‘Sometimes white doctors are not very friendly or inclusive’: A Critical Race Theory analysis of racism within and beyond sexual health settings

Abdi Hassan, Joshun Dulai, MacKenzie Stewart, Heeho Ryu, Praney Anand, Catherine Worthington, Mark Gilbert, and Daniel Grace

2025

Original citation:

Hassan, A., Dulai, J., Stewart, M., Ryu, H., Anand, P., Worthington, C., … Grace, D. (2025). ‘Sometimes white doctors are not very friendly or inclusive’: a Critical Race Theory analysis of racism within and beyond sexual health settings. *Culture, Health & Sexuality*, *27*(2), 236–252. https://doi.org/10.1080/13691058.2024.2367683

CULTURE, HEALTH & SEXUALITY
2025, VOL. 27, NO. 2, 236–252
https://doi.org/10.1080/13691058.2024.2367683

'Sometimes white doctors are not very friendly or inclusive': a Critical Race Theory analysis of racism within and beyond sexual health settings

Abdi Hassan[a,b*], Joshun Dulai[a*], MacKenzie Stewart[a], Heeho Ryu[a], Praney Anand[a,c], Catherine Worthington[d], Mark Gilbert[e,f] and Daniel Grace[a]

[a]Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada; [b]Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, ON, Canada; [c]Alliance for South Asian AIDS Prevention, Toronto, ON, Canada; [d]School of Public Health and Social Policy, University of Victoria, Victoria, BC, Canada; [e]British Columbia Centre for Disease Control, Vancouver, BC, Canada; [f]School of Population and Public Health, University of British Columbia, Vancouver, BC, Canada

ABSTRACT

Many Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour in Canada encounter racism when testing for sexually transmitted and blood-borne infections. Our objective in this study was to understand how racism shapes testing experiences for these communities in Ontario, Canada. Four peer researchers conducted recruitment and data collection in consultation with a community advisory board. Focus groups and interviews took place with 21 participants and their narrative accounts were analysed using reflexive thematic analysis. Participants identified three interrelated issues when testing: (1) experiencing judgement and discomfort due to racism; (2) lack of community and cultural indicators in testing spaces; and (3) barriers to accessing testing centres and services. Systemic racism was linked to each of these barriers, including increased distance to testing centres due to racial segregation. Participant accounts signal the need for antiracist testing spaces and practices. Key implications include the need for antiracism training for health service providers and others working with Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour, and the organisations that serve them, in order to make testing spaces safer. Dismantling systemic racism is imperative to achieve health equity for members of these communities.

ARTICLE HISTORY
Received 31 October 2023
Accepted 10 June 2024

KEYWORDS
Black, indigenous, and other people of colour (BIPOC); critical race theory (CRT); Ontario, Canada; STI testing; Two-Spirit, gay, bisexual, transgender, and queer (2SGBTQ+)

Introduction

Colonialism in Canada is responsible for the systemic racism that Black, Indigenous, and other people of colour (BIPOC) experience today. The Indigenous peoples of

---

CONTACT Daniel Grace daniel.grace@utoronto.ca

*These authors contributed equally to this work and share Co-first authors.

Canada – the First Nations, the Métis, and the Inuit – were removed from their lands and were made to live on reservations, with many being murdered, killed by disease, or forced to adopt European culture and customs, to ensure that white Europeans were the dominant group (Matheson et al. 2022). Scientific notions of white dominance and superiority were used to support the Trans-Atlantic Slave Trade, whereby individuals from Sub-Saharan Africa were brought to the Americas and Caribbean as slaves, and required to work for white Europeans (Jackson, Weidman and Rubin 2005; Kihika 2013). Many Black individuals living in Canada are descendants from slaves brought to the country or other parts of the Americas and Caribbean, with some also migrating directly from Africa or other parts of the world after the end of slavery (Kihika 2013). Other people of colour who have migrated to Canada have been similarly met with racism and hostility. Notable racist events include, but are not limited to, the head tax imposed on Chinese migrants, the internment of Japanese Canadians during World War II, and the Komagata Maru incident, when Punjabi Indian migrants were refused entry into Canada (Williams et al. 2022).

Systemic racism is defined as policies, practices, norms, and structures that reinforce white supremacy over Black, Indigenous, and other people of colour, resulting in unequal life opportunities and unfair treatment based on race (Neighbors et al. 2023; Rivara and Fihn 2020). It is embedded within institutions, cultures, laws, individual traits (e.g. memory, beliefs, values), and everyday interactions (e.g. habits) (Banaji, Fiske, and Massey 2021). Systemic racism operates on multiple levels, occurs outside of individual awareness, and exists despite absences of ill will or intention to do harm by perpetrators (Banaji, Fiske, and Massey 2021). Black, Indigenous, and other people of colour have increasingly reported experiencing racism in Canada (Grey et al. 2023; Statistics Canada 2024), which has been linked to health inequities such as diabetes, anxiety, and sexually transmitted and blood-borne infections, when compared to the predominantly white population (Public Health Agency of Canada 2018; Veenstra 2009; Williams et al. 2022).

For instance, among new HIV cases in 2020, where information on the race/ethnicity of the individual was available, Indigenous individuals comprised 11% of cases and Black individuals 6% of cases despite each group only comprising 6% and 4% of the national population respectively (Public Health Agency of Canada 2022a; Statistics Canada 2022b). In Canada's most populous province, Ontario, Indigenous and Black people comprised 6% and 25% of HIV cases in 2021 despite only comprising 3% and 6% of the provincial population respectively (Ontario HIV Epidemiology and Surveillance Initiative 2023; Statistics Canada 2022a, 2022b). The increased prevalence of HIV in these two populations is due to experiences of stigma, judgement, and discrimination, which in turn deter Black and Indigenous individuals from seeking HIV testing (Husbands et al. 2022; Negin et al. 2015). Increased access to STBBI testing may help to reduce this burden through the increased identification and treatment of positive cases (Public Health Agency of Canada 2021).

Black, Indigenous, and other people of colour who are also Two-Spirit, gay, bisexual, transgender, and/or queer, experience interlocking forms of discrimination, which leads them to be disproportionately affected by STBBI (Nelson et al. 2019; Saewyc et al. 2014). The term Two-Spirit refers to the Indigenous individuals of Turtle Island (colonially known as the Americas) whose gender and/or sexual identity exists outside of colonial understandings (Pruden and Salway 2020). While Two-Spirit can be used to refer to sexual orientation and/or gender identity by some individuals, it challenges Western notions of both and allows Indigenous individuals to reconnect with their traditions and cultures (Pruden and Salway 2020). However, when trying to access health services, Two-Spirit, gay, bisexual, transgender, and other queer individuals broadly report experiencing discrimination such as stigma, abuse and denial of services (Ayhan et al. 2020), particularly when getting tested for sexually transmitted and blood-borne infections such as HIV (Iott et al. 2022). These infections are also overrepresented in Two-Spirit, gay, bisexual, transgender, and other queer communities due to the marginalisation they experience for their sexual and/or gender identities (Public Health Agency of Canada 2018). Thus, we were interested in understanding the role systemic racism plays in shaping how Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour experience testing spaces in Ontario.

Materials and methods

We approached the study using Critical Race Theory. Critical Race Theory is a framework borne from legal studies which has since been adapted and applied in a variety of other disciplines, including public health (Delgado and Stefancic 2017; Ford and Airhihenbuwa 2018). Key tenets include the understanding that racism is pervasive in society, embedded within societal institutions, and privileges white individuals. The framework understands race as a social construct and underscores the importance of context as race and racism operate differently across time and place. Intersectionality, which is defined as when racism intersects with other systems of oppression to produce social and health inequities for those who occupy multiple marginalised social locations, is a core tenant of critical race theorising. Additionally, the voices of Black, Indigenous, and other people of colour should be centred when using this framework given their unique lived experiences of racism (Delgado and Stefancic 2017).

Previous studies have used Critical Race Theory to study sexually transmitted and blood-borne infections in Black, Indigenous, and other people of colour. One study examining engagement with HIV care services for Black and Latino individuals living in the USA found that participants felt dehumanised in health care settings and were excluded from making decisions about their care (Freeman et al. 2017). Another US study investigating the sexual health experiences of Black and Latina women similarly found that they encountered barriers when engaging with sexual health services and that service providers failed to consider intersectionality by ignoring their other identities when interacting with them (Small et al. 2023). Critical Race Theory has also been used to examine experiences of racism felt by Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour in Canada during the COVID-19 pandemic (Grey et al. 2023), with studies showing that Black and Indigenous individuals reported experiencing racism from health care providers, which was associated with decreased testing (Husbands et al. 2022; Negin et al. 2015).

We conducted this study with Two-Spirit, gay, bisexual, transgender, and other queer individuals to gauge their previous experiences with sexually transmitted and blood-borne infection testing. We designed the study using principles from community-based participatory research, which emphasises the active involvement of community members as the co-creators of knowledge (Fleming et al. 2023). We established a community advisory board, consisting of self-identified gay, bisexual, and other queer men who have sex with men residing and working in Ontario who were actively involved in the study and were diverse in terms of occupation and ethnoracial background. Board members were recruited from AIDS service and community-based organisations serving sexual and gender minority populations in Ontario and convened quarterly to provide feedback on study design and findings.

The research team was inclusive of diverse races, genders, and sexualities. Four peer researchers who identified as Two-Spirit, gay, bisexual, transgender, and/or queer conducted interviews and analysed the data. The lead author (AH), who identifies as Black and Indigenous, was hired to facilitate cultural connection and competency with Black and Indigenous participants. This intentional inclusion ensured active involvement of queer Black, Indigenous, and other people of colour in the study, including during design, recruitment, data collection and analysis, and knowledge mobilisation. The study was approved by the Research Ethics Board at the University of Toronto (37576).

Recruitment

We used purposive sampling to recruit participants (Ritchie, Lewis, and Elam 2003). Eligibility criteria included being 18+ years of age; self-identifying as a gay, bisexual, and/or queer man who has sex with men; and testing for STBBI within the preceding 12 months. We did not specify if the testing had to have been in-person. Individuals who identified as Two-Spirit and/or non-binary were not excluded from participating, however individuals who exclusively identified as cisgender or transgender women were. The recruitment strategy for the community advisory board was also used for participant recruitment. Participant recruitment occurred in two phases with the first of these occurring between June–September 2020 and the second between September–December 2021. The second phase was conducted based on feedback from the community advisory board that Black and Indigenous participants were underrepresented in the first phase. For the second phase, Indigenous and Black community advisory board members helped to recruit Indigenous and Black participants through their personal networks and community organisations serving the Indigenous and Black communities. Recruitment posters circulated during this phase specifically mentioned that we were recruiting Indigenous and Black Two-Spirit, gay, bisexual, transgender, and/or queer participants.

Data collection

Due to public health measures imposed by the Ontario government at the onset of the COVID-19 pandemic, data collection procedures were adjusted to comply with necessary social distancing measures. Peer researchers conducted semi-structured and researcher-directed focus groups and interviews with eligible participants through Microsoft Teams and Zoom. Participants received a $30 CAD honorarium for their contribution. The primary interview method for this study was focus groups. Participants who were not available to join focus groups were given the option to participate in individual interviews. Participants provided informed consent and completed an online sociodemographic survey. We obtained participant accounts about their experiences with in-person testing. We asked them about barriers to accessing testing spaces and their envisioned optimal testing environments. One probe was added to the focus group guide during the second phase to ask Black and Indigenous participants how their testing experiences had been as a Black and/or Indigenous individual.

Data analysis

Interviews and focus groups were transcribed verbatim and pseudonyms were assigned to participants to maintain anonymity. Data coding and analysis adopted a reflexive thematic analysis approach, which emphasises the active role of researchers in deriving meaning from the data and employing a theoretical lens (Braun and Clarke 2019).

Both lead authors (AH and JD) self-identify as queer, Black, Indigenous, and/or a person of colour. Author AH sorted the data into themes and both lead authors consulted with co-authors and community advisory board members on study findings. Most co-authors and board members identify as gay, bisexual, and/or queer men, with some also identifying as Black, Indigenous, and/or a person of colour.

Co-authors and community advisory board members reflexively engaged with their diverse identities and professional backgrounds when reviewing the study's findings and themes. The lead authors' lived experiences of racism and other forms of oppression informed their decision to use Critical Race Theory to frame the study. Biases that may have impacted analysis were remedied through consultation with co-authors and board members.

Results

Participant characteristics

The study included 10 focus groups (two to six participants in each group) and eight interviews, for a total of 38 Two-Spirit, gay, bisexual, transgender, and/or queer participants, of which 30 were from the first phase and 8 from the second phase. The present analysis focuses on 21 individuals who identified as Black, Indigenous, and/or a person of a colour (see Table 1). Over one quarter of the participants were Black and a fifth were Indigenous. Most participants were men, cisgender, gay, and 25–29 years old. The majority had received some post-secondary education and had tested for sexually transmitted and blood-borne infections within the past six months.

Overview of themes

Participants recounted experiences of racism when being tested in-person and described barriers that prevented them from getting tested. They also stated that testing spaces could be improved by acknowledging and celebrating participants' racial, ethnic, and/or cultural backgrounds. Participant responses have been organised into the following three themes: feelings of discomfort and judgement; lack of community and cultural indicators; and barriers accessing testing centres and services. This third theme was further divided into the following three sub-themes: denial of status, geographic dislocation, and lack of privacy and confidentiality.

Table 1. Participant characteristics ($n = 21$).

	n (%)
Age	
18–24	5/21 (24%)
25–29	12/21 (57%)
30–39	2/21 (10%)
40+	2/21 (10%)
Race/ethnicity	
Black-African	4/21 (19%)
Black-Caribbean	1/21 (5%)
Black-Caribbean and white	1/21 (5%)
First Nations/Indigenous	4/21 (19%)
East Asian	2/21 (10%)
Indo-Caribbean	1/21 (5%)
Latin American	3/21 (14%)
Middle Eastern	2/21 (10%)
South Asian	1/21 (5%)
Southeast Asian	2/21 (10%)
Sexual orientation	
Gay	10/21 (48%)
Gay and demisexual	1/21 (5%)
Gay and Two-Spirit	1/21 (5%)
Bisexual	2/21 (10%)
Pansexual	3/21 (14%)
Queer	2/21 (10%)
Questioning	1/21 (5%)
Straight	1/21 (5%)
Gender	
Man	15/21 (71%)
Non-binary	2/21 (10%)
Two-Spirit	2/21 (10%)
Prefer not to answer	2/21 (10%)
Cisgender/transgender	
Cisgender	12/21 (57%)
Transgender	4/21 (19%)
Two-Spirit	1/21 (5%)
Don't know	1/21 (5%)
Prefer not to answer	2/21 (10%)
Unknown	1/21 (5%)
Highest level of education	
Did not finish high school	2/21 (10%)
High school	3/21 (14%)
Post-secondary certificate or diploma	7/21 (33%)
Bachelor's degree or higher	9/21 (43%)
Most recent HIV test	
≤ 3 months ago	9/21 (43%)
4–6 months ago	7/21 (33%)
7–12 months ago	3/21 (14%)
Over a year ago	2/21 (10%)
Most recent STI test	
≤ 3 months ago	12/21 (57%)
4–6 months ago	5/21 (24%)
7–12 months ago	3/21 (14%)
Over a year ago	1/21 (5%)
Geographic location	
Greater Toronto and Hamilton Area	17/21 (81%)
Ottawa	3/21 (14%)
Rural Ontario	1/21 (5%)

Feelings of discomfort and judgement

Participants shared experiences of judgement and discomfort in sexual health testing centres. Jack (29, Black-African, queer, cisgender man) revealed a preference for self-swabbing, stating:

> When they ask me if they want to swab or check, I generally prefer to do it myself. I find that because it's so white sometimes I feel like there's a gaze. I think people look at like big black men with certain eyes and I just prefer to like have my own space and intimacy to do what I want.

Corey (26, Black-African, gay, cisgender man) emphasised the additional challenges faced by members of racialised groups:

> As a queer man, already you have to deal with family doctors and clinicians who might be judgemental about your sexual health. And like also um, uh, not care as much about your sexual health or think, you know, this is something you got yourself into, um, or gaslight you throughout the entire process… especially for, uh well, just men who have sex with men in general but especially like BIPOC men.

Bennett (27, Black-African, gay, cisgender man) highlighted how sexual health practitioners can be hostile towards Black individuals: 'Speaking from my own experience, sometimes white doctors are not very friendly or inclusive. So, I think bypass that experience altogether. And, um, have that conversation with other Black, gay men, especially newcomers not really feeling comfortable'. Here, Bennett conveyed the advantage of a workaround that would 'bypass' experiences of racism through alternate forms of testing whereby Black, Indigenous, and other people of colour could self-test in the privacy of their own homes and help to avoid negative interactions with white health care providers.

However, in response to a participant saying that Black, Indigenous, and other people of colour would experience more issues with testing, Boris (49, Indian-Caribbean, questioning, man) stated: 'I'm a person of colour and I have no negative experiences getting tested'. Here Boris meant that he had no negative experiences getting tested due to his race or ethnicity, as earlier in the focus group Boris did recount negative testing experiences due to judgement from health care providers based on his sexual practices: 'Um, when you do see the nurses, they are like – I find that's where you get the most of the judge – judgements, like 'Oh, you did that' or whatever'. Boris' unique experience demonstrates that Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour still encounter difficulty and judgement when accessing testing services, however not all are due to race/ethnicity.

Most of these experiences illustrate the underlying issue: the judgement and discomfort experienced by Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour within sexual health testing centres extends beyond their sexual orientation and gender identity, encompassing the complexities of their intersecting identities.

Lack of community and cultural indicators

Participants from diverse ethnoracial backgrounds stressed the crucial role that community plays in fostering feelings of inclusivity and comfort. However, it became evident that many sexual health centres lacked the necessary indicators to create a sense of community for many Black, Indigenous, and other people of colour, resulting in their exclusion and discomfort within these spaces.

When asked what makes a testing space comfortable, Sean (24, Black-Caribbean and white, bisexual, non-binary person) stated: 'As a Black disabled trans person… I don't go to any place unless I know that a Black disabled trans person has been there and felt safe there'. Similarly, Dylan (34, Indigenous, gay, Two-Spirit male) shared:

> I primarily have been tested at Indigenous ASOs [AIDS Service Organisations], um, and other than that I've went to a clinic a couple of times. I just feel like more comfortable at an Indigenous organisation as opposed to, um, an organisation where I'm sitting in a waiting room with a bunch of other queer men…

When asked to explain what makes these spaces more comfortable, Dylan explained that Indigenous organisations provide smudge,[1] medicines, community bonding, and a sense of familiarity for him. He also mentioned seeing Indigenous and Black art in testing spaces have provided him with comfort. Finn (40, Southeast Asian, queer, transgender man) similarly stated that 'diverse representation…in terms of imagery is really important'. These experiences highlight the importance of community and cultural indicators in sexual health centres for Black, Indigenous, and other people of colour.

Barriers accessing testing centres and services

Despite the critical role of sexual health centres in promoting sexual well-being and preventing sexually transmitted and blood-borne infections, Two-Spirit, gay, bisexual, transgender, and other queer Black, Indigenous, people of colour face additional barriers that restrict their ability to utilise these services effectively. Henry (31, Latin American, gay, cisgender man) noted that 'sexual and gender minorities or racial minorities… face, already barriers to access to testing.' This theme encompassed three sub-themes regarding access to sexual health testing centres: denial of status, geographic dislocation, and lack of privacy and confidentiality.

Denial of status. Some participants explained that sexual health centres often required them to be registered under the Ontario Health Insurance Plan (OHIP), the publicly funded health plan that Ontarians are enrolled in to receive health services (Ontario Ministry of Health 2023). This posed a problem for Indigenous users accessing these spaces with their Indigenous status cards, which provide benefits, programmes, and services for these communities (Ontario Ministry of Indian Affairs 2021) and Black and other migrants of colour who may not be registered under the insurance plan yet, since many service providers require a card or number to access health services. These users are denied access to these testing spaces and their services, leaving them unable to receive necessary healthcare. Jaden (28, First Nations, pansexual, transgender Two-Spirit person) shared:

> You need like either your OHIP card number or um whichever else. I know a lot of online forums specifically don't have a spot for like status card and things like that, um I know that's been a barrier for me in the past.

Jaden also stated:

> I think if we're talking about inclusivity and like especially through like a race lens, oftentimes people who don't have status are racialised. So I think if we're looking at a lens that's inclusive, then there should be an option for folks who don't necessarily have like a health card ID.

Jaden illustrated that because Indigenous Ontarians use their status cards to obtain health services, this poses an obstacle for them when trying to get tested for STBBI as they are unable to provide an OHIP number to access health services. Jaden also advocated for services being offered to those without a health card.

Corey (26, Black-African, gay, cisgender man) expressed a similar sentiment when trying to get tested: 'I don't have to disclose my status but I'm still going to because international students don't have OHIP. Um, so that complicates things any time I'm doing anything healthcare related'. The failure to provide testing services to Indigenous individuals with status cards, and to other individuals of colour who may not have OHIP yet, further shows how deeply racism is embedded within the Canadian and Ontario healthcare systems.

Geographic dislocation. Participants also mentioned that accessing testing services could be inaccessible due to distance and cost. Dylan (34, Indigenous, gay, Two-Spirit male) stated that: 'Especially like northern reserves. Um, if someone wanted an HIV test, chances are there's probably no one in the community who could do an HIV test'. Jack (29, Black-African, queer, cisgender man) added to this by saying that: 'A lot of Black and Indigenous people don't live in the centre of big cities. It's expensive. It makes it difficult to access testing services without spending money or a lot of time getting there'.

Glenn (25, Latin American, gay, cisgender man) mentioned that 'folks who are living in rural communities and their access to a sexual health clinic, for example, might not be existent, right? Or it might be three hours away', which further demonstrates that distance is a barrier when getting tested.

Lack of privacy and confidentiality. For individuals living in smaller, isolated communities, such as Indigenous reserves with limited testing options, the potential lack of confidentiality was noted as a barrier. Dylan (34, Indigenous, gay, Two-Spirit male) explained:

> I go into get some sort of testing done and my results come back positive, now this community health nurse knows my status of everything. And maybe she is my best friend's auntie, right. So, I think like – and it's just like a small community and now somebody very close to you, who just so happens to be a healthcare worker, knows my status. You know, knows all of my results.

Discussion

Our aim in this study was to understand the role systemic racism plays in shaping how Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour experience testing spaces in Ontario, Canada using Critical Race Theory. The themes of feelings of discomfort and judgement, lack of community and cultural indicators, and barriers accessing testing centres and services are related, as they are manifestations of the systemic racism that affects and is present within testing centres. Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour experience are judged and made uncomfortable by white service providers based on the colour of their skin and cultural identifiers, and may feel unsafe and unsupported by the lack of cultural representations within testing spaces. The barriers they face when trying to access testing services can be traced back to colonialism, racial segregation, the denial of socioeconomic opportunities to Black, Indigenous, and other people of colour, and the bureaucracy that serves white Canadians (Williams et al. 2022).

Participants' narratives also reflect Critical Race Theory's tenet of intersectionality; the identities of Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour are multifaceted, often subject to hypervisibility, and encompass a range of intersecting oppressions. Being racialised and a sexual or gender minority can lead to further judgement from healthcare providers than if one were to inhabit a single marginalised social location. Because of this, the layers of judgement Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour face in these spaces distinctly differ from the general discomfort that individuals, including other gay or bisexual men, may encounter in the same testing spaces. These experiences of judgement and discomfort within sexual health spaces have been reported in other studies as well (Freeman et al. 2017; Small et al. 2023). However, one person of colour who was neither Black nor Indigenous reported that they did not have negative experiences when getting tested due to their race or ethnicity, illustrating that some people of colour have different experiences when getting tested compared to Black and Indigenous individuals. Importantly, the term 'BIPOC' was created to demonstrate that the racism Black and Indigenous individuals face, differs from the racism that other people of colour face due to colonisation and slavery (Garcia 2020), which may be reflected in these accounts.

The importance of community was explicitly mentioned in the accounts of participants. Community serves as a key factor in fostering feelings of inclusivity and comfortability, as indicated by participants. The presence of community indicators, such as representations of diverse identities and experiences, create a sense of belonging and safety for marginalised communities. However, sexual health testing centres often fail to provide the necessary representation and indicators that acknowledge the unique needs and experiences of Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour. The absence of community and cultural indicators leaves them feeling excluded, unwelcome, and uncomfortable within these spaces. The lack of visible representation and cultural sensitivity exacerbates the challenges faced by these individuals, limiting their sense of belonging and safety within sexual health testing centres. As minority groups within both general sexual health testing centres, and queer and transgender specific testing centres, Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour rely on community as a vital signifier of safety.

The barriers that Black, Indigenous, and other people of colour face when accessing testing centres and services can be traced back to systemic racism through historical racial segregation policies such as forcing Indigenous communities to live on reserves and discriminating against people of colour in securing housing, which leads to many living far away from available health services (Matheson et al. 2022; Williams et al. 2022). Additionally, by denying access to health services to those with Indigenous status cards or those without provincial health cards, service providers and the healthcare system at large privilege white Canadians, given that most migrants to Canada are Black or other people of colour (Statistics Canada 2022b). Furthermore, participants pointed out that those without OHIP experience barriers not only when testing for sexually transmitted and blood-borne infections but when accessing health services more generally. This is supported by evidence from a scoping review in which researchers found that personal identification documents acted as either a barrier or facilitator when accessing health or social services in North America (Sanders et al. 2020).

For Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour living in rural and remote communities, the lack of privacy and confidentiality they experience may also be connected to racial segregation policies, as Indigenous individuals may not have the option to travel long distances to be tested by a stranger instead of a friend or family member. Privacy and confidentiality as concerns when being tested for sexually transmitted and blood-borne infections have been similarly shared by other groups living in rural and remote communities who experience higher rates of sexually transmitted and blood-borne infections, such as youth (Canadian Institutes of Health Research 2022; Heslop, Burns, and Lobo 2019).

Throughout the study, we noted some differences in how Black, Indigenous, and other people of colour responded to the study questions. Most notably, it was Black individuals who overwhelmingly reported experiencing feelings of discomfort and judgement due to negative interactions with providers when getting tested. While one Indigenous participant reported feeling more comfortable testing at Indigenous organisations, they stated this was because these organisations were able to provide cultural support through traditional medicines and displaying Indigenous artwork, rather than due to negative interactions with white providers. Despite no Indigenous participants explicitly mentioning negative interactions with white providers, there is an extensive literature on Indigenous individuals reporting racist interactions with health care workers (Negin et al. 2015). Indigenous participants particularly stated confidentiality as an issue in rural and remote communities, with status cards also being an obstacle to them accessing care. One Black participant also noted that not being registered with OHIP as an international student prevented them from accessing some services, however this barrier would be felt by other migrants too, particularly migrants of colour as they comprise the majority of migrants in Canada (Statistics Canada 2022b). Additionally, when reviewing participant accounts for differences between different sexual orientation groups we were unable to find any, however participants who identified as transgender, non-binary, and/or Two-Spirit did report unique experiences when getting tested for STBBI and these findings have been published elsewhere (Stewart et al. 2022).

Strengths, limitations and future directions

A key strength of this study is that we were able to recruit participants of diverse sexual, gender, and racial identities, which in turn provided varied accounts of getting tested for sexually transmitted and blood-borne infections in Ontario. However, the perspectives of cisgender and transgender women were not included and should be examined in future research. Also, despite participants in the overall project being diverse in terms of age, 80% of Black, Indigenous, and other participants of colour were under 30 years of age, which is another limitation, and should be addressed in future studies as well. In addition, some Black, Indigenous, and other people of colour are not open about their sexual orientation and/or gender identity to avoid stigma and may not have participated as a result. Future studies should aim to capture their experiences.

Additionally, during the second phase of data collection, Black and Indigenous participants were specifically probed about their race/ethnicity when asked about their testing experiences. Thus, individuals who participated in the first phase, including all those who were neither Black nor Indigenous, may have experienced a degree of racism when getting tested and may not have shared these experiences as they were not probed to do so. However, it is important to recognise that some participants in the first phase did report experiences of racism despite not being probed to do so.

Another strength of this study was the use of virtual interviews and focus groups, which allowed us to reach participants living outside the Greater Toronto and Hamilton Area. However, our sample still comprised mostly of participants living in urban areas, so the perspectives of Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour currently living outside of these areas may be missing from our study. Despite the overwhelmingly urban sample, some participants currently living in urban centres had lived in rural or remote areas previously, so their insights were still captured in the accounts presented.

A limitation related to conducting virtual interviews and focus groups is that this will have limited participation to those who felt comfortable enough in using Zoom and Microsoft Teams to participate. Those with either limited or no access to the Internet or a device for participating would have been excluded from this study. Conducting this study virtually may have also limited participation from those who did not have access to a space where they could participate privately. Furthermore, participants who speak languages other than English would not have been able to participate and we did not collect information during the sociodemographic survey about country of origin and preferred language. Future studies should aim to collect this information to examine the experiences of those who speak languages other than English.

Our use of differing data collection methods (focus groups and interviews) is a strength of this study. By giving individuals the option to participate in interviews if their schedule did not permit them to participate in a focus group, this may have helped us to recruit more individuals than if we only used focus groups. The Critical Race Theory framing for this study is an additional strength, as to our knowledge, only a few studies have explicitly reported using this approach to examine the experiences of Black, Indigenous, and other people of colour in sexual health settings. Our community-based participatory research design is a final strength, as Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour were involved in all areas of the research process as both research team and community advisory board members.

Recommendations

Providing alternative ways of getting tested may alleviate some of the concerns expressed by Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour when getting tested for sexually transmitted and blood-borne infections, and online testing is one possible mechanism that they could use. One study has found that Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour in Ontario, especially those who were also immigrants, reported being more likely to use an online STBBI testing service when compared to white Ontarians (Dulai et al. 2023). Individuals from these communities have also indicated that online STBBI testing methods would help to reduce the discrimination they experience (Dulai et al. 2024). However, racism within testing spaces needs to be addressed to truly meet the needs of Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour.

We argue that sexual health centres should develop not just racially inclusive spaces, but actively antiracist testing spaces in which to make members from these communities feel welcomed, safe, and included by providing anti-racism and cultural competency training to service providers, and developing and enforcing zero-tolerance policies for providers who stigmatise service users. Testing centres should also work with Black, Indigenous, and other community members of colour, and organisations serving these communities, to help create and foster these spaces without appropriating or tokenising their cultures or experiences. Additionally, health care providers and organisations should provide testing for those without OHIP and recognise Indigenous status cards as valid forms of documentation for receiving services. Furthermore, the Ontario government should provide those living in rural and remote communities with more ways to be tested such as through self-testing kits, which would increase confidentiality and privacy for service users. Educational institutions in the province should continue to enrol and train Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, students of colour in health care, with hospitals and clinics hiring more providers from these communities as well, so that community members can receive services from individuals with similar identities as them. Doing so may increase comfort of using in-person testing services. Lastly, while organisations serving Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour are increasingly more common in Ontario, there needs to be more funding allocated to pre-existing organisations serving Black, Indigenous, and other people of colour where they already feel safe and included.

Conclusion

Participants expressed a strong desire to see their communities reflected in sexual health settings. They emphasised the need for visual representations, testimonials, and the presence of individuals with shared identities, in order to feel welcomed, safe and validated. The continuing issue of judgement and discomfort experienced by

Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour within sexual health testing centres is critically important for several reasons. It highlights intersectionality, as Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour face unique challenges when navigating multiple intersecting marginalised identities, shedding light on the systemic racism and discrimination they confront. Recognising and addressing their specific experiences is key to dismantling intersecting forms of oppression and promoting health equity. The discomfort and judgement present in these settings can have serious consequences for their health, leading to delayed diagnoses and increased risk of sexually transmitted and blood-borne infection transmission (Husbands et al. 2022; Negin et al. 2015). Creating inclusive and non-judgemental environments is central to ensuring equitable access to healthcare and promoting overall well-being. By shedding light on these issues, we aim to foster a deeper understanding of the challenges faced by Two-Spirit, gay, bisexual, transgender, and other queer, Black, Indigenous, people of colour and advocate for more inclusive practices in Canada's sexual health services.

Note

1. Shawanda, Amy. 2023. "Pkwenezige (Smudging Ceremony): A First Nation Right to Ceremony." Asia-Pacific Journal of Canadian Studies 29 (1): 83–95. Smudge is a sacred ceremony for many Indigenous communities where sage or other traditional medicines are burned for variety of purposes including improving health and well-being.

Acknowledgements

We thank Ezra Blaque for assistance with participant recruitment and data collection and coding. We also thank Ryan Lisk from the AIDS Committee of Toronto (ACT) and the project's Ontario community advisory board for feedback and support throughout the study. We acknowledge all the organisations and individuals who helped to recruit participants. Most importantly, a thank you goes to all the men, non-binary people, and Two-Spirit individuals who participated in this study. Without you, none of this work would have been possible.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study was funded by the Canadian Institutes of Health Research (CIHR) [FRN: #CTW-1553878]. JD is supported by a Canada Graduate Scholarship – Doctoral Research Award from CIHR. MG is supported by an Applied Public Health Research Chair in Sexually Transmitted and Blood-Borne Infections. DG is supported by a Canada Research Chair in Sexual and Gender Minority Health.

References

Ayhan, C. H. B., H. Bilgin, O. T. Uluman, O. Sukut, S. Yilmaz, and S. Buzlu. 2020. "A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings." *International Journal of Health Services* 50 (1): 44–61. https://doi.org/10.1177/0020731419885093.

Banaji, M. R., S. T. Fiske, and D. S. Massey. 2021. “Systemic Racism: Individuals and Interactions, Institutions and Society.” *Cognitive Research* 6 (1): 82. https://doi.org/10.1186/s41235-021-00349-3.

Braun, V., and V. Clarke. 2019. “Reflecting on Reflexive Thematic Analysis.” *Qualitative Research in Sport, Exercise and Health* 11 (4): 589–597. https://doi.org/10.1080/2159676X.2019.1628806.

Canadian Institutes of Health Research. 2022. “CIHR HIV/AIDS and STBBI Research Initiative Strategic Plan 2022–2027 – CIHR.” https://cihr-irsc.gc.ca/e/52951.html.

Delgado, R., and J. Stefancic. 2017. *Critical Race Theory (Third Edition): An Introduction*. New York: NYU Press.

Dulai, J. J., M. Gilbert, N. J. Lachowsky, K. G. Card, B. Klassen, J. Dame, A. N. Burchell, C. Worthington, A. Ablona, P. Anand, et al. 2023. “Acceptability of an Existing Online Sexually Transmitted and Blood-Borne Infection Testing Model among Gay, Bisexual and Other Men Who Have Sex with Men in Ontario, Canada.” *Digital Health* 9 (May): 20552076231173557. https://doi.org/10.1177/20552076231173557.

Dulai, J., A. Hassan, M. Stewart, H. Ryu, P. Anand, C. Worthington, M. Gilbert, and D. Grace. 2024. “Perspectives on Digital Testing Services for Sexually Transmitted and Blood-Borne Infections from Two-Spirit, Gay, Bisexual, Transgender, and Other Queer Black, Indigenous, People of Color Living in Ontario, Canada.” *Ethnicity & Health* 2024: 1–20. https://doi.org/10.1080/13557858.2024.2337623.

Fleming, P. J., L. C. Stone, M. S. Creary, E. Greene-Moton, B. A. Israel, K. D. Key, A. G. Reyes, N. Wallerstein, and A. J. Schulz. 2023. “Antiracism and Community-Based Participatory Research: Synergies, Challenges, and Opportunities.” *American Journal of Public Health* 113 (1): 70–78. https://doi.org/10.2105/AJPH.2022.307114.

Ford, C. L., and C. O. Airhihenbuwa. 2018. “Commentary: Just What Is Critical Race Theory and What’s It Doing in a Progressive Field like Public Health?” *Ethnicity & Disease* 28 (Suppl 1): 223–230. https://doi.org/10.18865/ed.28.S1.223.

Freeman, R., M. Viorst Gwadz, E. Silverman, A. Kutnick, N. R. Leonard, A. S. Ritchie, J. Reed, and B. Y. Martinez. 2017. “Critical Race Theory as a Tool for Understanding Poor Engagement along the HIV Care Continuum among African American/Black and Hispanic Persons Living with HIV in the United States: A Qualitative Exploration.” *International Journal for Equity in Health* 16 (1): 54. https://doi.org/10.1186/s12939-017-0549-3.

Garcia, S. E. 2020. “Where Did BIPOC Come From?” The New York Times, June 17sec. Style. https://www.nytimes.com/article/what-is-bipoc.html.

Grey, C., I. L. Tian, S. Skakoon-Sparling, E. Daroya, B. Klassen, D. Lessard, M. Gaspar, J. Sinno, J. M. Sang, A. Perez-Brumer, et al. 2023. “Unpacking Racism during COVID-19: Narratives from Racialized Canadian Gay, Bisexual, and Queer Men.” *International Journal for Equity in Health* 22 (1): 152. https://doi.org/10.1186/s12939-023-01961-z.

Heslop, C. W., S. Burns, and R. Lobo. 2019. “Everyone Knows Everyone’: Youth Perceptions of Relationships and Sexuality Education, Condom Access and Health Services in a Rural Town.” *Sex Education* 19 (6): 644–660. https://doi.org/10.1080/14681811.2019.1566120.

Husbands, W., D. O. Lawson, E. B. Etowa, L. Mbuagbaw, S. Tharao, W. Yaya, S. Nelson, L. E. Aden, and M. Etowa, and J. Baidoobonso. 2022. “Black Canadians’ Exposure to Everyday Racism: Implicationsfor Health System Access and Health Promotion among Urban Black Communities.”*Journal of Urban Health* 99 (5): 829–841. https://doi.org/10.1007/s11524-022-00676-w.

Iott, B. E., J. Loveluck, A. Benton, L. Golson, E. Kahle, J. Lam, J. A. Bauermeister, and T. C. Veinot. 2022. “The Impact of Stigma on HIV Testing Decisions for Gay, Bisexual, Queer and Other Men Who Have Sex with Men: A Qualitative Study.” *BMC Public Health* 22 (1): 471. https://doi.org/10.1186/s12889-022-12761-5.

Jackson, J. P., N. M. Weidman, and G. Rubin. 2005. “The Origins of Scientific Racism.” *The Journal of Blacks in Higher Education* 50 (Winter/2006): 66–79.

Kihika, M. 2013. “Ghosts and Shadows: A History of Racism in Canada.” *Canadian Graduate Journal of Sociology and Criminology* 2 (1): 35–44. https://doi.org/10.15353/cgjsc.v2i1.3775.

Matheson, K., A. Seymour, J. Landry, K. Ventura, E. Arsenault, and H. Anisman. 2022. “Canada’s Colonial Genocide of Indigenous Peoples: A Review of the Psychosocial and Neurobiological

Processes Linking Trauma and Intergenerational Outcomes." *International Journal of Environmental Research and Public Health* 19 (11): 6455. https://doi.org/10.3390/ijerph19116455.

Negin, J., C. Aspin, T. Gadsden, and C. Reading. 2015. "HIV Among Indigenous Peoples: A Review of the Literature on HIV-Related Behaviour Since the Beginning of the Epidemic." *AIDS & Behavior* 19 (9): 1720–1734.

Neighbors, H. W., D. T. Mattingly, J. Johnson, and K. Morse. 2023. "The Contribution of Research to Racial Health Equity? Blame and Responsibility in Navigating the Status Quo of Anti-Black Systemic Racism." *Social Science & Medicine* 316 (January): 115209. https://doi.org/10.1016/j.socscimed.2022.115209.

Nelson, L. E., W. Tharao, W. Husbands, T. Sa, N. Zhang, S. Kushwaha, D. Absalom, and R. Kaul. 2019. "The Epidemiology of HIV and Other Sexually Transmitted Infections in African, Caribbean and Black Men in Toronto, Canada." *BMC Infectious Diseases* 19 (1): 294. https://doi.org/10.1186/s12879-019-3925-3.

Ontario HIV Epidemiology and Surveillance Initiative. 2023. "Current Trends for HIV in Ontario." *OHESI*. https://www.ohesi.ca/.

Ontario Ministry of Health. 2023. "Apply for OHIP and Get a Health Card." *Ontario.ca*. http://www.ontario.ca/page/apply-ohip-and-get-health-card.

Ontario Ministry of Indian Affairs. Ontario. 2021. "Indian Status and Identification Cards." *ca*. http://www.ontario.ca/page/indian-status-and-identification-cards.

Pruden, H., and T. Salway. 2020. "Meet the Methods Series: 'What and Who Is Two-Spirit?' in Health Research." Ottawa: CIHR Institute of Gender and Health, Government of Canada. https://cihr-irsc.gc.ca/e/52214.html.

Public Health Agency of Canada. 2018. *Reducing the Health Impact of Sexually Transmitted and Blood-Borne Infections in Canada by 2030: A Pan-Canadian STBBI Framework for Action*. Program descriptions. https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/reports-publications/sexually-transmitted-blood-borne-infections-action-framework.html.

Public Health Agency of Canada. 2021. "Sexually Transmitted and Blood Borne Infections (STBBI) Prevention Guide." Education and awareness. https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/stbbi-prevention-guide.html.

Public Health Agency of Canada. 2022a. *HIV in Canada, Surveillance Report to December 31*, 2020. Research. https://www.canada.ca/en/public-health/services/publications/diseases-conditions/hiv-canada-surveillance-report-december-31-2020.html.

Ritchie, J., J. Lewis, and G. Elam. 2003. "Chapter 4: Designing and Selecting Samples." *In Qualitative Research Practice: A Guide for Social Science Students and Researchers*, edited by Jane Ritchie and Jane Lewis, Thousand Oaks, CA: SAGE.

Rivara, F. P., and S. D. Fihn. 2020. "Call for Papers on Prevention and the Effects of Systemic Racism in Health." *JAMA Network Open* 3 (8): e2016825. https://doi.org/10.1001/jamanetworkopen.2020.16825.

Saewyc, E., T. Clark, L. Barney, D. Brunanski, and Y. Homma. 2014. "Enacted Stigma and HIV Risk Behaviours among Sexual Minority Indigenous Youth in Canada, New Zealand, and the United States." *Pimatisiwin* 11 (3): 411–420. https://doi.org/10.111/jpc.12397.

Sanders, C., K. Burnett, S. Lam, M. Hassan, and K. Skinner. 2020. "You Need ID to Get ID': A Scoping Review of Personal Identification as a Barrier to and Facilitator of the Social Determinants of Health in North America." *International Journal of Environmental Research and Public Health* 17 (12): 4227. https://doi.org/10.3390/ijerph17124227.

Small, L., R. M. Beltran, L. Cordero, C. Lau, S. Shanur, and A. Miyashita Ochoa. 2023. "The Invisibility of Black and Latina Women in Sexual Health Care: Shifting from Biological Individualism to Intersectionality." *Culture, Health & Sexuality* 25 (8): 1084–1100. https://doi.org/10.1080/13691058.2022.2124458.

Statistics Canada. ". 2022a. The Daily – Indigenous Population Continues to Grow and Is Much Younger than the Non-Indigenous Population, Although the Pace of Growth Has Slowed." https://www150.statcan.gc.ca/n1/daily-quotidien/220921/dq220921a-eng.htm.

Statistics Canada. 2022b. “The Daily – The Canadian Census: A Rich Portrait of the Country’s Religious and Ethnocultural Diversity.” https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm.

Statistics Canada. 2024. “The Daily – Police-Reported Hate Crime, 2022.” https://www150.statcan.gc.ca/n1/daily-quotidien/240313/dq240313b-eng.htm.

Stewart, M., H. Ryu, E. Blaque, A. Hassan, P. Anand, O. Gómez-Ramirez, K. R. MacKinnon, C. Worthington, M. Gilbert, and D. Grace. 2022. “Cisnormativity as a Structural Barrier to STI Testing for Trans Masculine, Two-Spirit, and Non-Binary People Who Are Gay, Bisexual, or Have Sex with Men.” *PLoS One* 17 (11): e0277315. https://doi.org/10.1371/journal.pone.0277315.

Veenstra, G. 2009. “Racialized Identity and Health in Canada: Results from a NationallyRepresentative Survey.” *Social Science & Medicine* 69 (4): 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009.

Williams, M. T., A. Khanna Roy, M.-P. MacIntyre, and S. Faber. 2022. “The Traumatizing Impact of Racism in Canadians of Colour.” *Current Trauma Reports* 8 (2): 17–34. https://doi.org/10.1007/s40719-022-00225-5.