and to their own fear of inconveniencing staff or experiencing a decline in service quality when making such requests. At the same time, participants recognized that these requests were necessary to improve French-language service availability.

- **I could have criticized them, I could have complained and insisted on speaking French. I imagine they could have accommodated me. You know, I'm an activist, but not to the point of causing problems either.**

OTHER BEHAVIOURS

Participants also applied a variety of behaviours and strategies to improve their access to care. These behaviours aimed to compensate for higherlevel barriers, such as the unavailability of care in French, long wait times, and a lack of inclusivity. The behaviours participants used to facilitate their access to care included bringing a book, writing their gender outside the "male/female" boxes on forms, choosing English-language walkin clinics, and using translation apps.

- **She spoke English, but I could always use my phone to translate, yeah. [...] It worked well. I just wrote that I wanted the medications and showed her the translation, and she understood.**

6.2.2. Interpersonal factors

Four interpersonal dimensions influenced how participants accessed and engaged with health care. First, providers' behaviours and attitudes—ranging from openness and empathy to various forms of judgment or denial of care—shape access to and engagement in care. Second, adapted communication refers to inclusive and accessible practices such as providing services in French, using chosen pronouns and names, and supplying materials or supports that meet specific needs. Third, knowledge and experience, which refer to providers' expertise in caring for 2SLGBTQI+ communities and Frenchspeaking patients. Lastly, identity-based affinities between patients and providers (for example, shared language, culture, or experiences), which help strengthen trust and foster a sense of mutual understanding.

6.2.2.1. Provider behaviours and attitudes

Participants reported discriminatory behaviours in the form of negative attitudes toward their 2SLGBTQI+ identities or related aspects of their identities, such as a desire to become parents. These attitudes were mainly expressed through inappropriate remarks and incorrect assumptions.

- **I mentioned my partner and she said, "Oh well, we only treat [condition] when people want children, so in your case there's no need." [...] And that's when I thought, "Oh no, things were going so well!" That was already a small microaggression.**

Discriminatory behaviours also included denial of care, particularly care specific to 2SLGBTQI+ people. This denial directly caused delays, distress, and interruptions in medication, with tangible and avoidable consequences for participants' health status and access to care.

- **I had to get a new prescription from my family physician. That's when she didn't want to prescribe it. So I had no [prescription], I think for about a month or a month and a half. [...] I can see how it could be dangerous to start something and then just stop cold turkey. It doesn't seem very healthy to do that. But that's what happened.**

By contrast, participants reported that providers were generally positive toward their sexual orientation and toward their 2SLGBTQI+ partners and family members. They did not report any instances in which their loved ones experienced discrimination in health care settings, even in the context of 2SLGBTQI+ relationships, and they felt that disclosing their sexual orientation had no negative impact on the care they received.

- **I was impressed. In general, when I said I had a husband, it was "no problem." I think that's largely because we're in the postCOVID era.**

In some cases, providers' openness—or, more broadly, their humility—helped to compensate for training gaps or rectify errors. These experiences indicate that participants were more tolerant of providers' limitations when they showed a genuine willingness to deliver appropriate, affirming care.

- **I can express myself the way I want. She may not understand everything right away, but I feel she wants to understand and will make the effort and ask more questions, which makes all the difference.**

6.2.2.2. Adapted communication

INCLUSIVE LANGUAGE

Participants most often described communication practices that were not inclusive, including gendered assumptions about them or their partners, the use of incorrect pronouns and inappropriate honorifics, and deadnaming. Providers rarely asked questions proactively, placing the burden on patients to correct these errors.

- **That was the big red flag that really made me uncomfortable: they were using the name assigned to me at birth and she/her pronouns. There was really no space for me to exist as a trans person.**

In contrast, participants also described experiencing inclusive communication, mainly in the context of 2SLGBTQI+ care settings but occasionally outside those settings. The language they used (e.g., "wonderful," "fantastic") suggests that inclusive communication practices have a major impact on the care experience.

- **They're great, fantastic, very inclusive. You know, they've always used my chosen name and my pronouns, and it's never been a problem.**

LANGUAGE OF COMMUNICATION

Most participants interacted with providers who communicated in English, even in designated bilingual organizations. Speaking in English was often perceived as challenging: many participants had to search for words and had more difficulty understanding providers' explanations, even when they had relatively strong English proficiency. However, some preferred speaking in English when discussing issues related to 2SLGBTQI+ identities, due to the lack of adequate French translations for certain terms.

- **When I was speaking, he didn't really understand, and there was no one else there. I was doing the translating, and he still didn't understand until I saw the doctor the next day, so I was there all night […] just sitting there, and I really didn't like that.**

6.2.2.3. Provider knowledge and experience

Participants identified major gaps in providers' knowledge and experience regarding the realities of Frenchspeaking and 2SLGBTQI+ people. In anglophone or bilingual clinics, including within 2SLGBTQI+ organizations, many providers were unaware that Manitoba has Francophone communities or did not recognize the importance of language-concordant care. Outside explicitly 2SLGBTQI+ clinics, providers' understanding of sexual orientations and gender identities remained limited. Participants also highlighted knowledge gaps related to 2SLGBTQI+ sexual health, Indigenous and racialized identities, and 2SLGBTQI+ family structures, which at times required them to educate providers.

- **They had a good understanding of gender minorities and sexual minorities, but when it came to anything else, you know, whether it was Indigenous identity or Francophone identity, there was really a big gap.**

Participants also encountered providers with substantial experience and expertise in 2SLGBTQI+ care, which significantly improved their care experience. They noted that clinical interventions and recommended resources were relevant, informative, and tailored to their situation, sometimes exceeding their expectations. However, all of these positive interactions occurred in English and predominantly in private clinics or programs, or in programs designed for 2SLGBTQI+ people.

- **She knows a lot about the specific challenges that people in the [2SLGBTQI+] community face. And it's extremely helpful to have someone who [...] can share things I didn't know or connect me with resources that can help me.**

6.2.2.4. Identity-based affinities

Participants indicated that identity-based affinities between patients and providers help facilitate access to health care. Providers who were 2SLGBTQI+, Frenchspeaking, or who shared other experiences—such as gender or migration backgrounds—were perceived as more competent. For participants, shared experiences made them feel more understood, supported a more nuanced grasp of their realities, and fostered a greater sense of inclusivity.

- **They have trans doctors and social workers who are non-binary and whatever, so they're giving opportunities to people who are actually part of this community, which I think makes a big difference, because there's this shared baseline. [...] It's like, we get each other, we're all part of this community, which is really cool.**

Conversely, when providers and patients did not share identity characteristics (e.g., age, religion, ethnicity), this was perceived as hindering access to care. Such providers were often viewed as less accustomed to, knowledgeable about, and competent in delivering inclusive care. Participants believed that disclosing their 2SLGBTQI+ identity to these providers would be more likely to trigger negative attitudes or denial of care, though several participants noted they were unsure whether these effects were real or imagined.

- **And I really feel like this is a huge judgment, but [...] I noticed at [clinic], for example, it's a [religious] woman doctor or someone who comes from [country]. What am I trying to say? They arrive with a different background. And progress on LGBTQ issues varies across cultures.**

6.2.3. Organizational factors

Two organizational factors were identified. First, operations and procedures, which refer to clinical processes that influence access, such as appointment booking, wait times, triage, policy implementation, and telehealth, including each organization's language practices. Second, signage and documentation, which include care-delivery tools (forms, records, information systems) and visual cues in physical or digital environments; the extent to which these are adapted to patient realities, and whether they project an inclusive approach, shape the care experience.

6.2.3.1. Operations and procedures

ACTIVE OFFER

Participants reported that administrative processes—appointment booking, forms, and communications—occurred exclusively in English, which was also the default language used by care staff, even when the staff were Frenchspeaking. Participants felt that staff members assumed they were Anglophone based on individual characteristics such as their name or accent, and did not actively offer services in French. This made it difficult for them to identify Frenchspeaking staff, and interactions in French were often a matter of luck. Such practices were common in English-language and designated bilingual clinics, as well as in paramedical services, but were not reported in officially francophone centres, where Frenchlanguage care was viewed as provided by default.

- **I don't have a Francophone name, or it doesn't sound French. So she assumed I spoke English and started off speaking to me in English. Then I asked, "Do you speak French?" And after that it was fine, you know, but it was really like we said at the beginning: the default language, for everyone, for everything, is English.**

Participants also sometimes drew explicit parallels between the active offer of Frenchlanguage care and an active offer of inclusive care, whereby organizations should create opportunities to acknowledge and address 2SLGBTQI+ identities. Practices seen as genuinely inclusive included providing forms with optional questions and open categories that allow for identity disclosure, asking only for information that is strictly necessary, and verbally creating space to share one's identity.

- **For me, it really comes back to the active offer. Like for French, you have to be able to say, "Hey, nice to meet you, I am going to be your doctor. By the way, would you prefer this in French? No judgment." You say, "I have no judgment, whether you're married to a man or a woman or whatever, or someone is not binary. […] What's important is that you can tell," to make a step, to open the door.**

INTERPRETATION SERVICES

Few participants reported using interpretation services, mainly because they had a good command of English. Interpreters were present only during scheduled appointments at bilingual clinics. No interpretation services were available in emergency situations, and participants generally relied on family members or friends to provide interpretation when receiving paramedical care.

- **Well, I don't know exactly how it works, but he came in first, introduced himself, and told me he was the interpreter for the appointment. He told me that everything we said would stay between us. Then he wrote down some notes but tore them up afterwards. So he just did his job.**

COLLECTION OF PERSONAL INFORMATION

Participants were unsure whether organizations collect information about their language or their 2SLGBTQI+ identity. This uncertainty reflects a broader context in which patients cannot access their own medical records: they cannot track their referrals, verify the accuracy of their information, or learn what data are used in clinical settings. This lack of clarity had several effects: default, noninclusive communication in English, difficulty changing providers, and gaps in followup.

- **With my health card, I just handed it over and I have no idea what gender is attached to it, because I have a new card and all the information is online, so I don't know whether I am categorized as a man on it.**

OTHER KEY PROCESSES

Participants identified several barriers related to what they perceived as an outdated health care system. They pointed in particular to unnecessary trips to appointments or to obtain their medical records. Telehealth and automated appointment scheduling were seen as important mechanisms for modernizing and facilitating access to care. In contrast, paramedical services were viewed as more modern, in part because they offer online appointment booking and automated reminder messages.

- **I feel like the health care system in Manitoba in general is not very modern. For appointments and so on, you always have to call during office hours. You have to call, and if you're there in person and booking your next appointment, they hand you a scrap of paper with the date and time written on it.**

Participants viewed walkin services as useful, especially when getting a medical appointment could take several months. Even telephone consultations with primary care providers often involved wait times lasting several weeks. However, the only facility offering walkin services in French does not provide access to a physician—only to nurses—which led participants to turn to English-language clinics.

- **At the St. Boniface Clinic, at one point I wanted an appointment, and the next available one was in three months. Come on! Three months from now is no use to me. I'll go to a walkin clinic and get seen in ten minutes. The funny thing is, the walkin clinics I know in Winnipeg, in St. Boniface, are all English. [...] Honestly, I could see an English speaking doctor there in ten minutes.**

In addition to the time it took to get an appointment, the limited time available for consultations meant that participants were unable to fully express themselves.

- **I felt really judged, like I was, I don't know, an alien or something. And I was rushed; it was like, "I have 15 minutes with you and then I'm on to the next person." I didn't have the space to express myself freely, even if I'd had enough time with her.**

6.2.3.2. Signage and documentation

INCLUSIVE AND BILINGUAL SIGNAGE

Participants described situations where inclusive signage, such as visible 2SLGBTQI+ symbols, helped build trust and created openings to disclose their 2SLGBTQI+ identity. For private organizations (mental health and paramedical providers), the inclusivity of their online content also influenced participants' decisions about where to seek care.

- **There was an LGBT flag at the woman's office; when I saw it, I knew they accepted LGBT people there.**

Conversely, when these symbols were absent, participants saw this as a sign that the setting was not inclusive of 2SLGBTQI+ people, and as a warning that they were not welcome.

- **I didn't see any rainbow flags. I didn't see anything like that; they didn't make an effort to signal anything to people who don't conform to gender norms. No, there was nothing to indicate I was welcome.**

Frenchlanguage signage was mentioned infrequently, but participants generally assumed that its absence meant the provider did not offer health care services in French, especially in anglophone neighbourhoods. Even when French or bilingual signs were present, if they were not backed up by real access to Frenchlanguage services, participants said they eventually stopped noticing them. Adding badges or other markers to clearly identify bilingual or Frenchspeaking staff was seen as a possible solution.

- **It's so rare that someone speaks French, you just end up tuning the sign out. You don't even see it anymore.**

Participants emphasized that inclusive or Frenchlanguage signage must be backed by care that is genuinely accessible, to avoid the opposite effect: creating an illusion of accessibility that causes additional harm.

- **Is putting up a rainbow flag in your waiting room really inclusive? Just putting up a flag doesn't mean you are. And it can even have the opposite effect, because people will go there thinking they're in a safe space and end up experiencing a microaggression.**

TOOLS AND DOCUMENTATION

Participants described filling out a wide range of forms, with varying levels of inclusivity and accessibility. Within 2SLGBTQI+ programs, forms allowed participants to specify their pronouns, indicate their chosen name, and choose from a wide range of gender and sexualorientation options.

- **The forms were fantastic. You know, things like "chosen name, pronouns, how do you identify?" And I also liked that there were no mandatory boxes or categories. It was more like, "How would you describe your sexual identity?" with a line to fill in.**

By contrast, organizations and clinics that were not explicitly geared toward 2SLGBTQI+ people used forms with multiple gaps in inclusivity. Gender options were usually limited to "man" and "woman" (sometimes with an "other" box that participants found awkward), and documents pertaining to parenthood did not always reflect 2SLGBTQI+ family structures.

- **It's really not welcoming. I mean, when I think about all the forms and things that I've had to fill out, they've just never been inclusive. They don't ask anything about sexual identity. For gender identity, it's always just "woman, man."**

In general, anglophone and bilingual organizations, including 2SLGBTQI+ programs, provided English-only forms, with only a few exceptions.

6.2.4. Structural factors

Four structural factors were identified. The first is the availability of care and information. This refers to the overall supply of services and providers (range, volume, wait times, tradeoffs between language and quality), as well as access to relevant public information and resources to help guide patients through care pathways, including these resources' language and suitability to local contexts. The second factor, training, refers to inclusive formal and ongoing training for providers (e.g., medical terminology in French and education on trans health). Policies, the third factor, include public and regulatory frameworks (funding arrangements, language legislation, clinical criteria, coverage rules) that shape access via administrative and financial mechanisms. Lastly, society refers to the social norms and beliefs (in workplaces, communities, and public discourse) that influence care experiences, including those specific to the Franco-Manitoban context.

6.2.4.1. Availability of care and information

AVAILABILITY OF INFORMATION

Participants found Manitoba Health's Family Doctor Finder tool particularly useful. They appreciated being able to search for providers based on language, location, or gender, but some wished the tool also identified inclusive providers and/or providers trained in transaffirming care.

- **When I first went on Family Doctor Finder—woo, Manitoba!—it asked me if I wanted someone bilingual, because it was like, "There's this bilingual person, you can go with her." So yes, she is bilingual, which is good.**

Participants reported that they were able to find useful information online, particularly from the Collectif and from Klinic; however, they noted that most information aimed at patients was available only in English. Klinic was described as the main reference point for transaffirming care, providing resources for patients and health care providers alike. Participants expressed a desire for more Frenchlanguage information on 2SLGBTQI+ health. They also reported having to switch to English with providers when discussing 2SLGBTQI+ identities on occasion, because they lacked the necessary vocabulary in French.

- **Yeah, it would really help to have those [2SLGBTQI+] resources in French as well, even for me, for my own understanding of which terms to use. It would be nice to have bilingual resources.**

Participants reported that organizations' websites sometimes contained unclear or incorrect information. This lack of information restricted their ability to access care and navigate administrative processes, including feedback mechanisms such as complaint procedures or PREMs.

- **Reporting incidents is not exactly a straightforward process. It's really almost impossible to find any information about how to do it.**

AVAILABILITY OF CARE IN FRENCH

Participants described the availability of French-language care as insufficient. In most cases, designated bilingual organizations failed to effectively deliver care in French, and some services were simply not available at bilingual or Englishlanguage clinics. Participants identified certain services as available only in English, including specialized care, preventive mental health services such as helplines, and walkin medical clinics. When such services did exist in French, access was often a matter of chance or involved significantly longer wait times. In the absence of care in French, people had no choice but to use services in English or avoid seeking care altogether.

- **Of the three services they recommended, the only francophone option was no longer adding people to its waiting list.**

AVAILABILITY OF INCLUSIVE AND 2SLGBTQI+ CARE

Participants generally reported adequate access to inclusive care, provided they sought it in English. The Rainbow Resource Centre and Klinic offer free services, including mental health counselling, hormone therapy support, and a sexual health screening clinic. The Rainbow Resource Centre's limited number of counselling sessions and Klinic's wait times were described as key barriers.

- **If someone wants good care or wants to feel included, Klinic would be a good fit for them, and I intend to go back myself.**

Significant gaps remain in transaffirming care, with participants reporting wait times of up to three years for hormone therapy and six years for genderaffirming surgeries. To access hormone therapy, patients are obliged to go through a primary care provider and are unable to go to Klinic for follow-up care. This creates additional barriers and adds to the already long wait times. In addition, the shortage of trained surgeons in Manitoba forces people to travel outside the province to receive appropriate gender-affirming surgeries.

- **I have Anglophone trans friends who went through the Manitoba system, and they did not receive proper care. Some ended up needing revision procedures after their surgeries.**

OTHER ACCESSIBILITY FACTORS

Participants reported relatively few geographic barriers when seeking care. They could usually find geographically accessible services, although this sometimes meant compromising on other aspects, such as language.

- **I tried to find a doctor who was more local because I was told there was a waiting list. So I looked for someone closer to home. I did find one nearby, but they were Anglophone.**

Financial barriers were another concern, with participants noting that free or low-cost services were not always a good fit in terms of language or inclusivity. This issue was particularly prevalent in paramedical and mental health services that are not covered by the provincial health plan.

- **It's not covered, it's expensive, and my current therapist uses a sliding scale. [...] I don't have much money, and she understands that and charges me less. It's not all that easy to find someone who really understands me and is also affordable.**

6.2.4.2. Provider training

Participants noted that access to care is strengthened when providers receive training on 2SLGBTQI+ health care, such as that offered by Klinic. However, because these training sessions are optional, not all providers take part, creating a gap between their actual and potential impact.

- **They've put together a lot of resources to help doctors learn more about health care for transgender people. That's part of what convinced my doctor to help me, so it had a direct impact on my care.**

Despite these professional development opportunities, training in both 2SLGBTQI+ health and French-language health remains limited, a gap that could be addressed through formal education or professional development. Certain providers continue to hold negative stereotypes toward 2SLGBTQI+ people or fail to recognize the importance of French-language care for Francophones, which participants attributed to a lack of training. Training is therefore seen as essential to improving accessibility of care, but it must be backed by a genuine commitment to addressing 2SLGBTQI+ and Frenchspeaking populations.

- **Training for health care workers could even benefit non-Francophone staff members. It could help English-speaking providers develop an understanding of the Francophone community, and help those who don't identify as LGBTQ+ to become allies.**

6.2.4.3. Policies

GENERAL POLICIES

Participants felt that the legal framework in Manitoba and Canada provides adequate protection for 2SLGBTQI+ people. They saw Manitoba's recent introduction of antidiscrimination protections for 2SLGBTQI+ people as an important step forward, and participants with migration backgrounds described Canada as a safe place to live.

- **I learned that here in Canada, the law protects LGBT people, and that's why I chose to come here, to live freely.**

At the same time, existing policies do not recognize all 2SLGBTQI+ family structures, which can create legal vulnerabilities for these families. Despite the legal safeguards in place, participants felt that the law still lags behind the lived realities of 2SLGBTQI+ people and does not protect them in every situation.

- **You know, there's the whole issue that my partner has no legal rights when it comes to my children. I wish there were some protections in place. If I die, the law does not allow my partner to become their father.**

CARE POLICIES

Participants had a favourable view of certain care policies, which they saw as improving accessibility in principle. Recent changes, such as revisions to the blood donation criteria that had previously excluded men who have sex with men, were also perceived as signs of greater inclusivity. Participants also appreciated that providers can prescribe hormone therapy, and that they have the option to change providers after an initial consultation.

- **Primary care providers are able to prescribe testosterone or estrogen, whatever, and followups are super easy.**

At the same time, being formally attached to a primary care provider also creates vulnerability, since it can be difficult to switch providers when problems arise, such as when a provider refuses to offer certain types of care. Access to care also remains challenging for people without a primary care provider, as many types of services, including trans-affirming care, require patients to have one. As a result, although centralizing care around a primary care provider has the potential to improve accessibility, in practice it introduces an additional layer of vulnerability without offering clear benefits in terms of access.

- **If you get a referral and you don't have a primary care doctor, they basically won't give you full access to services until you have someone who can do the followup. That can be a real problem. If you don't have a family doctor, you can end up waiting a very long time, there's a doctor shortage, et cetera.**

Participants also questioned the practical effectiveness of laws and policies relating to inclusive and Frenchlanguage care. They pointed out that while certain organizations are formally designated as inclusive and/or bilingual, in practice they are neither. Participants described this as the "illusion of bilingualism": institutions that are formally designated as bilingual may offer zero French-language health care services.

- **Shared Health is a prime example. They say, "We're an inclusive institution. We celebrate diversity, equity, and inclusion. Here are all our initiatives, blah blah blah," and I'm like, okay, but you're not actually implementing them. You say that you're inclusive—anyone can say they're inclusive or diverse, anyone can have a diversity, equity, and inclusion policy—but like, are you actually putting it in place? Are you doing it? Usually, the answer is no. It would be really great to see those policies actually implemented and enforced. Often, there are these policies, then something happens and suddenly the policy doesn't matter anymore. You know what I mean?**

FINANCIAL POLICIES

Participants reported benefiting from different types of financial coverage that helped them access care, such as the Canadian Dental Care Plan, coverage for refugee claimants, and programs providing free medications to trans people. These policies were seen as key for facilitating access to care.

Conversely, the lack of coverage for paramedical, 2SLGBTQI+, and mental health services limits access and forces participants to compromise on inclusivity, wait times, or language, and, in some cases, to avoid care altogether. Certain administrative fees in primary care (such as for transferring medical records) were criticized, because these costs limit the ability to change primary care providers when problems arise. Participants also reported having to pay out of pocket when publicly funded services did not adequately meet their needs, particularly in terms of inclusivity, quality, or wait times.

- **I ended up going out of province to get care faster. The wait lists in Manitoba are kind of outrageous, especially with the COVIDrelated backlog, and when they told me five or six years, I just couldn't handle it.**

6.2.4.4. Society

Participants reported that Manitoban society is generally perceived as fairly open to diverse sexual orientations. Older participants and those with migration backgrounds (who compared Manitoba with their places of origin) noted a clear improvement in social acceptance.

- **Since coming to Canada, I've noticed many more positive signs, and I'm much less afraid to signal that I'm part of the queer community than I would be in [country].**

Despite these advances, participants emphasized that more work is needed to achieve genuine inclusion, calling for stronger representation of 2SLGBTQI+ role models in media and cultural spaces. They also noted that gender identities are still largely discussed in binary terms, with gender diversity continuing to be perceived as marginal or outside the social norm.

- **It's still there, it's the same thing, it's the "other." Either you're accepted, or you're something else. And this was a stark reminder of that.**

FRANCOPHONIE

Participants associated Francophone contexts with stronger religiosity and a perceived lack of privacy. The fact that these services operate in small communities, "where everyone knows each other", raised doubts about the true confidentiality of Francophone settings, even though participants are aware that service providers are bound by professional confidentiality. The high likelihood of encountering someone they know when seeking care for sensitive issues (e.g., sexual or mental health) was also seen as awkward. Participants also described the Catholic identity of Francophone hospitals and care homes as omnipresent, troubling, and sometimes frightening, prompting some of them to intentionally avoid these overtly religious institutions.

- **I did some research because I knew that the Centre de santé was part of the Réseau Compassion Network and that it was more or less run by the Catholic Church and all that, so I didn't want to go there. I looked for other clinics that were accepting new patients, but ultimately I found it too hard to go clinic by clinic, so I went through the provincial portal thing instead.**

6.3. Cross-cutting factors

The interview analysis also revealed two crosscutting themes unique to the Franco/queer intersection. These themes were identified inductively, meaning they do not appear in existing literature on French-speaking 2SLGBTQI+ people.

6.3.1. Holistic inclusivity

Participants emphasized that inclusivity should benefit all marginalized groups, not just Francoqueer people. They highlighted the need for care that acknowledges the lived experiences of other communities, including people with disabilities and racialized individuals. Participants expressed a desire to consult or choose providers (e.g., via the Family Doctor Finder tool) based on other shared identities, such as ethnicity or disability. They also stressed the importance of removing barriers (e.g., negative attitudes, the cost of care, and language barriers) that affect all marginalized groups. In this sense, accessibility must be conceived more broadly: rather than uplifting a single group, the goal should be to dismantle structural barriers that affect everyone.

- **For me, it's all interconnected: accessibility for LGBTQ people means we have to include people with mobility challenges, people who face racism. Nobody is free until everyone is free. That's really what intersectionality and barriers are about. When we remove barriers for one group, we remove them for everyone.**

6.3.2. Holistic thinking

Participants also expressed a desire to move past traditional health care models. They suggested innovative alternatives to improve access to care, such as expanding the role of pharmacists and enhancing telehealth to provide services closer to home and reduce geographic barriers. Participants also expressed interest in approaches that are less strictly biomedical and more holistic, including a greater recognition of Indigenous medical knowledge. Overall, they called for more comprehensive models of care that engage the full range of health professionals—not only primary care providers—to better address their complex needs.

- **Especially pharmacists, because people often come in looking for advice about medications, like overthecounter products, and they might say, "I'm going to use this as a chest binder," and the pharmacist might say, "That's not safe; you could try this instead, and here's why I recommend it." I think pharmacists are really great. To be truly accessible, you don't have to make an appointment with them. They're there when you have questions, and sometimes it's hard to make an appointment and disclose everything to your doctor. And they might not even know what to suggest. So I think [pharmacies] are actually a really great place where you can actually get help.**

7. Discussion

This study sheds light on the specific conditions shaping Francoqueer people's access to care, revealing experiences formed at the intersection of minoritylanguage dynamics and 2SLGBTQI+ realities. Our findings suggest that the challenges faced by Francoqueer individuals stem not only from a lack of services, but also from a care system that addresses linguistic and identityrelated needs separately, even though these needs are experienced simultaneously. As a result, Francoqueer people are compelled to develop their own navigation strategies—including relying on bilingualism—to cope with an insufficient and fragmented service offering. Given that the study sample overrepresents urban and bilingual individuals, the barriers identified by participants are likely even more pronounced for populations with fewer linguistic resources or living in more isolated areas.

Consistency with existing literature

The findings confirm that the barriers documented among 2SLGBTQI+ populations and Francophone communities elsewhere are also present in Manitoba, although they manifest in ways specific to the Franco/queer intersection. At the individual and interpersonal levels, experiences of discrimination, denial of care, avoidance, and postponement align with previously established findings. Requests for services in French remain infrequent and are perceived as largely ineffective, and communication practices vary markedly across care settings: Designated francophone institutions offer French-language services, and 2SLGBTQI+ programs are inclusive, but the two dimensions almost never coincide. Nonetheless, providers' openness and humility emerge as important facilitators that can partially offset gaps in knowledge or experience.

Preferences vary when it comes to disclosing identities and receiving care in French. Whether a Francoqueer person discloses either element of their identity depends largely on their relationship with the provider: patients are more likely to be forthcoming when providers actively create an open and welcoming environment. This is consistent with the finding that nearly 60% of Francoqueer people do not disclose their identity unless opportunities for disclosure are explicitly created (Prada et al., 2021).

Participants also place greater importance than the literature would suggest on having providers who share their identities and lived experiences, describing this as a key factor in building trust and understanding. This priority remains underrepresented in current policies and research: only a few studies explicitly recommend recruiting a diverse workforce (Gomez & Bernet, 2019; Stanford, 2020), despite participants repeatedly emphasizing the benefits of this approach.

At the organizational level, services remain fragmented: 2SLGBTQI+ organizations seldom offer services in French, while francophone services are not consistently inclusive. Active offer is limited, even in designated bilingual institutions, and bilingual signage or an official bilingual designation does not guarantee access to services in French. Visible inclusion practices (e.g., inclusive signage or communications) remain rare and are found mainly in 2SLGBTQI+ settings. Feedback mechanisms also remain difficult to access, despite patients' interest in using them.

This siloed structure—with Frenchlanguage care on one side and inclusive care on the other—means that very few services combine both dimensions; this steers Francoqueer people toward English-language services. A similar divide is apparent in information resources: for the most part, 2SLGBTQI+ materials are available only in English, and tools aimed at Francophone patients (such as Frenchlanguage services directories) do not identify inclusive providers despite previous recommendations (Prada et al., 2021). Patients have difficulty locating inclusive providers, but they also face barriers to changing providers when problems arise, including fees for transferring medical records and the inability to access their own medical information. These barriers have significant consequences for trans individuals and people with chronic diseases, who are more heavily dependent on their primary care providers for their medical needs.

Lastly, some of the participants' concerns are specific to the Franco-Manitoban context, where religiosity and the dynamics of small, tightly knit communities heighten fears of involuntary disclosure and reinforce mistrust of care settings perceived as potentially unwelcoming. Although similar apprehensions have been noted elsewhere (Brooks et al., 2018; de Moissac, 2016; Hasselt et al., 2025; Westwood, 2022), they had not previously been documented from an intersectional perspective.

Beyond its empirical findings, this study reveals a largely overlooked continuity between research on Frenchspeaking populations and research on 2SLGBTQI+ communities. Although these populations are usually studied separately, several key findings overlap, including the importance of active offer, the value of hiring a diverse workforce, and the crucial role of signage and communication. The results therefore suggest that these analytical frameworks, developed in isolation, describe similar structural dynamics and can be used in a complementary manner to better understand care trajectories among Francoqueer people.

Reconfiguration of access to care from an intersectional perspective

The findings show that Francoqueer people are forced to make more compromises when seeking care than Francophones or 2SLGBTQI+ people. Language is just one criterion among many (quality, wait times, proximity, inclusivity) in a context where the service offering is insufficient and where policies governing inclusivity and Frenchlanguage services are unevenly enforced. The assumption that French speakers will naturally prioritize care in French is therefore less applicable to Francoqueer people, for whom language is but one determinant of access to care.

These compromises are exacerbated in Francophone settings: the small size of the communities and their perceived religiosity fuel concerns about confidentiality and the treatment of 2SLGBTQI+ people. This is why some individuals avoid care in French despite a declared preference for that language, and why nearly 60% of Francoqueer people opt for services in English even when French is available (Prada et al., 2021).

In this sense, bilingualism emerges as an adaptation strategy: when people can more easily articulate 2SLGBTQI+ realities in English, they tend to favour anglophone spaces. The term Francoqueer itself illustrates this tension: derived from an English word associated with a documented sense of discomfort (Elchacar, 2023; Tudisco, 2021), it describes an experience for which no widely recognized French term exists.

The findings reveal a tension between dominant approaches in 2SLGBTQI+ and Frenchlanguage health care—which are grounded in objectivist epistemology and focus mainly on training (Brown & Dueñas, 2020; Yu, Bauermeister, et al., 2023; Yu, Flores, et al., 2023) and on language skills (Forgues & Maillet, 2024; Savard et al., 2020 ; van Kemenade et al., 2024)—and the recognition of the importance of shared cultural and 2SLGBTQI+ identities. The latter perspective aligns more closely with standpoint epistemology, which centres lived experience (Harding, 2013). The participants' accounts therefore suggest that current recommendations should move beyond improving technical and language competencies to explicitly recognize shared lived experience as a key driver of accessibility.

Implications for the delivery of care

The findings suggest that inclusive care delivery should be modelled on the active-offer approach to Frenchlanguage services: organizations need to create a welcoming environment for 2SLGBTQI+ people, rather than leaving it to patients to disclose their identity or request adapted services. This approach is all the more necessary given that requests for care in French or for inclusive care are seldom granted, and patients seldom disclose their identities in the absence of clear invitations to do so. Active offer must also extend to feedback mechanisms, given that formal complaint systems are rarely used (de Moissac et al., 2015), in contrast with PREMs.

The findings also underscore the value of extending an inclusive approach to the broader population, rather than adopting policies that exclusively target Francoqueer people. Measures such as recruiting diverse staff, modernizing services, and improving financial coverage are perceived as benefiting all marginalized groups. This explicitly intersectional perspective aims to reduce common structural barriers, while avoiding often-criticized approaches that rely on increasingly segmented identities or essentialism (Vo, 2021; Wagner & Kitzie, 2023).

Participants also call for more holistic approaches, such as assigning pharmacists greater responsibilities, which better reflect their integrated experience of the health care system. However, health care services are currently siloed, forcing Francoqueer people to choose between care in French and care geared toward 2SLGBTQI+ communities, even though they inhabit both of these identities simultaneously. Rather than asking for new, more narrowly targeted programs, participants are calling, first and foremost, for providers to adopt genuinely positive, inclusive attitudes—a recommendation that aligns with other intersectional studies (Reeves et al., 2024; Singh et al., 2025).

Differences across care categories

Needs vary substantially, depending on the type of care being sought. When it comes to primary care and mental health services, participants want providers who will acknowledge and engage with both their linguistic and 2SLGBTQI+ identities at the same time. This engagement is essential due to the intimate and ongoing nature of these services, as previous research on the health of Frenchspeaking populations has shown (de Moissac, 2016). However, finding the right provider is challenging because of limited availability, long wait times, and the lack of tools to identify inclusive services, although some participants were able to locate a Francophone provider more easily than reported in Prada et al. (2021).

When seeking mental health services, patients tend to prioritize inclusivity over language. That is, they prefer inclusive English-speaking providers to noninclusive Francophone providers, a finding that aligns with the low proportion of mental health care provided in French (Prada et al., 2021). This trend reflects the limited availability of Frenchlanguage services, particularly in preventive care (including helplines) and emergency care, despite the bilingual designation of emergency medical services (Shared Health, 2024).

When it comes to specialized, emergency, or paramedical care, participants are less likely to actively seek out French-language or inclusive services. Speed, availability, and clinical expertise typically take precedence because of the ad hoc and technical nature of these services. The small pool of specialists also limits choice. These findings are consistent with previous research documenting the limited use of French-language hospital and paramedical services (Prada et al., 2021). In these settings, participants seldom disclose their identities, underscoring the importance of an active offer.

Patients face a paradox in accessing trans-affirming care. Although any primary care provider can, in principle, prescribe hormone therapy, many refuse to do so, and patients have difficulty identifying those who offer it.

The absence of mandatory training contributes to the denial of care and lengthens delays, increasing Klinic's wait lists. The result is a double barrier: not only are inclusive providers scarce, but they are also difficult to find. Klinic is currently the main point of entry, but it does not provide longterm followup. It also requires patients to have a primary care provider and operates almost exclusively in English, which further complicates access. Solutions suggested by participants include expanding training, increasing the number of trans or transcompetent providers, and enabling Klinic to offer longerterm followup.

Manitoba lacks a dedicated genderaffirming surgical clinic. Only one clinic performs mastectomies, primarily for medical indications. Its wait times can be up to six years, and its services are available only in English. Participants also reported witnessing noninclusive practices by the clinic's staff, including misgendering and deadnaming.

Lastly, access to reproductive care also remains fraught with barriers. 2SLGBTQI+ people may opt for adoption, home insemination, or formal fertility treatments. However, the latter option is hindered by several barriers, including the need for a referral, a lack of government coverage, and prioritization criteria that can disadvantage 2SLGBTQI+ patients. In response, some people turn to home insemination despite the legal and health risks. Other structural barriers persist, including the nonrecognition of multiparent families and the continued use of mother and father categories on forms.

Some people also have concerns regarding longterm care. They hope to find a care home where they can live in French, but they fear having to choose between an anglophone facility and going back into the closet.

Limitations of the study

The sample was sufficient to identify key themes related to the most common care experiences, but not to achieve full thematic saturation. Its small size can be partly explained by the confidentiality concerns of a small Frenchspeaking community. Francoqueer people also exhibit generally high satisfaction rates when it comes to their care (Prada et al., 2021), which may have dampened interest in participating.

The substantial dropoff between the online survey and the interviews represents another limitation. This is consistent with patterns reported in comparable online studies; for example, Thompson et al. (2024) conducted 16 interviews following 134 survey responses. Recruitment was also restricted by the limited dissemination of recruitment materials by partner organizations: of the 21 organizations contacted, only six shared the materials, citing internal constraints (lost emails, staff turnover), restrictions on circulating Frenchlanguage content, or hesitations related to an ethics certificate issued by a Francophone university.

The sample also exhibits common biases (Reinikainen et al., 2017; Scanlon et al., 2021; Willison et al., 2019), which have been documented previously in Francoqueer research (Prada et al., 2021): participants tended to be highly educated, urban, and bilingual. These biases persisted in this study despite strategies to reach lessrepresented groups, including recruitment via community organizations and snowball sampling (Bonevski et al., 2014). In addition, the sociodemographic questionnaire did not collect certain key variables (e.g., migration status, financial situation), and the use of the term “visible minority” may have led to underreporting by racialized participants whose experiences of racialization are not tied to visible characteristics (Song, 2020). In the absence of populationlevel data on Francoqueer people, the representativeness of the sample cannot be firmly established.

Frenchlanguage episodes of care were relatively rare, reflecting the low utilization reported in previous studies (Prada et al., 2021), the lack of services in French, the absence of designated bilingual 2SLGBTQI+ programs, and the small number of designated francophone facilities (Shared Health, 2024). Although official-language fields were recently introduced in medical records (Government of Manitoba, 2025), 2SLGBTQI+ identity data are still not systematically recorded, limiting any assessment of the sample’s representativeness.

Lastly, certain types of care are minimally or not at all represented, including rural care, telehealth, parenting support, preventive care, home care, palliative care, and longterm care. The conclusions that can be drawn for these domains are therefore limited. This underrepresentation may reflect real-world patterns, such as the urban concentration of Francoqueer people or their avoidance of preventive care services that are not inclusive or not offered in French (Heer et al., 2023). That said, care experiences related to parenting and reproductive care are explored in greater detail in a newly completed doctoral dissertation on Francoqueer parenting (Avanthay Strus, 2026).

Recommendations

The findings reveal that the barriers faced by Francoqueer people do not stem from a lack of individual adaptation, but rather from a failure to align linguistic accessibility with 2SLGBTQI+ inclusivity. Improving access to care will require taking action on both fronts simultaneously, at an organizational level, to reduce the navigational burden currently borne by patients and to better document Francoqueer care experiences.

For health and social service organizations:

1. Implement known facilitators of access to care for Frenchspeaking and 2SLGBTQI+ people:
   a. Frenchlanguage care: include Frenchlanguage skills as a hiring criterion; identify Frenchspeaking providers with visual cues (e.g., badges); ensure that the active offer is consistently and effectively practised; develop training on language needs in a linguistic minority context.
   b. Inclusive care: adopt inclusive language in all verbal and written communications; display visible markers of inclusion (e.g., posters); train providers on 2SLGBTQI+ health care; review and revise policies and procedures that have implicit discriminatory effects; develop recruitment strategies that support the hiring and retention of 2SLGBTQI+ staff;
2. Adopt tailored accessibility strategies for Francoqueer communities:
   c. 2SLGBTQI+ organizations: make resources available in French (e.g., websites, forms); clearly identify services that are accessible in French; embed the active offer of Frenchlanguage care.
   d. Francophone organizations: explicitly integrate 2SLGBTQI+ realities into resource directories, forms, and communications; minimize the display of religious symbols; actively offer inclusive care.
3. Implement accessibility measures that benefit the population as a whole: build a more diverse workforce that represents the communities being served; reduce financial barriers to care; streamline administrative processes by modernizing access to services and information (e.g., telehealth, patient access to health records).

For policymakers:

4. Support the development of Francoqueerspecific services, for example by funding clinical and community initiatives that combine Frenchlanguage and 2SLGBTQI+ expertise, and by strengthening support for existing programs that provide care in French or explicitly inclusive care.
5. Review legal and policy frameworks that hinder access to care, such as those that fail to recognize certain 2SLGBTQI+ family structures and those that require patients to have a primary care provider in order to access 2SLGBTQI+ care.

For researchers:

6. Document the blind spots in Francoqueer care, including home care, palliative care, sexual health, and denial of care, and explore emerging intersectional phenomena such as Francoqueer bilingualism;
7. Routinely apply an intersectional lens in research by systematically including variables that capture linguistic identities and 2SLGBTQI+ identities at the same time;
8. Improve the production of populationlevel data on access to care by incorporating linguistic and 2SLGBTQI+ variables into clinical data systems and by automating the collection of patientreported measures.

8. Conclusion

For Francoqueer people, access to care is shaped by multiple factors. Some arise at the intersection of linguistic and 2SLGBTQI+ identities, while others are tied specifically to either 2SLGBTQI+ or Francophone identity alone. This study shows how ecosystemic determinants unfold in the specific context of Francoqueer people in Manitoba. It also identifies features specific to the Franco/queer intersection and to each category of care, and it outlines intervention and research strategies to deepen our understanding and improve care for 2SLGBTQI+ people, French-speaking people, and Francoqueer people in Manitoba.

The active engagement of participants, the community advisory board, and the scientific committee was essential to the success of this project. Their contributions have enriched current knowledge on access to care for Francoqueer people, offering decisionmakers concrete guidance to reduce barriers and strengthen facilitators.

Statement of academic integrity

An artificial intelligence tool (Microsoft Copilot) was used for editorial support to improve the clarity and readability of the original French text, without contributing to the content, analysis or conclusions. A second tool, Elicit, was used to complement the search for relevant references. Two more tools, Perplexity Pro and DeepL Pro, were used for support in translating this report's original French text into English.

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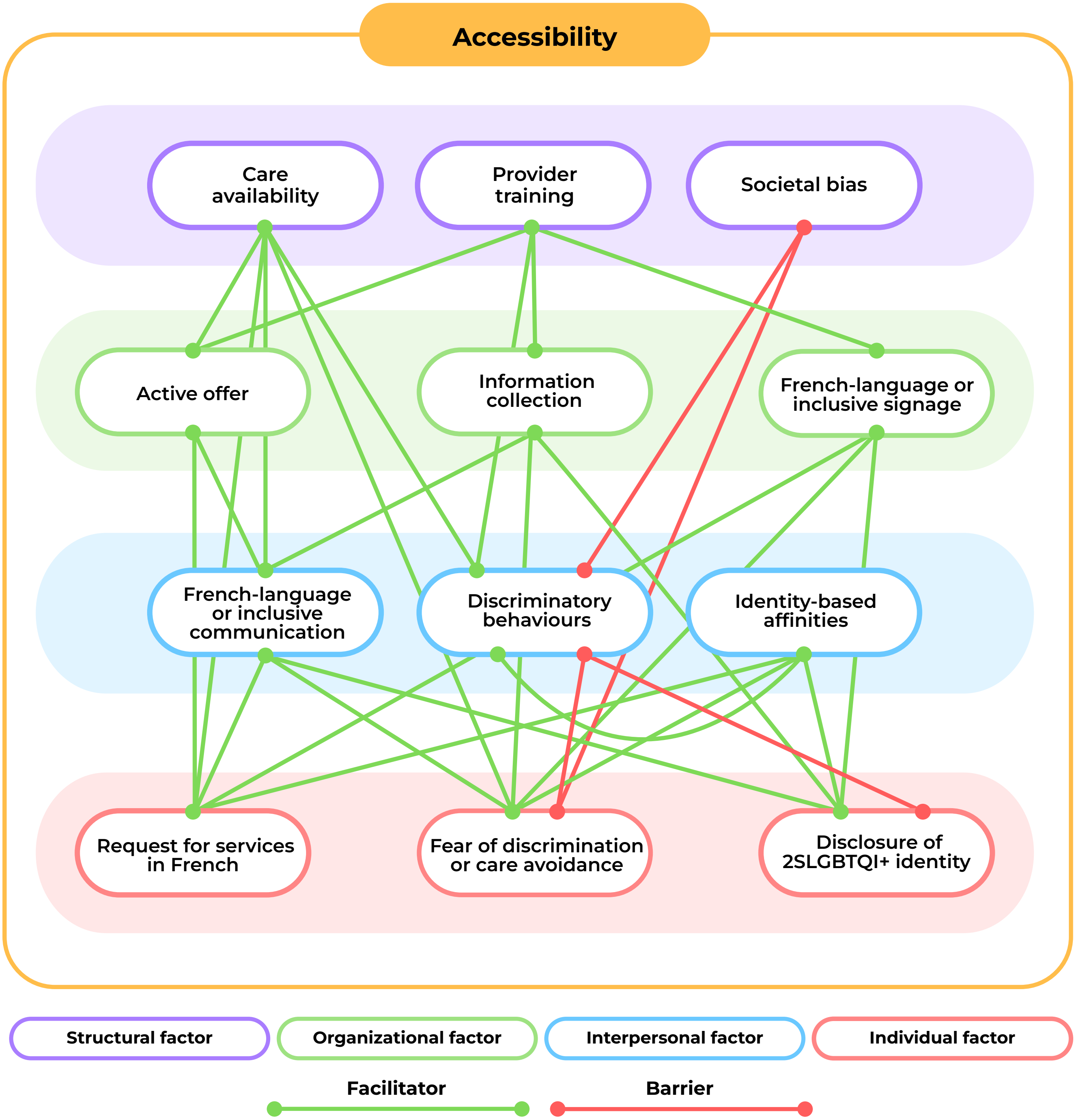
10. Annexes

10.1. Appendix A – PICOS framework

P : Population	I : Intervention/ Phenomenon	C : Comparator	O : Outcome/Effects	S : Settings/Context
Francoqueer people	Factors influencing access (barriers / facilitators)	—	Access to care	Manitoba, post COVID period

10.2. Appendix B – Summary of factors



10.3. Appendix C – Sociodemographic tables

Questions ending with an asterisk allowed multiple selection; the total may therefore exceed the number of people or episodes.

Profile of Participants (n=7)

CATEGORIES	NUMBERS
HOW OLD ARE YOU?	
16 to 24 years	1
25 to 34 years	3
35 to 44 years	2
45 to 55 years	0
55 to 64 years	0
65 years and over	1
DO YOU BELONG TO ONE OR MORE OF THE FOLLOWING MINORITY GROUPS?*	
Visible minority	1
Religious minority	0
Sexual minority	6
Gender minority	4
Person with a disability	2
Linguistic minority	4
Other	0
WHICH OF THE FOLLOWING GENDER IDENTITIES BEST DESCRIBES YOU?*	
Woman	1
Man	1
Non-binary / Agender / Neutral	3
Intersex	0
Cisgender	0
Transgender / Transsexual / Trans	2
Genderfluid / Genderqueer / Bigender	1
Two-Spirit	1
Questioning or evolving	1
Prefer not to answer	0
Other	1

WHICH OF THE FOLLOWING SEXUAL ORIENTATIONS BEST DESCRIBES YOU?*	
Lesbian	3
Gay	1
Bisexual	2
Polysexual	1
Pansexual	0
Asexual	0
Heterosexual	0
Questioning or evolving	1
Prefer not to answer	0
Other	1

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR LINGUISTIC IDENTITY?*	
Francophone	6
Anglophone	1
Francophile	0
Bilingual (French/English)	3
Bilingual (French and another language)	0
Multilingual (French and other languages)	1
Other	0

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?	
Primary school	0
High school or equivalent	0
College or technical trade training (e.g., welding, hairdressing)	0
Bachelor’s degree or equivalent	4
Professional degree (medicine, engineering, law, etc.)	0
Master’s degree	3
Doctorate	0

DO YOU LIVE IN AN URBAN OR RURAL AREA?	
Urban, east of the Red River (same side as Saint Boniface)	4
Urban, west of the Red River (same side as St. James)	2
Rural, southern region (south of the Trans Canada Highway)	0

Rural, Interlake and Eastern region	0
Rural, Western region (Prairie Mountain)	0
Rural, north of Lakes Winnipeg/Manitoba	0
Other	1

Profile of Care Received (n=37)

CATEGORIES	NUMBERS
CATEGORY OF CARE RECEIVED*	
Primary care	12
Emergency and specialized care	13
Paramedical care	8
Mental health care	6
2SLGBTQI+ care	4
FINANCIAL COVERAGE OF CARE	
Full	27
None	6
Partial	2
Undetermined	2
LANGUAGE IN WHICH CARE WAS RECEIVED	
English	24
Hybrid	9
French	3
Undetermined	1
REGION WHERE CARE WAS RECEIVED	
Urban, East of the Red River	17
Urban, West of the Red River	16
Outside Manitoba	2
Telephone	1
Rural Manitoba	1

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