we deserve **chlamydia care**

We Deserve Chlamydia Care
Community Report

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Authors: **Malek Yalaoui, Maryam Khan, Marie Geoffroy, KD King, Skye Wilson, Jaylene McRae, Lane Bonertz, Adam Arca, Jad Sinno**

Acknowledgements: **Anu Radha Verma, Nic McDonald, Jessy Dame, Nathan Lachowsky, Ciann Wilson, Jayashri Maraj, Fawzia Patel**

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Two-Spirit Program

University of Victoria

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Executive Summary

This report presents findings from *We Deserve Chlamydia Care*, one of the first community-based studies in Canada to explore how disabled, Indigenous, Black and People of Colour (IBPOC), Two-Spirit, Lesbian, Bisexual, Transgender, Queer (2S/LBTQ+) women and gender-diverse communities experience access to chlamydia testing and care in Ontario. The research was funded by a Canadian Institutes of Health Research (CIHR) Catalyst Grant and co-led by researchers from Wilfrid Laurier University, University of Victoria, and Dalhousie University, in partnership with Community-Based Research Centre (CBRC).

This project was created to respond to important gaps found in sexual healthcare in Ontario for IBPOC, disabled, 2S/LBTQ+ women and gender-diverse communities. Through 23 in-depth interviews, participants described systemic barriers rooted in racism, ableism, cisheteronormativity and sexism. These barriers shaped not only access to services but also emotional and cultural safety across both chlamydia-related care and broader sexual healthcare experiences. As part of this project, a dedicated Two-Spirit-specific analytic process was conducted in collaboration with CBRC's Two-Spirit Program team to ensure that Two-Spirit and Indigiqueer participants' experiences were interpreted through culturally grounded and community-led approaches. Two-Spirit and Indigiqueer participants additionally identified the impacts of anti-Indigenous racism, cultural and geographic isolation as well as colonized shame as key factors shaping their sexual healthcare experiences. Findings specific to experiences of Two-Spirit and Indigiqueer participants are presented in a separate **report available online**.

Participants shared experiences of being dismissed, misgendered, or denied appropriate medical information, revealing how sexual healthcare systems often fail to reflect the realities of IBPOC disabled 2S/LBTQ+ lives. Yet amid such challenges, participants also offered powerful visions for change. They described what an ideal testing experience would look like: routine, shame-free care that includes clear information, privacy, flexibility (such as options for self-sampling), and compassionate, unrushed interactions that acknowledge the emotional aspects of testing. Calls for cultural safety, trauma-informed practice, and comprehensive 2S/LBTQ+ health training extended beyond sexual healthcare clinics to all providers working in healthcare.

Community care was identified as a vital source of resilience. Peer networks, mutual aid, cultural teachings, and community-led education filled critical gaps left by the healthcare system, often serving as participants' primary sources of sexual health information, safety, and affirmation. These forms of community support highlight both the depth of systemic failures and the strength of collective care.

This report concludes with concrete recommendations for healthcare providers and institutions: invest in training that centres cultural humility alongside disability, IBPOC and 2S/LBTQ+ health literacy, and trauma-informed approaches; create safer spaces for care; and build partnerships with the communities most impacted. Rooted in disability justice and intersectional feminist frameworks, this work reminds us that equitable sexual healthcare is not a privilege but a collective right.

Introduction

Context of this work

Chlamydia remains the most common sexually-transmitted and blood-borne infections (STBBIs) in Canada, disproportionately affecting people assigned female at birth and trans and gender-diverse individuals.[2] Yet, public health research and clinical guidelines have historically overlooked disabled, IBPOC and 2S/LBTQ+ women and gender-diverse communities. These populations continue to experience multi-layered intersectional barriers – rooted in sexism, cisheteronormativity, ableism, and racism – that make access to testing, care, and information difficult to access and unsafe concurrently.

Using a community-based, qualitative approach, the study was nested in CBRC and co-led by academic researchers and community members. Research activities ran from 2024 to 2025. The research was conceptualized and guided using critical disability justice,[2–6] critical intersectional feminist,[3,4] and wholistic Indigenous[5,6], theoretical perspectives as well as CBRC's Research Principles[7] – emphasizing that health and access to care are shaped by intersecting social, cultural, and political factors. By centering lived experiences of underserved Two-Spirit, queer and trans disabled and racialized women and gender-diverse communities, this project hopes to contribute to building a foundation for more inclusive, culturally relevant, and just approaches to sexual healthcare in Ontario.

Team members

This project was led by Dr. Maryam Khan (Wilfrid Laurier University, Faculty of Social Work), in partnership with CBRC.

In addition to Dr. Khan, the research team included:

- Jessy Dame, Director of Two-Spirit Health, CBRC
- Marie Geoffroy, Associate Director of Research, CBRC
- Dr. Nathan Lachowsky, University of Northern British Columbia, Faculty of Human and Health Sciences
- Dr. Eli Manning, Dalhousie University, Faculty of Social Work
- Dr. Ciann Wilson, Wilfrid Laurier University, Community Health Sciences
- Anu Radha Verma, former Associate Director of Research, CBRC

With support from:

- Community Advisory Board (CAB): Five community members with lived experience, providing oversight and guidance
- Research Coordinator Malek Yalaoui (CBRC)
- Graduate students Nic McDonald, Jayashri Maraj, Fawzia Patel (Wilfrid Laurier University) and Adam Arca (University of Victoria)
- CBRC's Two-Spirit Program team (Lane Bonertz, KD King, Jaylene McRae, Skye Wilson)

The study was further supported by students, community organizations, healthcare professionals, and the broader 2S/LBTQ+ and disability justice networks connected through CBRC's research programming.

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2 Public Health Agency of Canada. Chlamydia, gonorrhea and infectious syphilis in Canada: 2020 (infographic) [Internet]. 2023 [cited 2023 Apr 12]. Available from: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/chlamydia-gonorrhea-infectious-syphilis-canada-2020-infographic.html

3 Alcoff L, Potter E, editors. Introduction: When Feminisms Intersect Epistemology. In: Feminist Epistemologies. 1st edition. London: Routledge; 2013. p. 1–14.

4 Hill Collins P. Black feminist thought: knowledge, consciousness, and the politics of empowerment. Revised tenth anniversary edition. Second edition. Abingdon, Oxon: Routledge; 2014.

5 Absolon K. Indigenous Wholistic Theory: A Knowledge Set for Practice. First Peoples Child & Family Review. 2010;5(2):74–87.

6 Absolon K. Decolonizing Education and Educators' Decolonizing. Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice. 2019;7(1):9–28.

7 Community-Based Research Centre. Research Principles [Internet]. Canada; 2023 Feb [cited 2023 Apr 20] p. 5. Available from: https://www.cbrc.net/cbrcs_research_principles

Methodology

Theoretical framings

The study was grounded in the following critical intersecting frameworks:

CBRC's Research Principles established a framework for conducting community-led, justice-oriented research with 2S/LBTQ+ communities. Grounded in decolonization, anti-racism, and disability justice, these principles act as aspirational guides for all our work. They emphasize access, equity, and community control over research processes. CBRC centres lived experience, values both community strengths and challenges, and defines health holistically encompassing emotional, social, cultural, and spiritual dimensions. CBRC commits to transparency, meaningful participation of people with lived experience at every stage of research projects, and partnerships that advance structural change and collective well-being.[8]

Disability Justice as a research framework moving beyond individual rights or accommodation to recognize how ableism intersects with racism, colonialism, gender oppression, and economic injustice (i.e. collective concerns and activism). It centres interdependence, acknowledging that all people rely on one another for care and survival, access, emphasizing the collective responsibility to remove barriers and design systems that work for everyone, and collective liberation, affirming that no one is free until all are free.[9-12]

Critical Feminist and Intersectional Analysis emphasized how systems of power such as sexism, racism, ableism, and cisheteronormativity interact to shape people's experiences of health, care, and belonging. It recognizes that gender cannot be understood in isolation from race, sexuality, or ability, and that these intersecting forces determine who has access to care, whose pain is believed, and whose health is prioritized. Rooted in feminist and anti-oppressive traditions, this approach called for research and policy that centre marginalized voices, challenge structural inequities, and reimagine health systems that affirm autonomy, dignity, and justice for all bodies.[10,11]

Wholistic Indigenous Framework: Although this framework was initially used to conceptualize the project, further engagement with Two-Spirit and Indigenous team members resulted in this specific framework to not be implemented throughout research activities; rather, the CBRC's Two-Spirit Program team were actively involved in data collection and analysis. Findings specific to experiences of Two-Spirit and Indigiqueer participants are presented in a separate report available online.

Together, these frameworks guided the research toward relational accountability, cultural safety, and community empowerment.

Community Advisory Board

To ensure the project remained community-led, a Community Advisory Board (CAB) was formed at the beginning of the research activities, consisting of five members with lived experience as disabled IBPOC 2S/LBTQ+ women and gender-diverse individuals. The CAB met monthly, offering guidance on study identity, recruitment, interview questions, accessibility, and knowledge translation. Members were compensated for their time and recognized as co-knowledge producers, not just consultants.

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8 Community-Based Research Centre. Research Principles [Internet]. Canada; 2023 Feb [cited 2023 Apr 20] p. 5. Available from: https://www.cbrc.net/cbrcs_research_principles

9 Berne P. Disability Justice - a working draft [Internet]. Sins Invalid. 2015. Available from: https://sinsinprocess.squarespace.com/blog/disability-justice-a-working-draft-by-patty-berne

10 Alcoff L, Potter E, editors. Introduction: When Feminisms Intersect Epistemology. In: Feminist Epistemologies. 1st edition. London: Routledge; 2013. p. 1–14.

11 Hill Collins P. Black feminist thought: knowledge, consciousness, and the politics of empowerment. Revised tenth anniversary edition. Second edition. Abingdon, Oxon: Routledge; 2014.

12 Branch, Legislative Services. Consolidated Federal Laws of Canada, Accessible Canada Act. 27 Apr. 2023, https://laws-lois.justice.gc.ca/eng/acts/a-0.6/FullText.html.

Ethics

In order to conduct this research, ethics approval was received from the Wilfrid Laurier University Research Ethics Board (REB). REB review is a multi-step and ongoing process that involves administrative review, initial ethics review, resubmissions and resubmission reviews.

Qualitative interviews

Recruitment methods

Participants were recruited primarily through CBRC's Our Health 2022 community survey recontact mechanism and through snowball and social media outreach in partnership with community organizations that focused on sexual health such as **Action Canada for Sexual Health & Rights**, Planned Parenthood (**Ottawa** and **Toronto**), **Safer Six**, **Sexual Health Resource Centre** and the **Native Youth Sexual Health Network**. Recruitment materials included email invitations via listservs, social media posts (images/videos) and postcards distributed locally throughout the Greater Toronto Area and the Waterloo region. Materials were available in English, French, American Sign Language (ASL), and Langue des Signes du Québec (LSQ), to increase accessibility. A total of 23 semi-structured interviews were conducted online via Zoom for Healthcare in English across Ontario between October 2024 and January 2025. People who were interested in participating in the study were directed to a Qualtrics screening tool used to assess eligibility.

Eligibility criteria

In order to be eligible to be interviewed, participants were required to self-identify with the following criteria:

- Age: Participants had to be 16 years old or older
- Ethnic/racial identity: Participants were either Indigenous, Black and/or a person of colour
- Gender identity: Participants could identify as either trans or cis women or as femme-presenting Two-Spirit or non-binary people
- Sexual identity: All 2S/LBTQ+ were welcome to participate
- Living with a disability
    - We used the Accessible Canada Act definition of disability as "any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment – or a functional limitation – whether permanent, temporary or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person's full and equal participation in society."[12]
    - We made all reasonable efforts to accommodate participant accessibility concerns and needs throughout the research process from recruitment to interviews including making all research materials accessible.
- Residence: Participants had to have resided in Ontario, Canada for at least three months in the past five years
- Participants had to have lived/living experience accessing chlamydia testing in Ontario
    - To help participants know if this criteria applied to them, we clarified that chlamydia testing is usually done through a urine sample or a swab at a sexual health clinic or other healthcare setting.
    - We used an expansive understanding of chlamydia to ensure that infections which may be related to chlamydia, but are not often included, are also counted in this definition. For example, urethritis, cervicitis, pelvic inflammatory disease (salpingitis), proctitis, bacterial vaginosis, mixed vaginitis infections, chronic asymptomatic infection, endometritis, perihepatitis, and ocular trachoma when caused by chlamydia.

We asked all potential participants to fill out a short Qualtrics survey to confirm their eligibility and a subcommittee of the research team met regularly to screen all applicant surveys. Decisions regarding who to interview were based on both the eligibility criteria and on the desire for a diversity of perspectives.

Interviews

The interview guide explored participants' experiences with:

- Access to and knowledge about chlamydia and STBBI testing
- Interactions with healthcare providers
- Barriers and facilitators to testing
- Emotional and cultural dimensions of care, and
- Recommendations for change within healthcare systems and policy frameworks

Interviews were conducted by four members of the project research team: Maryam Khan, Anu Radha Verma, Malek Yalaoui and Jaylene McRae. Interviews lasted between 60 to 90 minutes. Interviews were recorded on Zoom and transcribed word for word. These transcripts were then scrubbed of any identifying information such as names and specific locations.

In terms of accessibility, participants were encouraged to share their access needs prior to the interview and were offered ASL/LSQ live interpretation if needed. Other options given to participants included being allowed to turn their cameras off, use the chat function to communicate, and take as many breaks as needed.

All participants were provided with an honorarium as a way to thank them for their generosity in sharing their time and their stories with us.

Member checking

Participants were invited to review transcripts of their interviews through a process called member checking, to ensure their experiences were accurately represented and reflected their voices and perspectives.

Analysis

Coding process

A four-person subcommittee of the research team began by coding four transcripts separately to generate initial codes. With each transcript, codes were created for different segments of text (quotes) that were relevant to participants' experiences of, and reflections on, chlamydia testing and treatment. These initial codes were then compared, discussed, and modified before moving on to the rest of the transcripts. As the subcommittee worked through all the transcripts, new codes were created and sometimes existing ones were modified.

For this process, the data was analyzed using inductive coding in NVivo, a qualitative data analytic software. As we worked, a shared codebook was co-developed by members of the research team and CBRC's Two-Spirit Program team, focusing on how misogyny, ableism, racism, cisnormativity, and heterosexism shape access to care. Coding was iterative and reflexive, with multiple team members reviewing transcripts and discussing descriptive categories to ensure rigor and consistency.[13]

Once the codes were finalized, they were grouped into themes that captured significant patterns in the data. Many of these themes, and the codes that constitute them, are presented here as **key findings**.

A separate coding process was conducted for Two-Spirit and Indigiqeer participant data only. This is described in a separate **report available online**.

13 Maguire, Moira, and Brid Delahunt. "Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars." All Ireland Journal of Higher Education, vol. 9, no. 3, Oct. 2017. https://ojs.aishe.org/index.php/aishe-j/article/view/335.

Participants

A total of 23 participants took part in audio recorded interviews. All participants were currently living in Ontario in urban, suburban and rural communities, with most residing in the Greater Toronto Area despite efforts for recruitment outside urban areas. Each participant identified as IBPOC 2S/LBTQ+ with a diverse range of gender identities and experiences related to disability. Participants' ages spanned from 20 to 60 years old. Despite recruitment efforts and accommodations offered in different languages (ASL, LSQ and French), all interviews were conducted in English. Participants' sociodemographics are presented below in diagrams 1-6.

Table 1: Participants by age range (n=23)

20s	11 participants
30s	7 participants
40s	3 participants
50+	2 participants

Table 2: Participants by community size (Ontario, Canada) (n=23)

Large city (population >1M)	13 participants
Small-to-medium city (population 100K - 500K)	6 participants
Town or rural area (population <100K)	4 participants

Table 3: Participants by sexual orientation (n=23)

Pansexual	8 participants
Bisexual	5 participants
Queer	5 participants
Lesbian	4 participants
Asexual	1 participant

Table 4: Participants by gender identity (n=23)
*Some participants identified as both trans and non-binary

Cisgender	10 participants
Transgender	9 participants
Non-binary	7 participants

Table 5: Participant ethnic and racial identities (n=23)
*Some participants reported multiple identities

African, Caribbean, and Black	10 participants
Indigenous (Two-Spirit and/or Indigiqueer)[14]	8 participants
South Asian	5 participants
Mixed race	5 participants
Middle Eastern / Arab	3 participants

Table 6: Participants reporting disability, neurodivergence and/or mental health challenges (n=23)
*Some participants reported multiple experiences

Mental health challenges	14 participants
Neurodivergent	12 participants
Physical disability and/or chronic health condition	11 participants

Information in Table 6 reflects participants' self-described experiences, shared in response to an open-ended question about disability drawn from the Accessible Canada Act definition of disability available above in the **Eligibility criteria** section of this report. Participants reported a wide range of physical, sensory, mental health, neurodivergent, developmental, and chronic health conditions (e.g., ADHD, autism, depression, anxiety, PTSD, chronic pain, visual impairment, etc). Neither medical documentation nor formal diagnosis was required to be eligible to participate in the study; instead, participants' own understandings of their disabilities were accepted as valid.

Together, these participant demographics reflect a diverse range of identities, locations, and lived experiences across Ontario, shaped by intersecting forms of marginalization.

The following findings, and those in the **Two-Spirit-specific report available online**, draw directly from participants' narratives to illustrate how these realities influenced access to chlamydia information, testing, treatment, and broader sexual healthcare experiences.

14 Findings specific to experiences of Two-Spirit and Indigiqueer participants are presented in a separate **report available online**.

Key Findings

In this section, we will present the key findings related to participants' experiences of the difficulty accessing chlamydia information, testing and treatment as well as their experiences with healthcare providers, including experiences of discrimination and oppression, along with a look at how participants cope in the context of community and what their recommendations are both for healthcare providers and for community members.

These findings do not represent all identified themes, but rather those who were brought forward by the most participants.

Note that these findings emerged from analyzing all participant interviews. Findings specific and unique to the experiences of the subset of Two-Spirit and Indigiqueer participants were also analyzed, and those findings can be accessed in a separate report available online.

Difficulty accessing chlamydia information, testing, and treatment

Accessing accurate information, timely testing, and appropriate treatment for chlamydia was challenging for many participants. Across interviews, participants described structural, cultural, and geographic barriers that made it difficult to get clear guidance, consistent care, or safe and respectful support.

Lack of information on chlamydia and other STBBIs

Many people said they had to teach themselves about chlamydia and other STBBIs, often turning to pamphlets, nonprofits, or online sources because healthcare providers didn't explain much. Participants wanted clearer, non-judgmental education about prevention and testing.

> ***"They just saw me as a number, an appointment to get [it] over with. They wouldn't share other risk factors or co-infections or just basic details about chlamydia or other STIs that have been tested with. I had to do a lot of reading on my own."***

Lack of access to family doctors

Several participants did not have a regular family doctor, forcing them to rely on walk-in clinics or public health units. The lack of continuity in care left them feeling unseen and unsupported, and they struggled to build trust or follow-up relationships around their sexual health.

> ***"Services are not accessible because people lack family doctors, and that's one important access point that many queer non-binary and trans folks are not getting... many of them don't know where to [go] because there's a shortage of family doctors."***

> ***"If I had an ongoing physician I could see from time to time and tell them my struggles ... If I had that, then I feel like I would feel much better mental-health-wise. Also, I would be more open about my physical health."***

Lack of culturally relevant resources

Racialized and queer participants said they rarely saw materials, providers, or environments within healthcare settings that acknowledged their identities without judgment. Even when care was technically competent, it often lacked cultural sensitivity or affirmation of their lived experience. Participants emphasized that culturally relevant care is not simply about comfort, it's about safety, dignity, and avoiding social harm. For many participants, this lack of cultural grounding had serious consequences including stigma within their communities that carried real social risk, making privacy and discretion essential components of affirming care. In this context, they described how providers who lacked cultural awareness often underestimated what was at stake for them. As one participant shared about their own cultural context:

> ***"I think just be mindful of the stigma [around sex and sexuality] being tenfold in our community... I think for healthcare providers to know how sensitive it is, and it doesn't always result in how people think, "Oh, honour killings" ... But just people leaving you out, people not talking to you anymore, that's enough. That's the shame, the fact that you don't have honour anymore, the fact that your family doesn't have honour anymore. So I think just being culturally sensitive and knowing how to be discreet about these things is very important for healthcare providers."***

Geography as a barrier

Participants living in smaller or rural communities described major barriers to testing, from limited clinic hours to long travel times, sometimes exacerbated by their disabilities, and expensive public transport. Many said they had to leave their towns to find welcoming or reliable care, often making testing a full-day ordeal.

> ***"I'm only in school once a week, but even that is such a struggle at getting myself ready and getting there. I take the bus there. So, commuting to school and back just to pick up my results [at the campus clinic], it felt like, is it even worth it?"***

> ***"Because of my disability, I'm not really able to drive properly, so I have to take a bus, which for [large city], it can take up to three hours. A drive is an hour and a half."***

For many, these access barriers set the stage for the complex, often fraught interactions participants described within clinical settings. What happened once they met with a healthcare provider introduced a new set of obstacles that often shaped whether they felt respected, safe, and willing to return.

Experiences with healthcare providers

While structural barriers made it difficult for participants to access chlamydia care, their experiences once inside the clinic often carried the greatest emotional weight. Participants consistently emphasized that the quality of provider interactions, not just the availability of services, determined whether they felt safe pursuing chlamydia care.

Anxiety and fear before testing; Lack of follow-up and reassurance after

Many participants spoke about the emotional toll of preparing for STI or chlamydia testing. For some, anxiety came less from worrying about the infection itself and more from not knowing how they would be treated by healthcare providers. After testing, several people described being left in the dark, with little follow-up or reassurance once results were in – especially if results were negative – compounding feelings of frustration and fear.

> ***"It's that part that causes me worries and concern – the before part, just prepping up for the appointment and thinking about how it's going to go."***

> ***"I think the worst part was 'just wait for a phone call.' And if you get it, you have a phone call... if you don't, then you're good... But I think you should still call somebody to say, 'No, you're okay, you're in the clear.' I hated that."***

Provider ignorance about 2S/LBTQ+ community-specific sexual health

Participants often described their providers as uninformed about queer sexual health, including basic facts about STBBIs, PrEP[15], and non-cisgender bodies. Some said their doctors made incorrect assumptions about who was "at risk," while others were outright denied care. Several participants spoke about how healthcare providers often underestimate or misunderstand the risks of STBBI transmission between women and gender-diverse people, leaving queer women, trans and non-binary people overlooked or dismissed. This lack of knowledge led to fewer offers of testing, inappropriate guidance, and a sense that their sexual health was "invisible" in medical settings.

> ***"He was like, 'How many partners?' ... Then he asked if it was with men or women. Then, upon saying women, he was like, 'Oh, I mean, you don't really have to get tested.' That was his first response."***

> ***"Even at the [University Health Clinic], when I asked to access PrEP... I had a doctor denying me because he said that 'Oh, I don't think you need it because you're not seeing enough cis guys.' I'm like, 'Girl, just give me PrEP', you know? But he denied. Well, not denied, but I feel like if I hadn't of kept pushing him, he would have done that... When you're in a doctor's office, you're already very vulnerable... it makes you less likely to just keep pushing back just because you're in that state of mind."***

Burden on patients to educate providers

Many participants said they were tired of having to "teach" their doctors or nurses about their own bodies, gender, and sexual practices. This educational labor, done in moments when they were seeking care, was emotionally exhausting and reinforced power imbalances in the healthcare system.

> ***"I will refuse to work with people who aren't racialized at the very least. I don't need to explain myself to folks, nor do I need to deal with whiteness, blurring my ability to access care."***

Invasive questioning

Participants shared that providers sometimes asked personal or irrelevant questions about their gender identity or sexual history that felt voyeuristic or judgmental. These moments left them feeling exposed and mistrusted rather than cared for. Others who were trans described being asked unnecessary or invasive questions unrelated to the care they sought.

> ***"If I'm walking into an STI clinic, I only want to talk about just STI stuff. Some of them are just like, 'Oh, so are you doing anything about your transgenderism?' or comments like that. I'm like, 'My God, why does that matter that if I'm cis or trans or non-binary, I still deserve sexual healthcare.' "***

Concerns about informed consent

Participants emphasized how crucial it is for testing and treatment to respect bodily autonomy, especially for people with histories of trauma or those whose gender identities are often misunderstood. Some said healthcare workers rushed or failed to explain procedures clearly, which could feel violating or retraumatizing.

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15 "Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention strategy. People who are HIV negative can use it to lower their chance of getting HIV. Using PrEP involves taking medication and having regular medical appointments for monitoring and support." (Source)

> ***"And I'm thinking specifically around testing where speculums are involved. I've heard from so, so, so, so, so many [people]... And this has happened to me as well. Repeatedly being like, "Can you please use the smallest speculum and tools you have?" And then [after they've started the procedure] them being like "Oh... I should go get a smaller one. And it's like, "Well, I told you that before and now I'm in extreme pain. Now I'm screaming, and I never want to come back here, and you could have just grabbed the smaller one before."***

Breaches of privacy and confidentiality

Some participants described feeling unsafe sharing sexual health information with family doctors in small towns, where "everyone knows everyone." This fear of outing discouraged people from seeking relevant care. Others noted that clinics often lacked anonymous or discreet feedback systems, making it hard to hold providers accountable or report harm without risking exposure.

> ***"I remember being young and being terrified to go get testing because what if my parents find out? Actually, ironically, they called the house one time and told my mother that, "Oh, she has to call back the doctor's office because there's an irregularity in her PAP test." My mother's having a sh*t storm, what's going on? The receptionist broke confidentiality because at the time, I was 17."***

Importance of the option to self-sample

Participants emphasized the importance of having the option to self-sample during STBBI testing, describing it as an empowering and affirming experience that allowed them to feel more in control of their bodies. For many, self-swabbing reduced anxiety, discomfort, and vulnerability associated with provider-administered tests – particularly for those who had previously encountered judgment or trauma in clinical settings. The opportunity to collect their own samples was seen as both a form of bodily autonomy and emotional safety, reinforcing trust in the testing process.

> ***"In the last few years, it's been really great because I have been given the opportunity to go swab myself, which I didn't know was a thing. I'm very proud of myself... It was nice to have autonomy over my own body. And so I really appreciated that... it's also really validating to know this is my body, and I can also care for it, and I'm very much a part of it."***

> ***"My most recent visit to the doctor, I was like, I know what this is. This is what I need. I'm going to do it. I'm going to do the swab myself so you can just give me the swab... People don't know that they can do those kinds of things, that there's a level of power and advocacy that you can have... So that helped. I think that helped me ... now that I have the education and the confidence around STI health."***

Importance of trust with 2S/LBTQ+ providers

When participants did encounter affirming, knowledgeable 2S/LBTQ+ providers, it made a profound difference in their comfort and willingness to seek ongoing care. They highlighted how trust, understanding, and shared identity can transform a vulnerable experience into an empowering one.

> ***"I think my provider now goes out of her way to make it clear... I can tell by her language, by the questions she asks, by how she asks them, by what she clarifies. I also know she's queer, so that's helpful, to be honest, because... I really don't feel like a specimen sitting here. Definitely. I've never felt like that before."***

Together, these experiences show that clinical interactions were shaped by broader social biases that deeply influenced how participants were treated. Participants made clear that their encounters with healthcare providers did not happen in a vacuum. The anxiety, dismissal, and gaps in care they described were often tied to larger patterns of discrimination woven through the healthcare system. These moments reflected not only individual provider behavior but the systemic discrimination embedded in healthcare more broadly. To fully understand these interactions, it is helpful to examine the forms of discrimination and oppression that shaped them, as reported by participants.

Discrimination and oppression in healthcare

Across interviews, participants described how systemic and intersecting forms of oppression (e.g. ableism, anti-Blackness, cisheteronormativity, transphobia, sexism, and the stigmatization of neurodivergence) directly shaped their experiences of chlamydia care. These forms of discrimination were not isolated incidents but recurring patterns that shaped not only how they were seen and spoken to but also whether they felt safe, respected, and able to access the care they needed or even trust the healthcare system at all. Participants' stories revealed that many of the challenges they faced were rooted in systemic forms of discrimination that go far beyond poor bedside manner.

Ableism

Participants with disabilities described being stereotyped, shamed, or physically mishandled during testing as healthcare workers assumed noncompliance rather than approaching care with compassion or nuance. Participants also reported that healthcare providers often desexualize disabled patients, assuming they are not sexually active and therefore do not require sexual or reproductive healthcare. This ableist assumption erases disabled people's sexual agency, leading to missed opportunities for STBBI testing, prevention, and open discussion about sexual well-being.

> ***"My disabilities are invisible, but I have friends with more visible disabilities, and it's like, according to them, it's like the concept that they have an active sex life is baffling to sexual health clinics. I remember my friend, she's in a wheelchair, but she just goes to get herself screened ... And they're like," are you sure it still works down there?" ... She said, put your head down there and find out ... it's like the concept that you can be a sexual being with a disability is baffling to them."***

Anti-Blackness and misogynoir

One notable finding from this study includes that Black participants noted that anti-Black racism intersects with gender, shaping how they're seen and treated in healthcare. They described being perceived as "difficult," "promiscuous," or "noncompliant," and said these biases created mistrust and avoidance of care.

> ***"Them [healthcare providers] view me as angry Black woman, [as] problematic, and them not want to help me. So that's another thing when it comes to advocating for yourself as a Black woman. You don't want to seem like the 'angry Black woman' and them in turn be like, 'Yeah, I knew she was going to be like this, and this is why.' It's very difficult to gauge what you can do and when. And then now that I'm at the age where I'm like, 'I don't give a fuck! You're going to hear me. If you don't like what I have to say, that's fine. But you're going to test me for what I need to be tested for. And if this comes back positive, you're going to look like the idiot because you're the doctor!' "***

To learn more about participants' experiences of self-advocacy and their advice for community members, see **Reclaiming Autonomy: A Community Outlook**, an adjacent specific report from this project by Community Advisory Board member Oghenetega Ubor.

Cisheteronormativity

Across interviews, participants highlighted how sexual healthcare is designed around cisgender, heterosexual norms from intake forms to clinic language to the assumptions behind screening questions. This left queer, trans, and gender-diverse participants feeling excluded or pathologized.

> ***"If you're non-binary [or] trans, I think it's just about whether or not that person is respecting you... Even with [2S/GBTQ+ healthcare centre in a large city]... a lot of them – my perception of them – are cis gay men ... so I don't necessarily engage very openly with them. I think my biggest trigger points are when I have to deal with cis folks who are supporting me through the process."***

Heterosexism

Many queer and pansexual participants said healthcare providers assumed they were heterosexual, often ignoring or erasing same-sex experiences. This led to discomfort and distrust, as they had to decide whether to "come out" to receive appropriate care.

> ***"I had an IUD, and it was causing me more pain than my periods were before.... I went to ask to get it out, and I think I was turned away by one person. That was really distressing... Then I went to see another person after a few months ... that second doctor ... did take the IUD out, [but afterwards] he was really pushy about being on birth control. At the time, I was still in a long-term relationship with someone who didn't have sperm. I was like, 'I'm really not concerned, and I'm really triggered by all of it. Can I just not please?' That was definitely really hard at times."***

Neurodivergence

Several participants spoke about how Attention-Deficit/Hyperactivity Disorder (ADHD) and other forms of neurodivergence shaped their experiences of navigating healthcare. They described challenges with executive functioning, overstimulation in clinical environments, and feeling misunderstood or judged when expressing anxiety or difficulty following medical routines. For some, the fast pace or impersonal nature of clinical encounters intensified feelings of shame or overwhelm. Participants called for providers to slow down, check in frequently, and communicate with patience and clarity.

> ***"Talking about scheduling, testing, going back for results, those are things that require a consistency that is not as present with someone who has ADHD."***

> ***"I think that's why cumulatively, it's overwhelming to navigate the healthcare system. I will say that being neurodivergent, or if you're specifically ADHD, or if your executive dysfunction is heightened, it's impossible to try to follow all these steps to go and get the care you need."***

> ***"A lot of times the autistic side of me does not show up when I get tested [because] if that shows I'm the angry Black woman. I do not have the luxury of being able to be angry. I will be considered reactive... So a lot of times I'm prepping, I'm doing the math for potential interactions that can make me uncomfortable. And I'm practicing on my bed. "Oh, this is what we do. This is how we move. This is what we say." But when it deviates from the plan in my head, it becomes so overwhelming. So, so, so overwhelming. And I think it applies to a lot of people of colour that are neurodiverse. A lot. You don't have the luxury of being able to be neurodiverse."***

Sexism

Participants described feeling judged or dismissed by healthcare providers because of gendered assumptions about their sexual behavior or morality. Women and femme-presenting participants, in particular, reported being spoken to condescendingly or having their symptoms minimized.

> ***"Being a woman in general, I find sometimes that can be a bit of a barrier when it comes to accessing healthcare... More so just not being taken as seriously... being a woman and thinking about all these sexual healthcare things, it was more just pushed aside, if that makes sense."***

Transphobia and transmisogyny

In their experiences of chlamydia related healthcare, trans and non-binary participants reported being misgendered, called by the wrong name, or having their gender identity treated as irrelevant or a burden to staff. These experiences caused lasting emotional harm and often deterred people from returning for care.

> ***"I also have a nurse who works in his clinic and she has been a bit transphobic towards me throughout the years, constantly asking if I want to change my mind, pushing for me to go on birth control instead of hormone blockers and those kinds of things. So like there is kind of that constant fight that you have to combat unfortunately."***

Impact of compounded barriers on participants' mental health

For participants living at multiple intersections of marginalization, discrimination and burnout within the system compounded every barrier to care. Participants shared that repeated experiences of discrimination, misgendering, and dismissal in healthcare settings were emotionally taxing and created lasting anxiety and mistrust leading some to avoid care entirely. For some, even thinking about booking an appointment could trigger stress or fear of being retraumatized.

> ***"Sometimes when having bouts of low mood or just straight-up depression, it would really prevent me from going to these healthcare services because it would just be even more emotional burden on me at the end of the day. I don't want the physical burden of potentially having an STI and then having that mental trauma [at the doctor's office], so I would choose one in that case."***

These experiences of oppression were profound, but they were not the end of the story. Despite the weight of these intersecting forms of discrimination, participants did not meet these challenges passively. Even as participants described the emotional and systemic toll of discrimination within healthcare, they also spoke about the ways they resisted, adapted, and found support beyond clinical settings.

Coping in community

Resilience despite barriers

Even in the face of systemic neglect, participants demonstrated deep resilience by turning to community care networks, personal research and self-advocacy as well as cultural teachings to fill the gaps left by formal healthcare. They described learning, adapting, and advocating for themselves when institutions failed them.

> ***"It gets to a point where I have to tell myself: if I want to get myself checked out, I'm not here for them. I'm here for me. I'm here for my partners... Not my health alone, I'm here for their health too. So, suck it up. Just suck it up. It won't take that long. Just get through."***

Importance of culturally relevant, queer-affirming providers

When participants encountered providers who respected their gender, culture, and sexuality, they felt seen, supported, and safe. They emphasized that culturally relevant and queer-affirming care isn't "extra" – it's essential to equitable health access and mental well-being.

> ***"I would recommend healthcare providers to have clear and inclusive language for non-binary and trans folk ... healthcare providers have to understand that they may be meeting people from my community without them saying that [i.e., disclosing their gender identity]. I think that there may be fear of discrimination or stigma behind making decisions to fully trust the healthcare provider [and] part of the healthcare system's role has to be to overcome that stigma and make sure that there's a confidential safe space for people to discuss their health needs."***

Role of community

Participants described their communities, both local and online, as sources of strength, solidarity, and life-saving information. Talking openly about STBBI testing, sexuality, and care helped to reduce stigma and build mutual trust.

> ***"I had community around. I had people to ask around things. It was more like there was a lot of community care happening. I could ask pretty much any question that I had to people around me, and someone had a resource for something."***

> ***"That's when I turned to community. I also turned to the internet. Reddit is a place that I really turn to, for better or for worse... It is quite a resourceful space where you can sift through some of the chaos and get to real good pieces of information around anecdotal experiences of people who've been on it, sharing the symptoms, sharing... any side effects and stuff like that."***

> ***"I grew up actively involved in my community. I spent a lot of time around our Elders and our aunties... So I kind of had that support from them. They didn't understand half of it, but, you know, they tried and, you know, but having that experience of having them in my life was definitely helpful.***

These stories revealed not only the harms of oppression but the powerful ways they turned to community and self-advocacy to navigate a system not built for them and to care for themselves and each other. These experiences show that community care often stepped in where formal healthcare failed.

In sum, participants' experiences illustrated how gaps in information, discrimination within healthcare, and the need for culturally grounded community support all shaped their chlamydia testing and care journeys. Taken together, these stories reveal a landscape in which participants navigated misinformation, systemic discrimination, and deep reliance on community care to meet their sexual health needs. Yet participants also identified clear pathways for change. Alongside the challenges, participants offered concrete recommendations for improving sexual healthcare. These recommendations to strengthen access, safety, and affirming care (directed toward healthcare providers and community members alike) are presented in the following section.

Key Recommendations

In response to the barriers and harms they experienced, participants offered thoughtful and actionable recommendations to improve access to sexual healthcare. Their guidance reflects both the changes needed within healthcare systems and the strengths that already exist within communities, outlining pathways toward safer, more affirming, and more accessible chlamydia care.

For healthcare providers

Drawing from their lived experiences, participants outlined what meaningful, affirming care should look like and identified several concrete actions that healthcare providers can take to make chlamydia testing specifically and sexual healthcare generally safer, more respectful, and more accessible. Their recommendations focus on building culturally-safe environments, improving 2S/LBTQ+ competency, and adopting trauma-informed practices that acknowledge the diverse realities of patients' lives. Their recommendations highlight the need for approaches that prioritize dignity, autonomy, and emotional safety.

Cultural Safety

Participants called for healthcare spaces where cultural identity is respected, not questioned or erased. They emphasized that cultural safety means understanding the histories and lived experiences of Indigenous, Black, and racialized communities. Not treating everyone "the same," but treating everyone with care and respect.

> ***"I'm Black [and] you are creating an environment where generational fear of the healthcare system is perpetuated. Because if I have a child, how do you expect me to tell them to trust the healthcare system, especially in sexual health, when I do not have a positive experience that they can identify with, that I do not logically see getting better anytime soon? I can hope, but there's the reality of what it is. So sometimes it's not just me impacted, it's families... this is why we do not like the medical system... And then that is how so many things go undiagnosed, because then there will be some people that will not be able to push past that fear... But was the environment safe enough for them to feel that this is something they can walk in with?"***

2S/LBTQ+ health training

Participants urged that all providers, not just those in sexual health clinics, receive meaningful training in 2S/LBTQ+ health. This includes using correct pronouns, understanding diverse sexual practices, and avoiding harmful assumptions about gender and sexuality.

> ***"It's really important to get education and training around working with queer folks, terminology questions, how to approach asking about [sexual and romantic] partnership. It's not just like 'cis het regular' the world that we live in... So to approach without judgment because it's not about them, it's about us and about care. I think that's really important. To consistently or continuously keep learning and educating... Not everyone is aware and could keep up, especially when you're not part of the community, and that's very much okay. But what's not okay is not taking the time and the onus to learn, if you're going to be providing care for people."***

Trauma-informed care

Participants emphasized the need for trauma-informed approaches that centre empathy, consent, and emotional safety. For many survivors of violence or discrimination, medical exams and testing can be triggering; being believed, asked for consent, and treated gently makes a profound difference.

> ***"For me, it's specifically around bedside manner that, like, shockingly, a lot of healthcare providers in Ontario do not have. They could really use a refresher ... it's not routine... it's not just another day for patients. And I think the sterile apathy with which doctors deal with patients is just very appalling, and frustrating and sometimes traumatizing. So I feel like, yeah, just bedside manner and also just ongoing consent throughout the testing process or diagnosis process is really important. And also for any hands-on things, describing what you're doing as you're doing it... I've said this ten thousand times in ten thousand places, but actually believe patients. Whatever they're saying or suspecting, give it the attention that it deserves."***

> ***"I just need individuals to know that when I'm coming in, I'm nervous to come in. So, when you see me nervous, I'm fidgeting and so forth. Take that as in 'Okay, this person is nervous. Let's be gentle with them.' ... Just ask simple questions, but take it slow, because, like, if you ask me too many questions... my anxiety starts acting up and I can't handle that and my ADHD. So, it's like just compassion again, right? Take it slow. And just like, you know, breathe. Let that person breathe ... Let me just calm down a second and then answer your questions and then like go from there, you know? And then if I'm asking you questions, don't ignore me. Look at me because you have two eyes, like I have two eyes and look at me and talk to me. Don't look at your computer... No, have a conversation because I'm also human."***

For communities

Alongside recommendations for healthcare providers, participants emphasized the power of community-led strategies and identified ways that communities can strengthen sexual healthcare access from within. They highlighted the importance of mutual support, collective learning, and developing self-advocacy skills as essential tools for self-empowerment in navigating a system that often fails to meet their needs.

Strengthen peer networks and knowledge-sharing

Participants celebrated the power of their communities to fill the gaps left by the healthcare system. Peer support, mutual aid, and community-led education were seen as critical for sharing accurate information, building resilience, and reducing shame around sexual health.

> ***"I had a lot of comfort in the friend that I told because, like, she had also gone through, like, the same thing. And so, she was clearly, like, there to be a support and, like, not judgmental at all. So, I did really appreciate that."***

> ***"That's how I've had support because I do have friends who either work for [or] they're associated with [sexual health] organizations. So, without that knowledge, I wouldn't have known half of what I know. So, yeah, the community has been very helpful in that way."***

> ***"My friend told me about that [PrEP], actually, the gay male friend that I had. I never knew about that. And I remember when he told me about that for the first time. My mind was, I'm not kidding, it was blown. Honestly, that there's actually solutions to things because I was never taught that there were solutions. So if it's solution-based and it's compassion-based, I think that really helps people."***

Importance of self-advocacy

Participants stressed that while systems need to change, individuals also need tools to navigate those systems as they are now. Self-advocacy training, especially for young people, newcomers, and trans folks, can help people feel more confident asking questions, asserting boundaries, and demanding fair treatment.

> ***"You got to help yourself. No one's going to help you. You got to help yourself... You have to help yourself, advocate for yourself."***

> ***"Honestly, just advocate, advocate, advocate for yourself... Don't let them persuade you into not getting the help that you need or that you want... Don't let them talk you out of care. Yeah, don't let them talk you out of care."***

To learn more about participants' experiences of self-advocacy and their advice for community members, see **Reclaiming Autonomy: A Community Outlook**, an adjacent specific report from this project by Community Advisory Board member Oghenetega Ubor.

Together, these recommendations highlight the concrete changes participants believe are necessary to improve chlamydia care by emphasizing dignity, safety, cultural relevance, and community support as essential pillars of equitable care. Building on these insights, participants also described what an ideal testing experience would look like by offering a vision of care that is accessible, respectful, and supportive. The next section outlines these ideal testing experiences, offering a roadmap for what truly affirming sexual healthcare could look like.

The ideal testing experience

Across the interviews, when participants were asked how they would ideally like to receive chlamydia care, several common elements consistently emerged as people envisioned accessible, affirming, and informative sexual healthcare experiences. They wanted testing that was nonjudgmental, offered clear information and next steps, and took place in safe, inclusive environments. Many stressed the need for privacy and flexibility, such as options for self-sampling or community-based drop-in testing, and valued compassionate, unrushed care that recognized the emotional aspects of testing. A recurring theme was that the "ideal" experience would normalize STBBI care by making it routine, informative, and shame-free, while ensuring patients felt respected and empowered rather than anxious or judged.

> ***"Getting information beforehand would be amazing. Knowing how to prepare for it, knowing what questions you want to ask, going into it and then asking all those questions, kind of being told like what the next steps are before just saying, 'Wait for your results.' Like 'Oh, you'll get a call. And these are the things it could be. And if it's any of these [STBBIs], this is how we treat it. Super easy. Don't worry.' And then yeah, when you get the information that, you know, you're going to be on antibiotics, maybe just explain a little bit more about what that means. And yeah, just more information in general and a little more compassion."***

Discussion

Ultimately, participants' experiences reveal that the barriers they encountered when seeking chlamydia care are neither isolated nor accidental but are patterned expressions of broader inequities embedded throughout sexual healthcare systems. The findings echo long-standing evidence that intersecting forms of oppression and marginalization are not confined to any one clinical encounter or diagnosis; rather, they shape the entire landscape of healthcare access for IBPOC, disabled, 2S/LBTQ+ women and gender-diverse communities. Participants consistently described how these oppressions accumulate over time and across contexts, producing emotional strain, mistrust, and ongoing fear of harm.

From an intersectional feminist perspective, the weight of these barriers is particularly profound because participants live at the crossroads of multiple systems of oppression. Their stories illustrate how race, gender, sexuality and disability interact to constrain access to information, safe environments, and respectful treatment. This intersectionality deepens the stakes of sexual healthcare encounters: a moment of dismissal or misgendering is not simply a poor interaction, but part of a larger pattern of exclusion that has historical and intergenerational dimensions. Participants' narratives make clear that chlamydia testing becomes difficult not because the procedure itself is complex, but because the systems surrounding it were not built with them in mind.

The findings also affirm insights from disability justice, which frames access not as an individual problem but a collective responsibility. Participants described how inaccessible processes, desexualizing assumptions, and failures in consent reproduce structural ableism within sexual healthcare. These dynamics not only undermine disabled people's autonomy and dignity, but also create missed opportunities for early detection, prevention, and holistic well-being. When healthcare systems fail to anticipate diverse access needs, they place the burden of adaptation on the very people experiencing harm.

Similarly, wholistic Indigenous and community-centered paradigms emphasize that health is relational meaning it is not only physical, but emotional, cultural, and social. Participants described the profound role of community care networks, aunties and Elders, queer kinship, and peer education in sustaining their sexual health in the absence of reliable formal care. These relational practices counteracted institutional neglect and offered spaces where dignity and safety could be restored. Community support was not merely supplemental; it filled critical gaps left by the healthcare system, often functioning as the primary site of accessible sexual health knowledge. Findings specific to experiences of Indigenous participants are presented in a separate **report available online**.

Taken together, the results point to a series of missed opportunities for care. Providers often had the chance to offer reassurance, accurate information, trauma-informed support, or culturally safe communication but these moments frequently passed unrecognized or unmet. Participants were left to navigate care alone, absorbing the emotional and practical burdens created by systemic failures. These missed opportunities are consequential: they deter people from returning for testing, delay treatment, and erode the foundational trust on which public health depends.

Yet, the findings also demonstrate that meaningful transformation is possible. Participants articulated clear pathways toward safer and more affirming care – rooted in cultural humility, queer and trans literacy, disability-informed practice, and trauma-aware relationality. Their visions of the ideal testing experience offer a roadmap for what sexual healthcare could become when approached as a site of dignity, not judgment; empowerment, not surveillance; and healing, not harm.

Ultimately, this research shows that sexual healthcare cannot be disentangled from the intersecting structures of power that shape people's lives. Addressing inequities in chlamydia testing and treatment requires not only technical improvements, but a reorientation toward justice: systems that listen deeply, honour lived experience, and are accountable to the communities they intend to serve.

Study Limitations

While this research offered valuable insights into how 2S/LBTQ+ people in Ontario experience chlamydia healthcare, it is important to recognize its limitations.

Our findings are based on interviews with 23 participants, which means that while the themes highlight real and meaningful experiences, they do not represent all communities or perspectives. In particular, despite efforts to recruit participants from these communities, our sample did not include newcomers to Canada, Francophones living in Ontario, or Deaf and Hard of Hearing participants. For example, we worked with the interpretation team at **Asign** to create recruitment videos in American Sign Language (ASL) and Langue des Signes Québécoise (LSQ), but despite these efforts, we were unable to connect with participants from those communities.

Similarly, most participants lived in urban areas, particularly larger cities in Ontario. This means that the perspectives of people living in rural or remote areas are underrepresented. We recognize that people in smaller or northern communities may face additional and specific barriers to accessing culturally safe, gender-affirming, and trauma-informed sexual healthcare. Such gaps reflect the limits of our own networks and reach and should be addressed in future community-based research.

All interviews were conducted on an online Zoom platform, which limited the ability to build rapport in the ways that in-person interviews sometimes allow. Despite strategies used to support connection and accessibility, we may have missed some nuance, particularly non-verbal cues and other aspects of interaction more easily observed in shared physical spaces. At the same time, conducting interviews online enabled broader geographic reach and allowed participants to take part from environments where they felt safer and more comfortable, such as their homes. This flexibility may have reduced barriers to participation for some individuals, even as the physical distance inherent to virtual interviews introduced its own limitations.

Finally, because all interviews were conducted with people living in Ontario, participants' accounts reflect how structures of power, oppression, and institutional practices within this specific healthcare context shaped their access to chlamydia testing and care. These findings do not aim to be statistically generalizable, but instead offer rich insights into how systemic forces are experienced in everyday healthcare encounters. While the recommendations that emerge from this work speak to shared structural issues, their implementation will necessarily need to be tailored to the unique healthcare landscapes, policies, and community needs of different regions, including across Ontario and in other provincial or territorial contexts.

Despite these limitations, this study provides important, community-grounded evidence about how sexual healthcare systems are experienced by IBPOC, disabled, 2S/LBTQ+ women and gender-diverse people in Ontario.

Conclusion

Across interviews, participants made it clear: the barriers they faced in accessing chlamydia-related care are not specific to chlamydia, but present in many experiences with sexual healthcare in general. These barriers were also not only individual failings but systemic ones. When healthcare environments remained inaccessible, discriminatory, or uninformed about the realities lived by 2S/LBTQ+, IBPOC, disabled, neurodivergent women and gender-diverse communities, they reproduced harm and deepened mistrust ultimately leading to people avoiding seeking out care.

Participants described many missed opportunities for providers to offer reassurance, clear information, compassion, or culturally safe communication; moments that, when absent, shaped whether they felt able to return. Yet participants also demonstrated resilience through teaching themselves, supporting each other, and continuing to seek care despite repeated exclusion.

The findings of *We Deserve Chlamydia Care* highlight both the urgency and the possibility of change. Cultural safety, trauma-informed practice, and meaningful 2S/LBTQ+ training are not optional add-ons; they are the foundation of ethical and effective care. Two-Spirit and Indigiqueer participants additionally emphasized the need for consent-based, culturally grounded care that honours Indigenous understandings of wellness. Across the study, participants also outlined what affirming care should look like through their visions of an ideal testing experience that is routine, shame-free, informed, private, flexible, and grounded in dignity. Healthcare systems must move beyond token inclusion toward genuine accountability to the communities they serve, and toward models of care that honour consent, autonomy, and emotional safety.

This report is both a record and a call to action: to listen to the expertise of lived experience (including the knowledge carried by Two-Spirit communities), to build systems grounded in respect and justice, and to ensure that every person, regardless of cultural identity, race, gender, sexual orientation or ability, can access sexual healthcare without fear or shame. The future of equitable sexual healthcare depends on it.

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