# TWO SPIRIT PEOPLES' EXPERIENCES ACCESSING AND RECEIVING CARE IN COMMUNITY PHARMACIES

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By

MARISSA PIRLOT

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# ABSTRACT

Two Spirit Peoples (a term used by some Indigenous Peoples to encompass diverse gender and sexual identities) face unique challenges in accessing and receiving healthcare in Canada due to health services, including community pharmacy services, being built on hetero- and cis-normative models that impede appropriate care for Two Spirit Peoples. They are more likely to experience mental health disorders such as anxiety, depression, substance use disorders, and are at a higher risk of suicide. The aforementioned prejudices present within the healthcare system produce significant barriers to accessing and receiving appropriate care for Two Spirit Peoples. Coupled with a lack of representation and lack of programming, these issues have resulted in a lack of awareness and understanding of the obstacles faced by Two Spirit individuals in the Canadian healthcare system. Currently there is no published information on Two Spirit Peoples' experiences accessing and receiving care in community pharmacy settings. To address the lack of published information on this topic, 21 Two Spirit individuals were asked to share their experiences and knowledge in a focus group setting. Four different focus groups were held with Two Spirit individuals residing in various locations across Canada including one in Saskatoon for the Prairies-area and one each in Vancouver, Edmonton, and Toronto. Informed by Indigenous Methodologies, data was recorded via audio-recording and notetaking. The audio was transcribed and then analyzed for themes using the Voice-Centred Relational Method. Findings suggest that there are three major structural systems that affect the experiences of Two Spirit Peoples in community pharmacies. These systems include white supremacy, capitalism, and heteronormativity. These three systemic issues presented themselves in the form of racism, homophobia, transphobia, pharmacists' lack of knowledge about Two Spirit individuals and their health, and lack of time spent educating or building a relationship with this group of people. In addition to sharing knowledge about their experiences in community pharmacies, the participants provided suggestions for how community pharmacists can better serve the Two Spirit community. The results suggest that dismantling the current structures and ideology in community pharmacy and society needs to happen to overcome these issues.

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# DEDICATION

*This project is dedicated to the Two Spirit participants, Elders, and others whom I got to work with throughout this study.*

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# LIST OF ABBREVIATIONS

**2SLGBTQQIA+:** Two Spirit, Lesbian, Gay, Trans, Queer, Questioning, Intersex, Asexual, and additional sexual and gender orientations

**AFN:** Assembly of First Nations

**AIDS:** Acquired Immune Deficiency Syndrome

**ARVs:** Antiretrovirals

**CBRC:** Community Based Research Centre

**CHASR:** Canadian Hub for Applied and Social Research

**COVID-19:** Coronavirus disease of 2019

**HIV:** Human Immunodeficiency Viruses

**HRT:** Hormone Replacement Therapy

**NAPRA:** National Association of Pharmacy Regulatory Authorities

**NIHB:** Non-Insured Health Benefits

**NIMMIWG**: National Inquiry into Missing and Murdered Indigenous Women and Girls

**PrEP:** Pre-Exposure Prophylaxis

**STI:** Sexually Transmitted Infection

# CHAPTER 1: INTRODUCTION

Two Spirit Peoples experience health inequities due to homophobia, transphobia, heteronormativity, and racism embedded in the Canadian healthcare system because of colonization (Czyzewski, 2011; Gebhard et al., 2022; Hunt, 2016; Hunt & Holmes, 2015; National Aboriginal Health Organization, 2021; Reading & Wien, 2009). They are more likely to experience mental health disorders such as anxiety, depression, and substance use disorder, and are at a higher risk of suicide (Fieland et al., 2007; Hunt, 2016; Lyons et al., 2016). The aforementioned prejudices present within the healthcare system produce significant barriers to accessing and receiving appropriate care for Two Spirit Peoples (Casey, 2019; Hunt, 2016; Lehavot et al., 2010; Lorenzetti et al., 2017). Coupled with a lack of representation and programming, these issues have resulted in poor awareness and understanding of the obstacles faced by Two Spirit individuals in the Canadian healthcare system (Casey, 2019; Hunt, 2016; National Aboriginal Health Organization, 2021). It is imperative that the perspectives and knowledge Two Spirit Peoples hold are centred in processes that seek to inform positive change and greater inclusivity in Canada's healthcare system. Currently, there is no published research on Two Spirit Peoples' experiences and opinions on accessing healthcare in community pharmacy settings, nor on the extent of community pharmacists' knowledge of or experiences with Two Spirit individuals. Pharmacists are the most accessible healthcare professionals and are often considered the most trustworthy by the general public (Murphy, 2020; Proulx, 2017), but whether that is the case for the Two Spirit community has yet to be explored. Community pharmacies should be places that are accessible, have knowledgeable healthcare providers, and facilitate a space to create meaningful relationships between patients and healthcare providers. It should be noted that this project is looking at community pharmacy as a system rather than looking at individual pharmacists.

In addition to the lack of published literature on Two Spirit Peoples' experiences within community pharmacy settings, pharmacy education in Canada is focused solely on the biomedical model of health (from here on referred to as "Western"). Yet pharmacy students are never made aware of this incomplete and colonized curriculum (Swidrovich, 2020). Content taught in pharmacy education is presented as *the* way of healing. The lack of Indigenous representation in pharmacy practice and education results in current and future pharmacy

professionals being unaware and insensitive to the unique cultural ways of healing for many Indigenous Peoples (Swidrovich, 2020). It is essential that pharmacy professionals are well equipped to care for Indigenous Peoples as Western society has created a system in which Indigenous Peoples have been made vulnerable because of the systems put in place that ultimately harm Indigenous Peoples. As Swidrovich (2020) states, it is Western knowledge and medicines that are the foundation of pharmacy education in Canada, meanwhile, the ways of healing and the medicines that come from the land that pharmacy schools are sitting on, are labelled and taught as Complementary and Alternative Medicines. Given that Western knowledge is dominating Canadian pharmacy school discourse, it is necessary for there to be educational opportunities for pharmacy professionals to engage with Indigenous Knowledges and stories, even if for right now that means post-licensure education only. Although this work primarily looks at Western or Indigenous ways of healing and worldviews, it should also be noted that there are more ways of healing than these two. Additionally, it is not the intent of this writing to imply or reify a binary between these two systems.

Lastly, I want to bring forth this quotation from Hunt (2016) in which she states, "There is a need for research and policy which includes Two Spirit [P]eoples' perspectives on issues of gender-based violence, access to housing, education, health care and many other social determinants of health." (p.13). It is in healthcare research that this project aims to answer one of the requirements to address Two Spirit health that Hunt calls for. Additionally, Hunt (2016) notes that Two Spirit voices need to be central and need to be informing health proposals and/or plans for Two Spirit Peoples which is why this project aims to elevate Two Spirit voices.

### 1.1 Two Spirit

Two Spirit is a term that some Indigenous "queer" people use to describe themselves (Lezard et al., 2021). By "queer," I am referring to what may be considered queer in a Western worldview. This may include anyone who is not heterosexual or cisgender or anyone who has varying roles and expressions (Lezard et al., 2021). The term "Two Spirit" is not a universal term across Indigenous cultures and has changed over time (Robinson, 2017; Wilson, 1996). Two Spirit could be used by Indigenous individuals to describe their gender or their sexual orientation; however, this does not mean that the term Two Spirit needs to describe gender or sexual orientation. And for some, a Two Spirit identity or descriptor goes beyond gender or sexual orientation. For example, A. Wilson (2008) describes Two Spirit as finding oneself in

their cultural roles. This example helps show the complexity of cultures and languages which I will discuss further in the Language section of this introduction. Ultimately, the term Two Spirit doesn't fully capture what it means to be Two Spirit and the complexities that come with being Two Spirit (Robinson, 2017). Two Spirit is more than sexuality or having both a masculine and feminine spirit; it is relationships and community (Bowers & Paul, 2019). Two Spirit is about breaking down the gender binary and other binaries as well. I plan to ensure my writing, speech, and actions move away from the binary ideology that is entrenched in Canada. It is important to acknowledge that one's being is fluid and continually changing, so ascribing a rigid term or definition to a person is not realistic (Bowers & Paul, 2019).

I also want to consider that one of the traditional roles that Two Spirit Peoples held, and still hold, is medicine keepers (Bowers & Paul, 2019). The medicine keeper role of a Two Spirit individual is important to think about as this project is focused on these medicine keepers' experiences with Western medicines and the ways in which Western medicine forced its way into "Canada", like the colonizing force it is.

### 1.2 Colonization

What the Western world views to be true about sex, gender, and sexuality is a result of colonization (Hunt, 2016). Colonization has had, and continues to have, a profoundly negative effect on Indigenous Peoples and is considered the main determinant of health for Indigenous Peoples (Assembly of First Nations, 2013; Greenwood, de Leeuw, & Lindsay, 2018). Residential schools and the 60s Scoop aimed to erase gender and sexual diversity, mainly through Christian indoctrination (Ristock et al., 2019; Sinclair, 2007). As such, white colonizers (and some Indigenous Peoples because of colonization) predominantly have homophobic and heteropatriarchal views. The colonial ideologies practiced have resulted in fewer Indigenous People over time (Hunt, 2018). An example of this erasure of Indigenous Peoples is through the law that status Indian women will become "disenfranchised through marriage to non-status men" (Hunt, 2016, p. 24).

Ultimately, colonizers, through "categorization," aimed to completely erase Two Spirit and trans people through the strict gender binary (Hunt, 2018). Hunt (2018) describes categorization as a tool used by colonizers to impose their worldviews over Indigenous worldviews. She goes on to describe how generations of this indoctrination have resulted in a predominant society in which it is hard to question the gender binary or even think outside of it.

As such, Two Spirit individuals likely face some of the most negative effects of colonization, but because of the lack of research on this topic, it is difficult to measure the extent of the effects. Additionally, while there are many Indigenous languages that have words to express varying genders, sexualities, and sexes, the loss of language through colonization has negatively impacted many Indigenous understandings of the varying genders, sexualities, sexes, etc. (Lezard et al., 2021; Robinson, 2020).

Due to the deeply ingrained homophobic, transphobic, and patriarchal ideology in Canada, it is not a surprise that healthcare professionals predominantly hold these views as well. For this reason, it is vital that healthcare programs take a decolonial approach (Hunt, 2016). Specifically, for this project, Two Spirit voices will be included and centred in all levels of anticipated healthcare programming. There can be no decisions made about Two Spirit individuals and their health without having those decisions come from Two Spirit voices.

In pre-contact times, many Indigenous cultures did not uphold heteronormativity but rather they embraced the varying sexualities and diverseness of sexuality (Hunt, 2018). Similarly, there was no gender binary prior to contact thus gender and sex were fluid concepts (Hunt, 2016). Colonization has created a society that values and upholds homophobia, transphobia, and patriarchal ideologies to the extent that we sometimes cannot comprehend anything outside of these views. It is important to realize this issue because it helps to guide the project, and it helps me to see that there are concepts and words that I will not be familiar with. It is necessary to be aware that there are various worldviews that Indigenous Peoples hold that may and will be different from Western worldviews, and it is essential that Two Spirit Peoples' worldviews are valued and visible. Hunt (2016) notes that “Rates of suicide go down if Two Spirit are connected to their cultures and traditions” (p. 17). This is another reason why it was necessary for Two Spirit voices to be at the center of this research project; they are the ones who know what will be beneficial and helpful to their health and wellness.

### 1.3 Language

I want to focus on language as it is an important piece of human connection and interaction. There is a theory, the Linguistic Relativity Hypothesis, that suggests that “the structure of anyone’s native language strongly influences or fully determines the world-view [they] will acquire as [they] learn the language” (Kay & Willet, 1984). It goes on to suggest that language has the ability to guide what we take to be real and the truth (Kay & Willet, 1984). This

is something important to keep in mind as white people, including myself, begin to unlearn the harmful ways that we exist with Two Spirit Peoples. I will share an example of the importance of language that was presented in Dr. Alex Wilson's *N'tacimowin inna nah' Our Coming In Stories* (A. Wilson, 2008).

Wilson explains that there is "no word for homosexual and no gender specific pronouns" in her Swampy Cree dialect (A. Wilson, 2008, p. 193). The Swampy Cree dialect has a categorization system in which there are animate and inanimate things with everything animate being "spiritually meaningful" (A. Wilson, 2008, p. 193). The way that I was taught to understand the world based on a binary English language is fundamentally different from the Swampy Cree dialect and worldview. Another example, expressed by S. Wilson (2008), that demonstrates the ways that dialect influences thought is when he describes the relational nature of the Cree language. Shawn explains that a chair is "the thing that you sit on" and kookoom is "*my* grandmother" or "*your* grandmother", but never grandmother. This shows that relationships are what makes something what it is (S. Wilson, 2008). Another example of this is found in the Mi'kmaq language. The language describes what people do (e.g., "he chases men") rather than describing who they are (Bowers & Paul, 2019, p. 46). The terminology in English focuses on the person/identity as a noun rather than the relationships that that person holds which may not be all that helpful (Bowers & Paul, 2019). This concept of being made up of relationships will be discussed further in the Methodology and Methods.

Many of the Indigenous languages (over 160) have words for Two Spirit Peoples that encompass not only gender and sexuality but also culture and spirituality and roles (Hunt, 2018; Robinson, 2020). For example, a Mohawk Two Spirit person may like to be identified as *Onón:wat*, which roughly translates to "I have the pattern of Two Spirits inside my body" (OUTSaskatoon, 2021). I think that this is important to know because it reinforces how the different ideologies can be found within the different languages. It is also important to show how an English-speaking person may potentially be completely naïve to the varying genders and sexualities and identities that exist. And lastly, it is important to recognize that languages, like people, change with time, and we need to make room for new ideas, words, and identities as nothing is static (Lezard et al., 2021).

### 1.4 Healthcare System

Two Spirit health is impacted by the societal and healthcare "exclusion of gender and sexually diverse peoples, as well as homophobia and heterosexism amongst front-line healthcare practitioners" (Hunt, 2016, p. 23). Additionally, due to the gender-based nature of some programs for Indigenous Peoples, Two Spirit individuals may be left out of these programs. There are many intersecting factors that affect Two Spirit People, which may include historical trauma, race, gender, and sexuality amongst others which need to be included when looking at the unique health needs of Two Spirit individuals.

There is an invisibility of Two Spirit health and wellness in healthcare. There is a lack of focus on this specific group of people, a lack of statistical data, and a lack of actively pursuing this data as well (Casey, 2019; Hunt, 2016). For example, healthcare research on Indigenous Peoples' health does not include Two Spirit health as a separate group (Hunt, 2016). This leads to invisibility and further harm to Two Spirit Peoples. Due to invisibility, lack of programming, and -phobias and -isms amongst healthcare professionals, Two Spirit Peoples are faced with barriers when it comes to accessing services for their health and wellness such as for mental health, addictions, or harm reduction (Hunt, 2016). In response to these barriers and downfalls, there must be programs created that are, as Hunt (2016) explains, "culturally relevant, inclusive of non-binary gender identities, and not structured around heteronormative models" (p. 23). One of the goals of this project is to increase the health and wellness of Two Spirit individuals, and the ideas, strategies, programs, and/or education to achieve this will come from the Two Spirit participants. As (Hunt, 2016) states, "Two Spirit voices, needs, and identities need to be at the center of any Two Spirit health initiative" (p. 25).

The last point I want to touch on is the paternalistic ways Western healthcare workers act toward Indigenous Peoples (Gebhard et al., 2022). In the edited book *White Benevolence: racism and colonial violence in the helping professions*, the authors demonstrate the various ways that helping professions, such as healthcare and pharmacy, are implicit in continually harming Indigenous Peoples, even if they think they are being helpful (Gebhard et al., 2022). I think that this concept is of utmost importance in this research as pharmacists may currently think that they are being helpful when they may be acting in harmful ways. This idea is critical for pharmacists to realize as there is this belief and assumption of non-maleficence (i.e., that healthcare professionals are doing no harm).

### 1.5 Education

Another key goal for this project is educating pharmacy professionals about Two Spirit Peoples and making Two Spirit Peoples more visible in the healthcare field. The information and education that will be shared with pharmacy professionals will come directly from Two Spirit individuals. As Hunt (2016) has said, "Education and affirmation of Two Spirit roles and identities is inherent to improving the health of Two Spirit [P]eople" (p. 12), which is why bringing the stories and knowledge shared within the focus groups to the pharmacy community, and broader healthcare community, will help to improve Two Spirit Peoples' health. Similarly, the Assembly of First Nations (2013) emphasizes that a necessary step to reducing the stigma and discrimination that Two Spirit Peoples face is to educate people about the traditional community roles of Two Spirit Peoples have held and still hold.

As mentioned previously, there has been an erasure of Two Spirit People from health research due to the strict gender binary which forces Two Spirit People to choose only one of two genders (Hunt, 2016). Health initiatives should focus on being inclusive of Indigeneity and queerness. An initiative as simple as using non-gendered language would be a step toward creating an environment that is safe and more welcoming for Two Spirit individuals. As Hunt (2016) states, the programming put in place does not necessarily have to be exclusively focused on Two Spirit individuals as "queering" and "decolonizing" programs in healthcare will help to create positive experiences for Two Spirit individuals accessing and receiving care. Hunt and colleagues (In Press) describe the need to normalize various genders and sexualities to create a shift in the dominant heteropatriarchal worldview. By doing this research and mobilizing the knowledge and stories, we take one step in the direction of normalizing diversity.

### 1.6 Considerations

The foundations of this research come from a variety of Indigenous scholars. One lens that I viewed this research through was the "holographic epistemology" idea as described by Dr. Manu Meyer (Meyer, 2013). Meyer describes how knowledge comes from the body, mind, and spirit, and it is through these three modes that we come to know and understand things. This concept is important in this project because we are looking at not only the experiences of Two Spirit folx in community pharmacies but the experiences and how they affect the body, mind, and spirit. For example, we need to be aware to look for more than just physical barriers when it comes to accessing a pharmacy. We need to look at the ways that racism, homophobia,

transphobia, etc. play into creating barriers, and the ways that holding a Western worldview as superior to others creates barriers.

This concept of the "holographic epistemology" is also important to frame the research itself. This concept is about breaking down science's rigid walls and structures and allowing for qualitative, quantitative, and beyond to work together to answer questions (Meyer, 2013). It is focused on dismantling the false hierarchy that is in science about what disciplines or methods are more valid than others. We must accept that the body, mind, and spirit are all necessary and rely upon each other to solve problems, understand things, and move forward.

### 1.7 Positionality

I come from a small rural town in the southeast area of Saskatchewan. I was born in Redvers and raised on a nearby farm located on Treaty 2 territory. My mom is from a farm near Weyburn, Saskatchewan, on Treaty 4 territory, and my dad is from the farm I grew up on. My grandmother on my dad's side immigrated to Canada from Norway in 1958 when she was 17 years old and, my grandfather on my dad's side was born in his family's barn on Treaty 2 territory. My grandparents on my mom's side were both born and raised in Weyburn. I spent my childhood learning from my mom about plants and gardening while my dad would teach me about soil. I developed a connection with the Earth from a young age, and I continue to develop my relationship with her as I move through my life. The land has always been an important part of my life, and as I learned and unlearned throughout this project, I became aware that this land I am working, living, and playing on is stolen land. And the only reason I am able to be here today is because of the treaties that were signed. As I work and live on this stolen land, I want to give back to the Indigenous Peoples as much as I can, in this project and in my life in general.

I would like to state, without a doubt, that I come from a very privileged place. My whiteness, cis-genderedness, and able-bodiedness have allowed me to go through much of my life without discrimination. I speak English as my only language which has afforded me the luxury of not having to navigate an English-dominant society through a different primary language. All these factors have created a place where I am, most of the time, comfortable. Being a lesbian woman who does not fit the societal expectations of what a woman should look like, I have faced, and continue to face, homophobia and sexism. This is where my passion for 2SLGBTQQIA+ health comes from. Additionally, due to the clear lack of Indigenous education in my pharmacy schooling career, I felt that I was missing something very important. In my

fourth year of pharmacy school, Dr. Jaris Swidrovich, was teaching our class about the therapeutics of pain, and he introduced the topic by saying that what we would learn is the Western way to treat pain. This was a pivotal moment for me. Here I was in my last year of pharmacy school, and I had not heard that said before. When I heard that Jaris was looking for graduate students, I knew that this would be an opportunity for me to not only learn but to unlearn and relearn.

I have and will still become a more knowledgeable and well-rounded version of myself because of this project. I have identified Indigenous and queer health as something that I am lacking in my education thus far. In a system that is built on colonialism and racism, I feel that it is required of me to get a better understanding of the obstacles that Indigenous and queer people face for me to be the best healthcare provider I can be. I fear that without this understanding and knowledge, I will only be perpetuating the systemic racism and oppression embedded in our healthcare system and society. I cannot see myself truly fulfilling a role as the most accessible healthcare provider if there are barriers to groups of people that make pharmacists not as easy to access as it is for others. I hope that I will continue to grow as an effective listener, collaborator, and a successful and appropriate advocate for/with Two Spirit People to advance their health and wellness, but also for/with the Indigenous and queer communities as well. I plan to incorporate my new knowledge into my own practice as a pharmacist and promote the visibility of this group in the healthcare system.

I anticipated that these unearned privileges I have may, and perhaps did, contribute to power imbalances in the research between myself and the participants. I was actively aware of this potential power imbalance throughout the research project. I practiced reflexivity, which is the practice of acknowledging my own position in research and throughout the whole research process (Kovach, 2010; Patton, 2015). By acknowledging and making known my positionality within the research, I hope I made myself and others recognize the personal and societal factors that may have influenced my research. I also want to note that the learning and unlearning because of this project have been immense, and I anticipate that my thoughts, ideas, and worldview will continue to change as I embark on a lifelong journey of learning and unlearning.

I want to close off this section with this reflection; Indigenous scholar, Dr. Manu Meyer, came to my Indigenous Methodologies class in the Winter of 2021 and shared the five ideas that helped her become an Indigenous researcher. She was a captivating speaker who spoke with

tenacity and care. The five ideas that Dr. Meyer shared made a huge impact on me and the way I viewed research. I wrote down the five ideas that she shared on a piece of paper and hung the paper in my home office. These five ideas have helped me in this research project and in life. The five ideas Dr. Meyer shared are 1) Answer with your life the questions that give it meaning, 2) Find the truths of your people and bring them forward, 3) Heal yourself because our healing heals the world, 4) Understand coherence and its role in your thinking and doing, and 5) Bring forward the wholeness of knowledge, not just its parts. Although all ideas had a significant influence on my own ideas, numbers one and three resonated with me the most. This research journey has been one of learning, unlearning, and growing. I used to envision growing as quite literally, growing. However, I now envision growing as looking inward rather than continually looking outwards. Dr. Shawn Wilson (RRU, 2020, February 26) said, "If your research doesn't change you, then you haven't done it right." This project has changed me more than I could have imagined. I feel more curious and unsure than ever before and know that my journey is not done. I have come to realize that learning is a lifelong process that is not only about acquiring new information but rather, it is about understanding where that information is coming from and why.

# CHAPTER 2: LITERATURE REVIEW

The purpose of this literature review was to look at the current published knowledge surrounding Two Spirit Peoples and pharmacy in what is known today as Canada. This literature review helped me put into context the objectives and goals of this research project. While looking at the available published literature, following the guidance of S. Wilson (2008), this review builds upon the people and scholars who came before me rather than being critical of this previous work. This is an effort to destabilize the colonial powers that are ever-so-present in Canadian institutions, especially universities, as there is a culture of "being the best" and cutting others' work down to get to the top spot in academia. By approaching a literature review in this way, I developed relationality and accountability to the past and present work that has been done. Although I strived to avoid being critical of previous work, I did look for gaps in the literature that have either been overlooked or have yet to be studied.

First, and most broadly with respect to this project, a look at population health and determinants of health is reviewed with a specific examination of queer, Indigenous, and Two Spirit health. Second, I address current published literature on queer, Indigenous, and/or Two Spirit education in pharmacy schools in Canada. Lastly, the review looks at existing literature on Two Spirit Peoples and community pharmacies.

## 2.1 Population Health

When looking at populations in research, there are three key ways to view and approach interventions. The first approach is Lalonde's Population at Risk. This approach identifies a population that is at the highest risk of being exposed to a risk that would be detrimental to their health (Frohlich & Potvin, 2008). This approach is criticized for viewing the populations in the high-risk category as having self-imposed behaviours that would lead them to be in this group (Frohlich & Potvin, 2008), which results in victim blaming and stigma. Additionally, this is a retroactive way to view population health and interventions as it focuses on a group of people who are already in a high-risk group instead of focusing on societal forces that would make people engage in these "self-imposed" high-risk behaviours (Frohlich & Potvin, 2008). As a result, this means that there will always be a group of people in this high-risk group because no interventions are focussed on preventing this group from becoming "high-risk."

The second way to look at populations and health is Rose's Population Approach. In this

approach, an intervention is applied to the entire population to try to achieve a healthier population (Rose, 1992). This approach is criticized for applying a broad stroke to the entire population which causes those at the lower risk already to benefit the most from the intervention, whereas the section of the population that is at the higher level of risk exposure benefits least from these interventions (Frohlich & Potvin, 2008). Therefore, this results in further health inequities. Additionally, this approach does not address the various mechanisms that lead to the different distributions of risk exposure in the first place.

The third approach is the Vulnerable Population Approach which looks at a shared social characteristic that populations have. This approach is intersectional in the way that it looks beyond the "health" field and looks to social and societal factors that can determine the wellness of a person (Frohlich & Potvin, 2008). This approach, therefore, focuses on changing societal conditions that make these groups of people more vulnerable to certain risks. Frohlich and colleagues found that being Indigenous and/or having an income that is categorized as being in the poverty group puts these groups at a higher risk of negative exposures and thus increases their risk of being in a vulnerable population (Frohlich et al., 2006). Additionally, living in a neighbourhood or place that has accessibility issues with healthcare, green space, and education increases one's chance of being in a vulnerable population (Frohlich et al., 2006). This Vulnerable Population Approach is a key consideration for the proposed project. It is societal factor changes that will have the most positive impact on these so-called vulnerable populations.

### 2.1.1 Determinants of Health

Determinants of health are the factors that contribute to why a person is ill or well. Social determinants of health look beyond the individual and include factors such as social, economic and political aspects (Assembly of First Nations, 2013). These social determinants of health also "establish the extent to which people possess the physical, social, and personal resources to achieve aspirations, satisfy needs, and cope with the environment" (Raphael, 2009). As there are many factors that impact a person's health, there needs to be a focus on all these factors. The focus on addressing social determinants of health, therefore, must focus beyond healthcare and healthcare services. For example, The First Nations Wholistic Policy and Planning Model incorporates Traditional Knowledge, unique health perspectives, and self-governance in its framework to achieve health and wellness (Assembly of First Nations, 2013).

#### *2.1.1.1 Determinants of Health for Indigenous Peoples*

When looking at determinants of health, much research has been done examining the various determinants of health for Indigenous Peoples, which is beneficial as it allows one to see the specific ways that determinants of health may affect Indigenous Peoples in Canada as opposed to non-Indigenous peoples in Canada (Assembly of First Nations, 2013; Greenwood, De Leeuw, Lindsay, et al., 2018). Additionally, when looking at determinants of health for Indigenous Peoples, it is necessary to look at the subgroup of Two Spirit Peoples as well. The Assembly of First Nations' documents on social determinants of health for First Nations in Canada outlines 16 key areas that affect the health and wellness of this group of people (Assembly of First Nations, 2013). One of the 16 social determinants of health listed is gender. The document describes inequities that First Nation women experience due to the gender discrimination and racism that is ubiquitous in Canadian society. Additionally, "historical conditions and colonialism" is listed as another key social determinant of health for First Nations living in Canada (Assembly of First Nations, 2013). This describes the way that colonization caused and continues to cause intergenerational trauma, as well as racism, loss of culture, and connection to land. It is interesting to note that neither of these sections looks at the way that colonization has impacted gender, or the way that we perceive gender. Additionally, among the 16 social determinants of health, sexuality is not mentioned at all. Greenwood and colleagues, however, do have a chapter in "Determinants of Indigenous Peoples' Health" dedicated to gender and Two Spiritedness (Greenwood, De Leeuw, Lindsay, et al., 2018).

The effects of colonization have shaped and continue to shape the health and wellness of Indigenous Peoples living in Canada. Colonization has been shaping Indigenous Peoples' health for 500 years and continues to this day (Raphael, 2009). Decolonization must happen for the negative impacts on Indigenous Peoples' health to be resolved. A key step to decolonization is reinstituting the right of self-determination for Indigenous Peoples (Raphael, 2009). This would allow Indigenous Peoples to have control over their own lives. Additionally, the United Nations Declaration of the Right of Indigenous Peoples needs to be implemented as it will allow for more processes of decolonization (Raphael, 2009). In terms of identifying concrete examples of how colonization has negatively impacted Indigenous Peoples' health, the major themes that arise in the literature are racism, inequities in access to resources, and lower socioeconomic positions (Raphael, 2009).

#### *2.1.1.2 Determinants of Health for 2SLGBTQQIA+ Peoples*

In 2019, a House of Commons Report of the Standing Committee on Health concluded that 2SLGBTQQIA+ individuals have worse health outcomes compared to the heterosexual, cisgender people that make up the majority of the population (Casey, 2019). This report found that 2SLGBTQQIA+ individuals are more likely to experience discrimination and stigma while seeking and receiving care in the health field, which results in this population being less likely to access healthcare in the future when they need it (Gahagan & Subirana-Malaret, 2018). It has been shown that Indigenous Peoples anticipate and experience racism and discrimination while seeking care (Browne et al., 2011; Tang & Browne, 2008). Due to this anticipation, they are forced to make plans to try to avoid this racism or avoid getting the care they need altogether (Browne et al., 2011; Tang & Browne, 2008). There are even programs in place that are racist against Indigenous Peoples, such as the Non-Insured Health Benefits Program. This program provides access to medication and health services for Indigenous Peoples; however, it excludes non-status First Nations and Métis from this coverage that would otherwise enhance access to health services (Allan & Smylie, 2015).

The report shows that 2SLGBTQQIA+ people face poorer mental health and have a higher rate of cancer and chronic diseases, such as arthritis, compared to their heterosexual counterparts (Casey, 2019). It is important to note as well that there is a lack of data on the physical health of 2SLGBTQQIA+ people in Canada (Casey, 2019). In terms of sexual health, gay and bisexual adult men made up almost half of all new HIV cases in Canada even though they only make up about 3-5% of the population (Casey, 2019). As more research is being done on 2SLGBTQQIA+ people in Canada more statistics and results will become available; however, we are only beginning to see a focus on 2SLGBTQQIA+ health. Factors that affect the health of 2SLGBTQQIA+ individuals include but are not limited to, stress, access to healthcare, income, and housing (Casey, 2019).

It is important to note here that the report is titled “The Health of LGBTQIA2 Communities in Canada,” where the 2 represents Two Spirit. I have chosen to use the acronym “2SLGBTQQIA+” in my writing to purposefully put Two Spirit individuals at the forefront as they were the first sexual and gender minority individuals here on this land, and it signifies that we are not just simply adding or tagging this group of people on to the end of the queer community (Pruden, 2021).

#### *2.1.1.3 Determinants of Health for Two Spirit Peoples*

When looking specifically at the subgroup of Two Spirit individuals, one must look at the specific intersecting factors that contribute to health disparities. Two Spirit Peoples are at an intersection of multiple minority groups, resulting in various forms of discrimination such as misogyny, racism, and transphobia, which contributes to increased health inequities (Fieland et al., 2007; Hunt, 2016). There is a need to recognize that Two Spirit individuals cannot be lumped together with Indigenous Peoples or with the 2SLGBTQQIA+ community when looking at health disparities. Hunt (2016) observes that while Two Spirit individuals do face health disparities that are similar to Indigenous Peoples in general, they also have other health disparities that are not addressed or cannot be fully captured if Two Spirit Peoples are not adequately studied and given their own voice. Additionally, the sample size of sexual minorities in Canada is too small to allow for an understanding of the health of Two Spirit Peoples (Casey, 2019). This leads to invisibility and further harm to Two Spirit Peoples (Hunt, 2016). An example of including Two Spirit voices specifically rather than lumping them together with other voices can be found within the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG) Calls for Justice. The NIMMIWG core working group has a 2SLGTQQIA+ sub-working group to inform the National Action Plan and calls to action to ensure that 2SLGBTQQIA+ voices are heard and included (Lezard et al., 2021).

It is important to note that when discussing Two Spirit Peoples and their health, we should not talk about this group of people being vulnerable. They are at an increased risk of certain medical conditions and inequities because Western society has created a system that harms and causes disparities for Two Spirit Peoples.

#### *2.1.1.4 Colonization as a Determinant of Health*

When looking at determinants of health for Indigenous Peoples and/or Two Spirit Peoples, the primary factor that impacts health is found to be colonization (Assembly of First Nations, 2013; Greenwood, De Leeuw, Lindsay, et al., 2018; Hunt, 2016). In Hunt's 2016 manuscript, she illustrates the ways that colonization has impacted Two Spirit individuals. The ideas that the Western world assumes to be true about gender, sex, sexuality, etc., are a direct consequence of colonization (Hunt, 2016). Colonizers brought a rigid gender binary and a heteropatriarchal system. In "Indian Residential Schools," Indigenous children were being taught that there are only two genders and heterosexuality is the only valid sexuality. Anything outside

of this was taught to be wrong or bad and punishment would be accompanied by any thoughts, ideas, or behaviours outside of this. At the same time, children not in Indian Residential Schools were being taught the same things (Sinclair, 2020). As a result, we have a society that functions on the foundation of heteropatriarchy and the gender binary (Hunt, 2016).

Due to the colonized society that we live in, the healthcare system is also founded on heteropatriarchal views (Fieland et al., 2007). As such, healthcare professionals are predominantly white, cis-gender, heterosexual, and homophobic (Hunt, 2016). As noted previously, there is the invisibility of Two Spirit health and wellness in healthcare due to the lack of focus on this specific group of people and a lack of statistical data gathering as well as the aforementioned erasure of Two Spirit Peoples from health research (Fieland et al., 2007; Hunt, 2016). As such, there is a lack of programming that is specific for Two Spirit individuals which leads to barriers when it comes to accessing services for their health and wellness (Hunt, 2016).

Another one of the main goals of this research project is to make progress towards normalizing diversity. We can begin to dismantle the heteropatriarchal worldview by normalizing variations in peoples' genders, sexes, roles, expressions, and sexualities (Hunt et al., In Press). There need to be programs created that are inclusive of cultural values and worldviews, accepting of all gender identities, and founded on non-heteronormative ideals (Hunt, 2016). A goal of this project is to increase the health and wellness of Two Spirit individuals, and the ideas, strategies, programs, and/or education that will get us there will come from the Two Spirit participants. The voices of Two Spirit Peoples need to be centred to inform positive change (Hunt, 2016).

### 2.2 Education

Through this project, we will educate pharmacy professionals about the unique health needs of Two Spirit Peoples and, more broadly, increase the visibility of Two Spirit Peoples in the healthcare system. The Assembly of First Nations (2013) and Hunt (2016) both identify the necessity of making visible and educating people on the traditional community roles and identities that Two Spirit individuals hold in order to reduce stigma and discrimination, and ultimately, improve health and wellness for this population. As education and increased visibility are key factors to improve health outcomes, this project focussed on gathering stories and knowledge from focus groups and sharing this information with others, with a target audience of pharmacists and other healthcare professionals.

Although educating pharmacy professionals on the aforementioned areas is something we are striving to achieve, ideally, we need to move towards creating a space in which educators are working from an Indigenist and queer framework or pedagogy (RISE, 2022). This is beyond the scope of this project, but this is something that is needed and something that we need to work towards. There needs to be a foundational reform in the Canadian education system for meaningful change to occur.

### 2.2.1 Queer Knowledge amongst Healthcare Providers

Since education and visibility are so vital to improving the health and wellness of Two Spirit individuals, it is important to look at the education that pharmacy students and healthcare students receive. There are few published articles that address the topic of queer education and healthcare. As such, the findings may not be as specific as I would like for this project, but this area of research is receiving more attention and focus, so it is expected that there will be more information on this topic in the coming years.

Queer knowledge is something that is lacking in healthcare professionals' repertoire (Gahagan & Subirana-Malaret, 2018; Mandap et al., 2014; Schreiber et al., 2021). A study out of Nova Scotia found that 54.7% of healthcare providers reported that they never received any "LGBQ" competence training (Gahagan & Subirana-Malaret, 2018). This number increased to 60.4% when looking at trans training. When looking at the knowledge level of health issues related to sexual orientation or behaviour, the vast majority (90.6%) of "non-LGBTQ" healthcare providers in Nova Scotia felt less than "very knowledgeable" (Gahagan & Subirana-Malaret, 2018). It is important to note that 71.4% of "LGBTQ" healthcare providers also felt less than "very knowledgeable" when it came to health issues related to sexual orientation or behaviour. This is a key finding as it provides support for the implementation of 2SLGBTQQIA+ training and education in healthcare professionals' schooling. It is not feasible to have only 2SLGBTQQIA+ healthcare professionals which is why there needs to be queer education and training for healthcare professionals. It is hoped that the findings from this project will be used to strengthen pharmacy professionals' and other healthcare professionals' 2SLGBTQQIA+ knowledge base. This is a small way to increase competence when it comes to caring for 2SLGBTQQIA+ individuals. The integration of queer content into curricula is a more robust way to increase this competence (Schreiber et al., 2021). It has been shown that increasing the exposure to 2SLGBTQQIA+ healthcare education to healthcare professionals increases

competence and increases the level of care received (Schreiber et al., 2021).

*2.2.1.1 Queer Knowledge amongst Pharmacists*

There have been several studies which looked at incorporating queer education into pharmacy school to increase knowledge and care in this realm (Jann et al., 2019; Knockel et al., 2019; Newsome et al., 2018; Ostroff et al., 2018; Parkhill et al., 2014). It should be noted that in addition to increasing knowledge, it is also important to increase empathy and sensitivity while caring for minority groups which, as discovered in these studies, typically follows when knowledge is increased. Of the five published studies looking at implementing queer content into pharmacy school education, all studies examined pharmacy schools in the United States of America (USA). Additionally, only one of the studies examined the results of implementing a module or full course on queer topics (Jann et al., 2019). The other pharmacy schools that were studied had only implemented short sessions on queer health ranging from 2 hours to 3 hours and 40 minutes (Knockel et al., 2019; Newsome et al., 2018; Ostroff et al., 2018; Parkhill et al., 2014). All interventions resulted in an increase in knowledge for pharmacy students when it comes to queer health. In addition to increased knowledge, students also reported increased confidence and comfortability in providing care for 2SLGBTQQIA+ community members. It should also be noted that students received the courses or modules favourably. However, none of these sessions or modules focussed on Two Spirit content.

2.2.2 Indigenous Knowledge amongst Healthcare Providers

It is clear that there needs to be better cultural competence of healthcare providers in Canada when it comes to working with Indigenous Peoples (Min et al., 2020). There is ample evidence (as provided previously in this literature review) that shows Indigenous Peoples face increased health inequities compared to the non-Indigenous population in Canada, and we are aware of these reasons, yet this group of people continues to face considerable inequities. The Truth and Reconciliation Commission of Canada published a report in 2015 that outlines 94 calls to action regarding truth and reconciliation. These calls to action came from direct stories from over 6500 Indigenous Peoples who were affected by the Indian Residential Schools. (I want to note here that many more than 6500 Indigenous Peoples were affected by the Indian Residential School system, but this is the number of people who shared stories and insight to create the Truth and Reconciliation Commission Report in 2015.) Of these 94 calls to action, I want to focus on a

few that pertain to education for healthcare providers. I have listed these calls to action below as they appear in the report.

*#23: We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals (Truth and Reconciliation Commission of Canada, 2015)*

*#24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (Truth and Reconciliation Commission of Canada, 2015).*

It is clearly stated that there needs to be an increase in the competency and knowledge that healthcare providers receive when it comes to Indigenous health. This is an area of healthcare providers' knowledge that has been identified as lacking or inadequate. The call to action of having healthcare providers be culturally competent does not, and will not, solve all the issues. There needs to be an increase of Indigenous Peoples in healthcare professional roles as well. Additionally, the creation of an Indigenous health course, cultural competency training, or educational materials for healthcare professionals that is inclusive of Indigenous Peoples, needs to come from Indigenous Peoples and their voices. The results from our project will be the stories and knowledge gifted to us, and these results will give pharmacy professionals and others an opportunity to increase their cultural competence. Although cultural competency is what is called for, it may be more appropriate to incorporate anti-racist and anti-oppressive training rather than striving to be "competent" about a culture.

#### *2.2.2.1 Indigenous Knowledge amongst Pharmacists*

All healthcare professionals and their respective schooling and education should have mandatory courses for Indigenous health, but I want to focus specifically on pharmacy and pharmacists due to the unique position pharmacists hold in Canada. The general public typically

views pharmacists as the most trustworthy when it comes to healthcare professionals, and they are also the most accessible healthcare professionals (Murphy, 2020; Proulx, 2017). As one does not need an appointment to talk with a pharmacist, a community pharmacy is often the first point of contact for individuals seeking care. It is necessary that these accessible and trustworthy healthcare providers are also accessible and trustworthy for the Two Spirit community.

Out of the 10 pharmacy schools in Canada, the University of Toronto is the only one to have an elective course that focuses on Indigenous health (Min et al., 2020). Unfortunately, and not surprisingly, none of the Canadian pharmacy schools have required courses for Indigenous health (Min et al., 2020). There should be mandatory Indigenous health and anti-racism courses for pharmacy students in Canada, however, it is difficult to change curricula in a short period of time. One way to start incorporating Indigenous health into pharmacy education would be to include Indigenous Knowledges in every course. Swidrovich (2020) points out that in Canadian pharmacy schools, Western knowledge and its systems are dominant and create pharmacy professionals' education to be oppressive in nature. The authoritative way that Western knowledge is taught in pharmacy schools undermines other worldviews and ways of healing, and it privileges the Western worldview as superior and others as inferior (Swidrovich, 2020).

### 2.3 Two Spirit Peoples and Pharmacy

To date, there is no published literature on Two Spirit Peoples and pharmacies. Searching on various databases such as PubMed, MEDLINE, and ERIC yielded zero results when using search terms such as "Two Spirit" and "pharmacy." I expanded the search results by using terms such as "Indigenous," "LGBTQ," and "pharmacy." This yielded in very few results, and none pertained to Two Spirit Peoples and pharmacies. Additionally, I tried "Indigenous," "LGBT," and "pharmacy" as key words combined, but again, no results matched Two Spirit Peoples and pharmacies. One last area I searched was using Google Scholar to see if there were any published articles that were not in the other databases. I used a similar strategy to search, but again, there were zero published articles around the topic of interest. From this, it was determined that there is currently no published literature on Two Spirit Peoples and pharmacies. There is a gap in the literature on this topic. It is my hope that the knowledge produced from this research project will be the start of many future articles about Two Spirit Peoples and pharmacies.

Although there is no published literature on the competency levels of pharmacy

professionals when it comes to Two Spirit health and wellness, it is assumed that this level is low. I say this due to the lack of knowledge that healthcare providers have when it comes to queer health and Indigenous health (as previously discussed in sections 2.2.1 and 2.2.2). It is important that if/when pharmacy professionals and other healthcare professionals are at a point in which they are competent when caring for queer individuals or Indigenous individuals they are also competent when caring for Two Spirit individuals. Too often Two Spirit Peoples are not afforded the opportunity to use their own voice and become invisible in healthcare and beyond; they are often lumped together with the LGBTQQIA+ community or the Indigenous community, but rarely viewed in the unique context of their Two Spirit community. We hope this research gives Two Spirit Peoples their own spotlight and encourages pharmacists to care for this community as they would the dominant community.

### 2.4 Conclusion

This review looked at the current published knowledge surrounding Two Spirit Peoples' health and the current knowledge of healthcare providers regarding Two Spirit Peoples' health. The current published literature on these topics provides a foundation for the purpose of this study: Two Spirit Peoples' experiences accessing and receiving care in community pharmacies. The reviewed literature on determinants of health for Indigenous, queer, and Two Spirit Peoples demonstrates the inequities that these groups face. It has been demonstrated through this research that these groups are at an increased risk of health disparities or being discriminated against in the healthcare system, but the root causes of these inequities, such as colonial and heteropatriarchal systems, have yet to be challenged and changed. Indigenous Peoples know that resolving these disparities will only be achieved by dismantling the ongoing injustices (Raphael, 2009; Truth and Reconciliation Commission of Canada, 2015). Decolonizing the healthcare system is a task that will be difficult yet is vital to changing the realities that Two Spirit Peoples face in the system. A small step in the grand scheme of things is to share stories from Two Spirit Peoples about their experiences in the healthcare system, specifically in community pharmacy settings. That is what this project set out to achieve.

As there is no published literature on the topic of Two Spirit Peoples and community pharmacies, it is essential that we start to fill this gap in knowledge on the topic. It is important that any programs or services that come about from this project are created by, with, and for Two Spirit Peoples. This will allow for Indigenous stories and Knowledges to be at the core of such

services, and it will allow for the start of decolonizing the places (in this case, community pharmacies) that implement these services.

I want to acknowledge the many ways this literature review does not align well with the Two Spirit spirit. Dr. Alex Wilson explained to me that Two Spirit is about breaking down the dichotomies that exist. It's about the nature of all things being natural and interconnected. There is no "this" or "that" but rather there is everything. So, when I review the determinants of health of Indigenous Peoples and 2SLGBTQQIA+ peoples and Two Spirit Peoples, am I upholding the colonial view of everything being separate and comparing everything to the heteropatriarchal norms? Perhaps I am. I want to make a conscious effort to decolonize my work as much as possible. How can this be possible through a colonial institution? A starting point is having a Two Spirit supervisor, Two Spirit committee members, working with Two Spirit Peoples, and using Indigenous Methods. Although these measures alone are not enough to say that my work, through a colonial institution, is decolonized, it is one small step towards a more diverse and accepting future.

# CHAPTER 3: METHODOLOGY AND METHODS

This research project was informed by Indigenous Methodologies and used Indigenous methods, or as Shawn Wilson (S. Wilson, 2008) says: Indigenist methods. The important point to note here is that this research project used Indigenous methods that had the underlying beliefs and philosophy of an Indigenous paradigm which is necessary to carry out Indigenous Methodologies (S. Wilson, 2008). It is important to use Indigenous Methodologies when using Indigenous methods as using Indigenous methods with a Western paradigm can further perpetuate the colonial systems in place. The methodology reflects the way that the world is viewed. While conducting research with and for Indigenous Peoples, it is necessary to utilize Indigenous methods that are informed by Indigenous Methodologies as this will be the most useful for Indigenous Peoples. It is not productive or helpful to insert a Western paradigm into Indigenous research. In addition to being informed by Indigenous Methodologies, the project was informed by Two Spirit methodologies (Hunt et al., In Press). Hunt and colleagues (Hunt et al., In Press) discuss key principles of "relationality, accountability, body sovereignty, and gender self-determination" in Two Spirit methodology (p. 3), with individual bodies and the relationships they hold being central to Indigenous Knowledges. Specific methods that were informed by this methodology are discussed later in this chapter. It is important to start incorporating Indigenous Methodologies into pharmacy research as this area has and is lacking in current pharmacy practice publications, and by incorporating Indigenous Methodologies into pharmacy practice research, there is a new possibility of pharmacy research better reflecting Indigenous Peoples (Swidrovich, 2021).

The pieces that influence the methodology include epistemology, axiology, and ontology. All of these pieces work together to form an Indigenous worldview (S. Wilson, 2008). The fundamental belief is that everything is connected (Kovach, 2010; S. Wilson, 2008). We are our relations, and we cannot exist outside of those relationships (Wilson et al., 2019). An Indigenous ontology holds the belief that the truth of something is due to the relationship that one has with the truth (or rather, the truth *is* the relationship) (S. Wilson, 2008). Because of this, there are multiple truths and likely everyone will have their own truth based upon the relationships that exist for that person. Therefore, epistemology fits nicely with ontology in that one knows what is true based on their relationships. The axiology then is to be accountable to those relationships

that one holds (S. Wilson, 2008). Shawn Wilson explains that "Indigenist research is about who we are, how we know and engage with Knowledge, what we do as researchers, and the ways we enact relational accountability" (Wilson et al., 2019). This project strives to be accountable using the 3 Rs (Respect, Reciprocity, and Responsibility) of Indigenous research (Weber-Pillwax, 2001). Relational accountability was and will remain one of the most important parts of this research project. The past and current colonization of research about and "for" Indigenous Peoples has been and is harmful. Throughout this project, I focused on being accountable in the research. Shawn Wilson (Wilson et al., 2019) provides these guiding questions to ask oneself as they are doing research: 1) Am I fulfilling my responsibilities to my relationships? 2) Is this of benefit to the community? 3) Am I being true to my values? 4) Am I being true to the values and wishes of the communities with whom I'm working? 5) Is this research enacting an ethics of care? Specific methods used in this project with the intent of achieving these goals are discussed below.

To create a project that is respectful, reciprocal, and responsible to research participants, it is first necessary to create a project that is relevant to the community. This project was created by Dr. Jaris Swidrovich (my supervisor) who is a Two Spirit Person, pharmacist, and pharmacy educator. They consulted with multiple other Two Spirit individuals to design a project that would be relevant to the Two Spirit community. In addition to being relevant, the research should make positive change for the community (Kovach, 2010; S. Wilson, 2008). Preliminary results were shared with the participants to ensure that what was discovered was accurate. By doing this, the results will be the most accurate and be best situated to make that positive change.

Some specific Two Spirit methods that were employed during this project included inviting participants to share their pronouns if they felt comfortable doing so, allowing them to be as anonymous as they are comfortable with, giving participants an opportunity to review and edit their transcripts and results, and ensuring that the project is a reciprocal and helpful endeavour for the Two Spirit community (Hunt et al., In Press).

### 3.1 Listening to Stories (Data Collection)

The research method chosen to collect data for this project was focus groups. The use of focus groups was chosen as it aligns with Indigenous methods, and this method allows for personal voices to be heard. The focus groups facilitated storytelling sessions for each of the Two Spirit participants. The data that we collected was in the form of personal stories. I should

also note that there are negative connotations with the word "collection" which seems to imply that we, as researchers, are taking these stories from participants. The participants graciously took the time to gift their stories to us. So, instead of "collecting data" we were gifted stories, and we have a responsibility to respect and take care of those stories. Stories themselves are relational, sacred, and medicine (Bowers & Paul, 2019). They communicate the relationships that people hold in their lives (Wilson et al., 2019). Additionally, by listening to the stories as a researcher, one becomes a part of that relationship. There is a relationship that is formed between the participant and researcher and the story. The principles of Respect, Relevance, Reciprocity, and Responsibility were followed for each of the engagement sessions (Kirkness & Barnhardt, 1991).

Each focus group began with a Two Spirit Elder starting us off in a good way and ended with the Elder closing us off in a good way. The focus groups allowed participants to introduce themselves to the group and situate themselves. I find that the term "research" is daunting and uncomfortable, and having the space to take a few minutes to settle in and get to know each other put myself and others, or so it seemed, at ease. Jaris and I called on participants in order of introductions and asked them: "When it is your turn, please share any stories you have accessing or receiving care in community pharmacies." I had a set of guiding questions ready to use if participants were quick with their answers (see Appendix C). However, the participants were very willing to share stories about their experiences, so the guiding questions were not used. During one circle, participants seemed to be mainly focussing on Indigeneity and their experiences, so once everyone was done sharing, a more specific question was asked to try to see if being Two Spirit affected their experiences at all. The question was: "What role has Two Spiritedness played, if any, in your experiences with pharmacists or pharmacies?". A different circle seemed to focus on queer and non-binary stories, so a question regarding the intersections of being Two Spirit such as Indigeneity and gender or sexuality was posed to the participants after the first round of storytelling.

The focus groups lasted between 82-92 minutes in length. All focus groups were audio-recorded and automatically saved to the OneDrive password-protected cloud at the University of Saskatchewan. We let participants know that they could request that the recording be stopped at any time. The audio recordings were then transcribed into a transcript and analyzed. The Toronto, Vancouver, and Prairies focus groups were transcribed by the University of

Saskatchewan group, CHASR. The Edmonton focus group was transcribed by me. The transcripts were transcribed in such a way that all identifying characteristics were de-identified. Each individual participant received the completed transcripts of each of their individual contributions. They were asked if they would like to add, delete, or alter any of their stories or anything shared. Four of the 21 participants responded to the request, and all four of them said that their transcript needed no alterations. The participants were also asked if they would like their names or any specific pseudonym used for the study. The names used in the Results chapter reflect this.

### 3.2 Locations

Four focus groups were held in total. The locations included Toronto, Saskatoon for the Prairie-areas, Edmonton and area, and Vancouver. The focus groups in Toronto, Edmonton, and Vancouver were held virtually over Zoom due to the COVID-19 pandemic. The focus group for the Prairie area was held in-person at the Witaya Gathering. This gathering was held in the summer of 2022, and an organizer contacted us about hosting one of our focus groups there. Since the Witaya Gathering was already happening in person we decided to host this one in person.

We wanted to gather a variety of stories from across "Canada" to see if there was a difference in experiences depending on the geographical area. We initially planned to include more cities, but due to time restrictions for my graduate degree, it was decided that 21 voices from the four focus groups were sufficient.

### 3.3 Participant Recruitment

Participant recruitment was done by contacting local Two Spirit or queer organizations about the project and collaborating with them on finding participants. I initially searched the internet for organizations in each of the locations where we were planning to host focus groups. I will talk about each location separately as each location was unique in how participant recruitment and Elder recruitment unfolded.

#### 3.3.1 Toronto

For the Toronto focus group, I sent an email to the community organization "Two Spirited People of the 1st Nations" explaining our research project and the help that we were looking for. Amanda, Supervisor of Covid Programming, emailed me back letting me know that

she would be able to help with the project. I set up a meeting with Amanda over Zoom and we discussed the project, participant recruitment, Elder recruitment, and distributing honoraria. Amanda said that she would ask a few Two Spirit individuals she knew would be interested in the study if they wanted to participate. She also gave me an email for a Two Spirit Elder out of Toronto whom she said works closely with Two Spirited People of the 1st Nations. I thanked Amanda for her time and willingness to help and we kept in touch after that.

From there, I emailed the Elder to inquire about their interest in participating in the project, letting them know that proper protocol would be followed such as gifting them with tobacco and cloth before the focus group. The Elder asked if we could have a phone call to discuss their role in the project, so we set up a time and discussed this, and the Elder agreed to participate. Amanda then sent me the emails of several participants who expressed interest in the study. I sent them all emails with information about the project and the consent form and asked them if they were still interested in the project. We found a time that worked for everyone and set up a Zoom meeting. Jaris, who was in Toronto at the time, bought cloth and tobacco and headed to the Elder's house to offer these for their knowledge and guidance with the focus group. After this, we had a virtual focus group for the Toronto participants.

Once the focus group was complete, I emailed Amanda an invoice for her to look over. To limit the amount of time Amanda had to dedicate to this project, I created an invoice that she could fill out and send back to me. We paid Two Spirited People of the 1st Nations the money for the honorariums, the payment for the Elder, as well as compensation for Amanda's time and effort dedicated to this project. The only piece that Amanda had to fill out was her time spent on the project. The hourly rate was set at $50 per hour for time spent on the project. We then submitted this invoice to the university's payroll system to get the funds transferred to the Two Spirit organization.

We wanted to use this route of distributing payments for a variety of reasons. The first reason is that participants got paid more quickly than if they were to submit their direct deposit information to the university. The second reason is that there is a lot of personal information that must be disclosed to us as researchers and the university, a colonial institution, for the participants to get paid. This seems disrespectful to participants. Another reason is that not everyone has a bank account to send the money to. Amanda was able to either e-transfer or pay the participants in cash for their participation.

### 3.3.2 Vancouver

The general procedure for participant recruitment for the Vancouver area was similar to the Toronto one. I emailed three different queer or Two Spirit organizations based out of Vancouver, but all of them responded that they were unable to help with the project at this time. A fourth organization I contacted was the Community Based Research Centre (CBRC). Jaris had sent me a post that they shared on social media about Two Spirit terminology. I decided I would reach out to see if they had the capacity to help with the project. I got in touch with Jessy at CBRC, and we set up a meeting to discuss the project. This meeting's content was the same as the content discussed at the Toronto meeting with Amanda.

Jessy recruited participants who were interested in the project and passed along their email addresses to me. He also sent me an email address of a Two Spirit Elder that he said would be interested in the project. From there, I contacted the Elder to see if they would be interested in the project and gave him more details about the focus group and project. He confirmed that he would be willing to be present at the virtual focus group. I emailed the participants and the Elder and found a time that worked for everyone to attend the virtual focus group. After this, I coordinated with Jessy at CBRC to prepare an offering of cloth and tobacco for the Elder. Jessy prepared this and delivered it to the Elder before the focus group took place.

Similar to the Toronto focus group, I sent Jessy an invoice to fill out and send back to me. Again, the invoice included participants' honoraria, Elder payment, reimbursement for the Elder's offering, and compensation for Jessy's time spent on the project.

### 3.3.3 Prairies

The participant recruitment for this focus group was quite different from the other three. The Witaya Saskatchewan Two Spirit, IndigiQueer, and LGBTQIA+ Indigenous Gathering was taking place in June of 2022 on the Whitecap Dakota First Nations. Dr. Rachel Loewen-Walker contacted Jaris about hosting a focus group during the gathering. Jaris and Rachel decided that we could host a focus group for our research project. Rachel sent out the consent form to the Witaya Gathering participants to give them information about the project and to allow time for them to consider participating. I received a few signed consent forms back, but most participants signed up on the day of the focus group. Rachel generously offered to pay participants and the Elder for their time and participation, and I sent Rachel an invoice for her to send back to me. From there, Rachel was reimbursed for those funds and for her time. Before the gathering,

Rachel also let me know the name of the Two Spirit Elder who had agreed to hold space for us at the focus group. I arranged a time to meet her and offer cloth and tobacco along with my intentions. She accepted the offer.

#### 3.3.4 Edmonton

I initially tried emailing an Indigenous organization in Edmonton and a Two Spirit organization in Edmonton. The Two Spirit organization is Edmonton 2 Spirit Society, and the individual, Cheyenne, I was collaborating with was a tremendous help. They responded that they would be able to help, and we set up a meeting to go over more details. After that, they sent out a call for participants to their email list. I received several emails from participants who said they were interested in the study. The consent form and more information were sent to all interested participants. Cheyenne also provided me with the email address for a Two Spirit Elder who may be interested in the project, so I got in touch with them, and he indicated he would be happy to be the Elder at the Edmonton focus group. I arranged for an offering of cloth and tobacco to be prepared for this Elder through Edmonton 2 Spirit Society.

Again, the procedure for this focus group is the same as for the Vancouver and Toronto focus groups. An invoice was sent to Edmonton 2 Spirit Society to fill out and send back to us, and they were reimbursed for their time and efforts with the project.

### 3.4 Analysis

The method used to code and analyze the transcripts was the Voice Centred Relational (VCR) Method (also referred to as the Listening Guide) as outlined by Carol Gilligan (Gilligan, 2015; Gilligan et al., 2003). This method was chosen as it allows for a relationship to be formed between the participants and the person reading the transcript and analyzing it, which in this case was me. Gilligan and colleagues (2003) describe the Listening Guide best by saying that "[It] offers a way of illuminating the complex and multilayered nature of the expression of human experience and the interplay between self and relationship, psyche and culture." (p. 169) The stories shared were personal, and as a way to honour these stories, I chose this method. It also fits well within Indigenous Methodologies as the method is focused on creating a relationship with the transcripts (which are the gifted stories from the participants). The method utilizes four read-throughs in which the researcher listens for different things each time. The VCR method was important to use for this project because it ensured I was accountable to the various

participants that spoke during the focus groups. In other coding methods, I fear that I would have taken away the rich personalities that were in each story. As I read through the transcripts multiple times, I was able to remember each participant and feel more connected to them with each read. I also spent time re-listening to the recordings to listen to the various voices that the participants brought to the focus group. I will discuss this more below.

The first step in this coding and analysis method is to read through the transcript and reflect on personal thoughts or ideas. I used a blue pen to jot down my thoughts as I read through the transcript. This allowed me to see my own perspectives or preconceived ideas about the responses which would influence the way I analyze the stories. This was an important practice as there is subjectivity that goes into every type of research, and by doing this, it allows me and others to acknowledge and see which perspectives I am bringing to this project.

The second time reading through the transcripts I wrote down the plot of the stories. This included the who, what, where, when, and why (Gilligan, 2015; Gilligan et al., 2003). While listening for what was there, I also paid attention to what/who was missing from the stories. I wrote down these major themes in a purple pen beside the lines of the transcript. I also underlined recurring words and general themes. This second read-through was useful for figuring out the main stories and ideas that participants wanted to share.

The third time reading through I looked for every time the participants said "I." I circled all these occurrences with a green pen and included the verb after the "I." Sometimes, I included more than just the verb if I needed more context for what the participant was trying to relay. An example of an I poem that showed off the different voices that a participant brought was this poem from the Toronto focus group:

I never know
I don't know
I'm sorry
I'm old
I think

I need
I hear
I always think

I need

When the participant first started sharing, they prefaced their stories with an unsure voice. By the time they were telling the story, they were very confident and sure of what they wanted to say. I could hear the way their tone and rhythm changed in their speech as they became more confident. I gathered the I poems for each participant together and listened for the various voices. I jotted down the voices and what they brought to the transcripts themselves and worked towards splitting up the I poem into stanzas based on their voices. The different stanzas helped me compartmentalize where one voice ends and the next starts. The various voices guided me in what to listen for in the fourth reading.

The fourth read-through involved listening to contrapuntal voices as described by Gilligan (Gilligan et al., 2003), and I returned back to the research question to guide me as I listened. The word contrapuntal may at first seem that the various voices are in opposition to each other, but upon further investigating the true meaning of contrapuntal, it suggests that the various voices are in harmony with each other and creating a melody of both an individual's personal experiences as well as the community's experiences. Finding the contrapuntal voices of each participant was a challenge for me in that some participants only spoke for a short while. However, for many participants' stories, their contrapuntal voices came through loud and clear. This step in the process is critical as it demonstrates the unique nature of an individual and the multiple voices that they have, and it also highlights the shared and differing voices within the Two Spirit community. This is especially important to keep in mind as we look at the individuality of Two Spirit Peoples. Often this group of people gets grouped together as one, but it is necessary to realize the individuality of people. There are many aspects that Two Spirit Peoples share, but there are also many differing characteristics that each person holds that make them unique.

Upon finishing the readings, I gathered my thoughts and findings and began writing the analysis. The VCR Method is useful in that it is both a coding and analysis method, thus, the analysis had already begun during my sequential read-throughs. It is here that I tried to bring together the voices and stories with the research question. Our research question is: What are Two Spirit Peoples' experiences accessing and receiving care in community pharmacies? Gilligan and colleagues (2003) outline the questions that one may consider from the sequential listenings that go on to inform the analysis. The questions, as suggested by Gilligan (2003),

include: 1) “What have you learned about this question through this process and how have you come to know this?” and 2) “What is the evidence on which you are basing your interpretations?”. These questions helped guide me in analyzing the readings that I had done. I worked towards fusing the various participants’ voices together with themselves and with each other in relation to the research question. This coding and analysis method allowed me to identify the main themes that were produced from the participants’ stories, and it allowed me to do so in a way that listens to the stories rather than just hears them.

## 3.5 Ethics

This project was approved by the Research Ethics Board at the University of Saskatchewan. The participant recruitment form can be found in Appendix A, and the participant consent form can be found in Appendix B.

### 3.5.1 Privacy

Participants had the opportunity to read, review, and agree to the participant consent form prior to the focus groups. Additionally, the consent form was reviewed at the beginning of each focus group and participants were asked if they still consented to be in the study. The consent form included procedures, risks, benefits, compensation, confidentiality, storage of data, right to withdraw, follow-up, and contact information for questions or concerns. The virtual focus groups took place in a private area of the home that was not accessible to members outside of the research team. Participants were encouraged to find a private area to participate in as well. All data is stored in a University of Saskatchewan OneDrive password-protected file on a university-managed laptop (in the care of myself, Marissa Pirlot). The data and device are not accessible by anyone outside of the research team. Consent forms have been stored separately from the data. All data will be destroyed beyond recovery once the five-year post-publication retention period has passed.

I wanted to follow a relational approach to the project, so I sent each participant a copy of their stories to review along with a brief summary of the results. I also asked participants if they wanted their names to be used in the research or if they wished to remain anonymous. Some participants wished to remain anonymous, some chose to use a pseudonym, and some requested their full names be used. This piece was important to the research because it is the participants’ voices and stories that are making the research possible. However, a list of participants is stored

in a password-protected OneDrive account of myself, Marissa Pirlot.

### 3.5.2 Benefits

Two Spirit voices are central to this project, and their stories and voices informed the knowledge translation. As Two Spirit voices directed the results, it is expected that there will be an increase in knowledge about Two Spirit Peoples' experiences in community pharmacies. On a broader scale, by presenting the results and findings to the pharmacy community, it is anticipated that this will increase the visibility of Two Spirit Peoples in the community and in the healthcare system. By sharing the information and stories from this project with pharmacy professionals, it is expected that this will aid Two Spirit Peoples in having more positive experiences when accessing and receiving care in community pharmacies. Additionally, it will benefit community pharmacies by improving their access to knowledge about Two Spirit Peoples and the ways in which their experiences with the healthcare system are unique. This knowledge will also allow community pharmacists to develop stronger relationships with their patients of diverse cultural backgrounds and social identities. Thus, there is the potential that this research will improve the health and wellness of the broader Indigenous and queer communities.

In terms of compensation, participants were offered an honorarium of $50 for their time, and Elders were offered $500, tobacco, and cloth for their time and efforts with the focus group. Aside from the financial compensation, the time spent listening to and honouring their stories resulted in participants expressing direct benefit from having their stories listened to, respected, and valued. Habitually, Two Spirit Peoples are left out of the conversation, or their experiences and realities are deemed irrelevant. We ensured that their stories would be shared in the hopes to enact meaningful change in community pharmacy settings which left participants feeling proud and hopeful for the future.

### 3.5.3 Risks

It was possible that during the engagement sessions, participants could feel stress or discomfort while sharing their stories. As such, I expressed at the beginning that Jaris and the Elder were available if anyone did feel stressed or discomfort. Additionally, it was announced that they may privately message Dr. Swidrovich or me using the chat function on Zoom if they were experiencing stress or discomfort. Jaris has experience working with vulnerable and cultural groups in both clinical and research settings, so he was available for debriefing and

support. Additionally, Elders agreed to be there to support participants who may be feeling distressed during the sessions.

# CHAPTER 4: RESULTS

This section will focus on the gifted stories that the Two Spirit participants generously took the time to share. There was a total of 21 Two Spirit participants who gifted their stories to this project. There were 3 participants in the Vancouver focus group, 5 participants in the Toronto focus group, 5 participants in the Edmonton focus group, and 8 participants in the Prairie/Saskatoon (Witaya Gathering) focus group. I want to include the gifted stories from all participants to make sure that their voices are heard. These voices and their stories are invaluable in this research and beyond. I will not share the specifics of each participant to ensure anonymity unless participants explicitly requested their names to be shared. A draft of the results was shared with all participants via email. I asked the participants if they had time and if they wanted to, what they thought of the results and if there were any suggestions they had. Four participants responded in total, and those four thought the results were an accurate reflection of what was shared during the focus groups and accurately reflected the realities of Two Spirit Peoples' experiences in community pharmacies.

## 4.1 Toronto

The first focus group that took place was with participants from the Toronto area. Six participants confirmed that they would be attending the virtual focus group, and five participants ended up attending. Participants were sent a copy of the consent form via email two weeks prior to the scheduled session. The virtual focus group was held over Zoom. Participants started to log in to the Zoom room and immediately began chatting with each other. Some of the participants already knew each other and others did not know anyone, but all participants enjoyed a brief chat before formally beginning the research. Before starting the recording, I briefly introduced myself and then invited the Two Spirit Elder to start off the evening in a good way. After this, I went over the participant consent form as not everyone had signed it and returned it to me. At this point, I asked if everyone still felt comfortable participating in the research and being audio-recorded. I let participants know that they could request the recording to stop at any time. After the recording started, Jaris and I introduced ourselves and gave more information about the project. After this, I called on people around the virtual focus group to introduce themselves and do a check-in. Once introductions were completed, participants were asked to share stories and experiences about community pharmacies. The Two Spirit Elder participated in the virtual focus

group as well by sharing their experiences and stories in community pharmacies. Below are the results of the stories that were gifted to us by the Two Spirit participants.

P1 (Elder)

P1 introduced themself by sharing their name and second name which was given to them by a matriarch when they were brought into their clan. They let us know where their lineages are from, where they were born, and where they are currently residing. P1 said that they always knew that they were neither man nor woman and said that "gender binary never existed within our people. We always had space for gender diversity and for non-binary identities and for trans communities." P1 went on to explain that there are a lot of intersectional identities when it comes to being Two Spirit which in turn makes this group of people the most "unseen". P1 had this to say:

> I'm grateful to be here tonight to share with you some of my experiences and my family's experiences in how we have not been treated with respect and kindness through pharmaceuticals, through medicines, through that practice of Western medications, but always welcomed in our own communities of traditional medicines. One day, we may not have pharmaceuticals, and we need to return to the land, and we need those that have that Knowledge of those plants to be able to counterbalance the marvels of modern sciences.

When P1 was asked if they wanted to share any experiences or stories with the group, they told a story about requesting a pharmacy to put a note on their file that says that they will not take any narcotics. P1 requested this from the pharmacy because they were frustrated by the pharmacy team asking them if they take narcotics every time they went to the pharmacy. However, when they go to the pharmacy, the employees will still ask them if they are taking narcotics. P1 said that this assumption is because they are Indigenous. They said that as soon as the pharmacy team sees an Indigenous person, they are immediately condescending toward them and have preconceived ideas about them. P1 expressed frustration when discussing the assumptions that pharmacy professionals make about Indigenous Peoples, such as assuming they use narcotics, have AIDS, or have STIs. They suggested that if the question "Are you on narcotics?" must be asked every time, maybe it could be asked in a way that didn't first assume the person was taking narcotics, as this, P1 explains, is frustrating. P1 also shared that it is "off-putting" for Indigenous People when healthcare providers are uneducated about Indigeneity and

understanding spirituality and ceremony. They said that this is one of the main things that they complain about when it comes to pharmacy.

P1 added that there needs to be more inclusive and gender-neutral language being used in pharmacies. They shared a story about a pharmacist asking them if they were married and upon learning that they weren't, the pharmacist then went on to ask if they had a partner. The first question about asking someone if they are married is intrusive and unnecessary. P1 went on to say that once the pharmacist found out they did indeed have a partner, they asked them what *his* name is. P1 then was forced to "come out" and explain that their partner is a woman. Then the pharmacist asked them if they were a lesbian to which P1 stated that they are Two Spirit. P1 said that the pharmacist thought that being Two Spirit is synonymous with being gay. They also shared that there are assumptions about the health of a Two Spirit person. For example, they said:

> Of course, the assumption that you have HIV or AIDS, or that you have some hormone that you need, and that also you are on psychotic medication because that assumption is that if you are non-binary or part of the 2SLGBTQQIA community you must also have mental health issues. And yes, a lot of us do, and it's caused from the systems that exist.

P1 said that they would like to see something that could be put on a community pharmacy's computer screen that takes away some of those assumptions and judgements based on an identity that one may hold. They suggested that there could be a note about whether they are on narcotics and a note about what their gender identity is so that they are not constantly asked. P1 shared that misgendering someone can have an immense impact on someone's mental health. They shared this:

> Even when you're at a pharmacy, being misgendered can be harmful and can cause that ripple effect that can end up being a tidal wave or tsunami for someone. Honouring our identities is so important. When we go into a pharmacy, it's important that someone asks us 'Would you like to be known as a cis-gender person or a gender-diverse person or a trans person?' We can educate our pharmacists to treat someone by asking questions rather than making assumptions and rather than misgendering. I think there would be a closer relationship.

P1 ended by saying that they have been ridiculed by the colonial understandings of what it means to be Indigenous and/or gender-diverse, such as the stereotype that Indigenous Peoples

may be using alcohol and drugs and faking illnesses. Their ask of pharmacists and other healthcare providers was "to be treated like someone who doesn't look Indigenous, doesn't identify as Indigenous, and doesn't identify as gender diverse."

P2

P2 introduced themself by sharing their traditional name with the group and identifying her background. They said that they are a university student with a background in education, ethnobotany, and environmental sciences.

When it was time for P2 to share her experiences with community pharmacies, they said that they find accessing pharmacy care challenging. P2 said that in the wintertime she is white-passing, so things are easier then. However, she described how her skin turns darker in the summertime, so it is more difficult to access care because of racism. They said that they also suffer from a skin condition in which they break out in open sores. P2 told a story about experiencing racism in a community pharmacy when they were going in to fill their birth control prescription, and the pharmacist thought that they were there for methadone and that they may be stealing from the pharmacy.

P2 shared a story about going to a pharmacy, and upon the pharmacist learning that they were Two Spirit, they started to ask questions about being transgender, being non-binary, and taking hormone replacement therapy. They said that "It's just not known what Two Spirit really is." She explained that the lack of knowledge about what Two Spirit is has proven to be frustrating and, at times, awkward and uncomfortable for her trying to access and receive care. She explained that the confusion around this term has often derailed the conversation of why she is accessing care in the first place.

P3

P3 introduced themself by sharing the reserve that they are from and that they moved to Toronto eleven years ago.

P3 told a story about going to the pharmacy to pick up pain medications for their arthritis, and they were accused of stockpiling their medications. P3 said that the pain medications are narcotics and other controlled medications. They said that they typically get a certain "look" from pharmacy professionals when they go into the pharmacy. They said that they suffer from

joint pain due to arthritis, and some days, they find it hard to get out of bed because of the pain. P3 said that because of this, they sometimes look "like [they] just crawled out of bed." The "look" is something that P3 has to "deal with" now, and it is something that they have become used to. However, it is still an uncomfortable and hard moment to go through. They said that they feel as if they must prove to the pharmacy team that they are not faking their pain or stockpiling their medications.

P4

P4 shared where she is from and what her background is. She identified herself as a mother, a grandmother, and a social worker who is actively involved in the community. She said that she didn't grow up with her teachings or culture but is working on regaining that. P4 said that her mother raised her and her siblings on her own and decided that teaching the children about the culture was not something that was necessary at the time. She said that she is "really glad" to be a part of the focus group.

When P4 was asked if she would like to share any stories, she stated that she was quite nervous to share. She explained that she was nervous because she is on a methadone program and is unsure of how people will react when they hear that. P4 explained that she goes to a community pharmacy to pick up her methadone. She said that she doesn't tell anyone that she takes methadone because of the stigma around this medication. P4 described feeling shameful because of the need to rely on this medication and said that she feels judged and seen as "less than others." However, P4 described the pharmacist whom they deal with as "the most amazing human being," and she attributes this amazingness to the pharmacist's treatment of her. P4 told us that the pharmacist respects her, doesn't judge her for being on methadone, and always has a conversation with her which results in a feeling that the pharmacist cares about P4. She said that she knows she can call the pharmacist at any time and ask him a question. P4 states, "There is no barrier between me and him." She noted that she went to a lot of different places before they found a pharmacist that she felt comfortable with and respected by. P4 provided this important direction: "I think it's so important that our pharmacists are knowledgeable about people, and they treat us with dignity and respect."

P5

P5 introduced themself by sharing their spirit name, background, where they were born, and where they live now. They said that they are a youth programmer for Two Spirit youth in Toronto. P5 stated that they were both nervous and excited to be a part of the focus group.

P5 told us that they find accessing healthcare easier when they do not show their status card. They described themself as being white-passing, and they said that they experience racism when they show their status card. P5 shared a story about going to a community pharmacy to fill an antibiotic prescription and upon displaying their status card they got a "look" from the community pharmacy professionals and got questioned if the antibiotic is really what they were there for. P5 described not knowing how to respond to that comment and said that it was "very hard to be asked that."

P5 said that they are frequently misgendered in all areas of healthcare because of their masculine presentation. They said that because they look masculine, healthcare providers assume that they want to be addressed as a man. Additionally, they said that when they tell a healthcare provider that they are Two Spirit, this topic won't come up again. P5 shared that they feel that this is because many healthcare providers do not know what Two Spirit is, and they think it is something they do not have to acknowledge. They also shared that they feel that when they correct healthcare professionals who get their pronouns wrong, those people will become upset that they were corrected and treat P5 rudely. P5 also shared the struggle of speaking up and correcting these healthcare professionals when they misgender or deadname them. They described feeling nervous about saying something to people in a position of power. One recommendation that P5 provided was to encourage anyone working in healthcare to ask people what their preferred pronouns are, no matter the physical presence of someone.

### 4.2 Vancouver

The next focus group that took place was for participants in the Vancouver area. Six participants responded that they were coming, and a total of three made it to the session. The way this virtual focus group progressed was the same as the Toronto group in terms of sending out consent forms, going over the consent form, introducing ourselves, doing a round of introductions, etc. Please refer to the Toronto section for more details. The three participants in this virtual focus group all previously knew each other and were happy to see and catch up with one another. This virtual focus group flowed effortlessly because of the ease that the participants had with each other. They were open, candid, and willing to share stories, ideas, and critiques.

The participants openly expressed how much they enjoyed the virtual focus group and stated they would stay late if needed. Again, like with the Toronto focus group, the Elder was a Two Spirit person who participated in the research by sharing their stories and experiences with community pharmacies. Below are the gifted stories from the participants in the Vancouver area.

Daniel

Daniel introduced themself by letting the circle know where they were born and where they live now. They describe themself as a Two Spirit, gay, HIV-positive person with mental health conditions as well as being an intergenerational residential school survivor. Daniel seemed to be in high spirits and made light of the fact that they named their manual wheelchair that they use "Diva." When first speaking about their experiences in community pharmacies they prefaced their stories by explaining that they tended to avoid healthcare because they felt that this was a system that was not set up for them. Daniel described the healthcare system as something that is inaccessible and something that is only for wealthy people who have the luxury of following the rigid structures of the healthcare system such as driving to appointments and making it to appointments on time. Daniel had this to say:

> I thought I just didn't, I guess- I didn't deserve care. It wasn't for me. That's just for the people who have their shit together or whatever or who have money and who- yeah. Definitely was like a value placed on who can access it. And it was absolutely terrifying. It's just not a place where I could just go and just talk to somebody and just be like 'hey, this is what's going on.'

Daniel told a story about when they were sleeping on a park bench as they did not have a house to live in at the time, and they had an appointment scheduled for 9:00AM. They said that it is nearly impossible for people without houses to make it to appointments on time as there is no alarm clock or phone to ensure one wakes up in time for the appointment or to know the time. Because of this and their fear of the healthcare system, they said they only sought out healthcare in emergency situations.

Daniel shared a positive aspect of community pharmacy: it is more accessible than receiving care from nurses or physicians. They felt that being able to talk to a pharmacist quickly without having to navigate scheduled appointments is very important. This, coupled with a consistent pharmacy and pharmacy team, has resulted in a trusting relationship between each

other. Daniel shared this:

> I can just roll in and see a pharmacist almost instantly unless there are people in line or whatever. So, it's definitely different now because I can, I have a relationship with the place. But that definitely makes a difference, having that trust. When I go in, they know me. They know me by name. So that definitely has built that trust. And most of the pharmacists there have been there for a long time, so it's like you build that trust. So, having that consistency, being able to build that trust definitely makes a difference.

Although Daniel felt positive about this aspect of community pharmacy, there were some criticisms that they shared. They shared that they trust the pharmacist but are frustrated by the bureaucratic rules that are in place. These rules, such as dispensing controlled medications only weekly or monthly, have made Daniel feel like they have no bodily autonomy. They said that they have a feeling that their being is owned and controlled by someone else. Daniel said that going to the pharmacy every month to pick up a refill is hard on them because they want to be navigating and participating in the system less. Daniel said that some of these rules prevent care for people. They shared this:

> If [the pharmacies] are holding onto these rules instead of- like what's your goal at the end of the day? To follow the rules or to help people? If you're holding onto these rules and you're like, 'Yes, we followed the rules,' but someone is not accessing healthcare, getting what they need, are you missing the point?

Daniel shared a story in which they had to seek out care from a corporate pharmacy, and that pharmacy made them feel like an inconvenience. They said that the people working in the pharmacy made them feel like they had to do a lot of extra work to provide care. Daniel said that this leads to the feeling of shame which results in them being less likely to seek care in the future. Being treated this way made Daniel feel like a burden. An example of pharmacies making them feel this way was shared when Daniel told a story about a pharmacy telling them how much a particular medication costs. Daniel commented:

> Even my pharmacy now, they'll say 'Oh, it's so so expensive! And to me, that is the worst thing that they can say to me. As an Indigenous person who grew up poor, no. I don't need to hear that from the pharmacy that's making money. They're fine.

Daniel also spoke about using they/them pronouns and how that is a struggle in the cis-hetero-patriarchal system. They shared a story in which someone at the pharmacy called them

"mister" which made them feel very poorly. Daniel said that hearing that "sucks," and he has "gotten them to put they/them [on their file]." However, they shared this as well:

> The whole healthcare system.. if you're trans, forget it. It's so harmful. There's dead names all the time. I'm like okay, every other place you can change the he/him to she/her, they/them, whatever you want. But in the healthcare system, they still are harming trans people. It's absolutely unnecessary, and they're *knowingly*, knowingly and willfully harming trans people by dead-naming and using the wrong pronouns.

Daniel critiqued the healthcare system as a whole for having a narrow lens through which it views medicine. In discussing this concept, they said "[It's] this idea that Western medicine is the only way." Daniel said that they wished healthcare providers, including pharmacists, would respect their outlook on health and the ways that they choose to heal, as currently, they feel disrespected when discussing their traditional medicines. Daniel emphasized that traditional medicines, Western medicines, and other medicines need to work together, and healthcare professionals need to stop viewing one as superior. Daniel did note that there is bias in what gets funding to be tested in terms of medication. They said that many times it is unknown what types of interactions will happen between their chosen medicines and Western medicines, so the pharmacist will recommend not using the traditional medicines because they don't have any knowledge about them. Daniel said this is colonialist behaviour because they "came to our house and now they're telling us what to do and what not." This can turn into a patronizing interaction, Daniel explained. They said that the pharmacist will often dismiss them as they think they "know best," and when Daniel does not agree to take a prescribed medication, the pharmacist gives them "attitude." Daniel emphasized the need for a multi-faceted approach to healthcare that includes more than just physical health.

They said that respect, autonomy, and asking for consent are what build trust and relationships. Daniel shared that if these principles are followed, it is an "empowering" feeling. Daniel ended by stressing the importance of the relationship between a patient and a pharmacist, saying, "You need to approach this like it's a relationship because it is. And often, for me, it's going to be a lifelong relationship. And I don't want to have to be stuck in a terrible relationship."

The final comment Daniel made was about advocacy for the younger generation of people who need to access care. They stated that when they were younger, they wouldn't have

had the agency to speak their mind, so they are willing to be a pariah by advocating for the generations to come. Daniel emphasized the advocacy they do by saying, "[If] I don't speak up, it might not change."

Matthew

Matthew introduced himself by sharing where his father is from and where he lives now. He described himself as a volunteer, an advocate, a someone who "works in the community." Matthew said that he was "really excited" to be a part of this study.

When it was Matthew's turn to share his experiences with community pharmacies, he said that he could relate to a lot of what Daniel had shared. Matthew's first story he shared was about a pharmacy that tried to shame him into taking his medications by putting the price of the medication on the label/vial. He said that "minor little things [like that] add up to be so much." Another "little thing" that Matthew brought up was the number of questions that some pharmacists ask him about a medication he has been taking for years. He described feeling tired and frustrated by this and felt like he was being patronized by the tone of the language they used. Another negative story about a community pharmacy that Matthew shared was when he was picking up his HIV medications, and the pharmacist loudly said, "HIV medications." He said that this made him feel exposed and like his privacy was not being respected.

Matthew then shared a story about going to a corporate pharmacy and him having to explain to the pharmacy team how to charge the medication to the appropriate insurance plans. He said that the pharmacy team still managed to do this incorrectly even after he explained to them the procedure of how to charge to Non-Insured Health Benefits (NIHB). He was frustrated by how pharmacy team members are unfamiliar with how to bill NIHB. Matthew said that he went to another corporate pharmacy to try to find someone who could help him, but he ran into the same issue. It wasn't until he went to a small, locally owned pharmacy that he was able to find someone who could address the issue. Matthew described the pharmacist at this pharmacy as "frickin' amazing." He had this to say:

> You can tell the young pharmacists from the old ones. You can tell the eager, just out of-school kind of thing or just having their own little shop kind of thing apart from the corporate entities, where they say, 'oh, there's going to be 30 minutes to get your stuff.' The longest 30 minutes of my life is waiting in pharmacies. It's just horrible. And then

they call out your name, so everyone knows we're there!

In this quote, Matthew also made it clear that they do not want to be exposed by his name being called out for everyone in the pharmacy to hear. This is similar to his story about the pharmacist loudly disclosing what type of medications he is on in the pharmacy.

In another story Matthew shared, he expressed some concern about what pharmacists might be thinking about him for being on specific medications. He told a story about being on an antipsychotic medication and shared that he often wonders what the pharmacist thinks of him for being on that particular medication.

Matthew described a challenge in accessing his medications by disclosing that in Vancouver, he has to get his ARVs from a pharmacy in the hospital; that is where all people in Vancouver must go to get their ARVs. Matthew stated that he must go to three different pharmacies just to pick up all of his medications, and he said that this takes up a lot of his time. Matthew explained that this is a barrier to accessing healthcare in community pharmacies. One recommendation Matthew offered was to let patients know the services that community pharmacies can offer. Matthew said that he just recently found out that pharmacies could fax physicians to request refills on medications instead of him having to make a doctor's appointment every time to get his medications refilled. He stated that he wished he would have known this sooner as it saves a lot of time and hassle around getting refills.

P8 (Elder)

P8 introduced himself by identifying himself as a researcher who works with homelessness. He said that he is a 60s Scoop survivor, and his mother was a Residential School survivor. P8 said that he was glad and thankful to be a part of the focus group.

When it was P8's turn to share his experiences with community pharmacies, he shared that he has had a few different pharmacies in his life. He described one pharmacist at a corporation as being "useless." Currently, P8 said he goes to a new corporate pharmacy where the pharmacist is very good. He said that he feels that the pharmacy he goes to is good because there is a relationship that has been built, and they know who he is. He also said that if he calls the pharmacy and they don't answer, then the pharmacy makes sure to call him back. P8 shared that "The head pharmacist comes up to me, 'How you doing, P8?' So, we have a relationship built and mostly everybody in there knows who I am."

A criticism of community pharmacists that P8 shared was that pharmacists often do not take enough time to explain things to patients. He said that every four months he, and others, get a printout of the medications that they are on. P8 commented that not many people know what this printout means. As P8 works with a lot of Two Spirit Peoples, he said that he often hears from them that they do not know what their medications are for. P8 recommended that pharmacists need to slow down and take the time to explain things better to patients. He said that when pharmacists take the time to educate him on his medications it makes him feel more comfortable and rids him of some of the anxiety he has about taking medications.

P8 brought up the lack of knowledge that Western-trained pharmacists have when it comes to traditional medicines. He touched on the important fact that not many research dollars go towards traditional medicines and their effects and interactions with other medicines. P8 shared this:

> We have to be careful how we use our traditional medicines and the Western medicines as well. Because we don't know how they're going to interact. Because we don't know the side effects, right? We use our traditional medicines, like many of our traditional medicines, and we don't know how they're going to interact with our Western medicines. We cannot be accountable for how this is going to interact with our Western medicines. [They] say 'You can't use this because we don't know how it's gonna interact with your Western medicine.'

In this quote, P8 also pointed toward the way that Western medicine takes precedence over traditional medicines. He showed how, because of the lack of focus and training in non-Western medicines, pharmacists are not equipped to properly care for people who use traditional medicines.

The last comment that P8 made was about the Two Spirit youth. He had similar thoughts as Daniel about the youth not having the power to speak up and advocate for their needs. He said that when he was younger, he just wanted to get in and out of the pharmacy as quickly as possible. P8 wondered what the Two Spirit youth might have to say about their experiences accessing and receiving care in community pharmacies. P8 ended by saying, "We're older, we get mouthy, and we're all activists. We're all [at] the frontlines of everything, speaking for other people who can't speak for themselves. And we're able to speak for ourselves for the first time too."

### 4.3 Prairies

This focus group was unique from all the others in that it took place in person. The Witaya Gathering was taking place in June of 2022 on the Whitecap Dakota First Nation. An organizer of this gathering reached out to Jaris to ask if we would like to host one of our focus groups at the gathering since Two Spirit Peoples would already be gathered at the event centre. We decided that since people would be gathering anyways, we would host a focus group for any Two Spirit attendees who wished to participate. Participants were from Alberta, Saskatchewan, and Manitoba. Unfortunately, I was unable to attend as I was at a pharmacy conference. However, Jaris told me about the amazing energy in the room and I was able to listen to the audio recording of the session. There were nine participants who took part in the research. Similarly, to the other circles, the Elder was Two Spirit and contributed stories and experiences in community pharmacies. Another Two Spirit Elder was in the focus group as a participant. This Elder later participated in the Edmonton focus group in the Elder role. Their stories from this focus group have been included in the Edmonton section. Due to the number of participants, the initial round of introductions (as in the other circles) was incorporated into their storytelling time. Participants were only able to talk once each due to the time restriction. Below are the stories that were gifted by participants at the Witaya Gathering.

P9

P9 briefly introduced himself as a Métis man from Edmonton. He joined the focus group with his husband who is also Two Spirit. P9 said that he has had "really good" experiences with pharmacists. He said that he picks up medications for his husband at the pharmacy, and the pharmacist has always been inclusive and "understanding about the both of us." From this comment, I believe that P9 was suggesting that the pharmacist is not openly homophobic. P9 shared a story about going to the pharmacy to pick up medications for his husband and the pharmacist asked if the person he was picking up for was P9's partner. P9 said that he responded by saying "No, I'm his husband." I was very pleased to hear the intentional gender-neutral language used by the pharmacist. Simply using "partner" instead of "wife" or "husband" allows the patient to decide whether they want to disclose their status or not. P9 also said that the pharmacist took the time to counsel him on the medications and is "very helpful."

P10

P10 gave the group a brief introduction which included his name and where he is from. He directly went on to share that he has had positive experiences with pharmacists. He said that it can be difficult to navigate the healthcare system, and he finds that the pharmacy is the first place he goes for information. P10 went on to say that the pharmacist can help them find the care they need. He also applauded the pharmacy he goes to as being open and accepting when it comes to being Two Spirit and queer, saying:

> I don't feel discriminated against or judged. Which is weird, because sometimes I'll go to some doctors, and I kind of don't feel that [comfort] that I do with the pharmacist. So, I tend to ask the pharmacist a lot more questions when I need, like, how to take this medication or how long I'll be on this. And it just, it sets me at ease.

P10 is able to have better experiences when it comes to his health because he has a trusted healthcare professional he can go to ask questions that he might not feel comfortable asking other healthcare professionals.

P11

P11 shared their name and where they are from with the group and said that they initially didn't think they had anything to contribute to the focus group, but then thought that they should share *why*.

P11 said that they haven't interacted with many pharmacists and only recently thought about why this was because of the topic of this focus group. They shared that they are nervous and overwhelmed when it comes to going to a community pharmacy. P11 said that one of the reasons they feel this way is because when they were a child, they always felt uneasy about using their status card for insurance purposes. They said that they think they have carried this nervousness with them since the time they were young. P11 also described feeling on edge about needing controlled medication. They described the feelings around controlled medications and know the judgments and preconceived ideas that people have about people who need to use controlled medications. P11 shared this when talking about making appointments for prescription refills for their controlled medication:

> I called and asked, 'When can I see my doctor? And what do I do if I run out?' And they're like, 'Just go to your pharmacist and explain it, and they'll get it.' But I'm like

> "are they not gonna look at me and be like 'you're just trying to get this very controlled substance?' And it's just the stress of trying to advocate for me is too much. So, I would rather just be less productive on my weekends until I can make it to the doctor.

This story highlights the importance of reducing stigma and educating pharmacy professionals on the hurdles people have to go through to get their medications as well as the courage it takes to advocate for yourself within a powerful system. P11 also commented that they didn't know they could ask questions to a pharmacist without a prescription and wished that they had known that a pharmacist is there to talk to about medications or their health. This is something that P10 talked about during the focus group as well. P11 only just learned that pharmacists are that accessible because P10 shared this. In addition to sharing stories and experiences from the focus groups, some participants, such as P11, learned about services and capabilities that community pharmacies have that can help better serve them.

P12

P12 introduced themself by sharing their name and where they grew up. He said that the reserve he grew up on did not have a pharmacy. They said that when they moved to La Ronge they then "had to engage with pharmacists." However, when they did interact with pharmacists later in life, they had positive experiences and felt that the pharmacists were very knowledgeable about their medications. He said that he has had traumatic experiences with doctors and nurses and less so with pharmacists. P12 attributes the positive experiences to their mother who advocated for them when they were younger in a pharmacy, and that gave them the confidence to advocate for themselves later in life. He shared this short story:

> I had really bad asthma growing up. And I remember one time we went to a pharmacy, and there was a big inhalant problem in the north, and they thought I was going through my puffer so fast because I was providing them to other kids. And that was.. my mom took care of that. But that lives in you.

P12 did share a story about a negative experience in a pharmacy where the pharmacy team was insisting that P12 picked up their controlled medication already because they couldn't find it. P12 told us that the pharmacy had to watch hours of video footage to find out that the medication bag fell into a pail while the pharmacy team members were moving something else. The interaction and accusation left P12 feeling uneasy. He wondered what would have happened

if they didn't watch the video.

However, they do find that the pharmacist is often a source of comfort when it comes to the cascade of visiting healthcare professionals. P12 shared this when talking about going to the community pharmacy:

> For the most part, I find [pharmacists] are almost like the last defence for your experience, from seeing a nurse to seeing a doctor. And then it's like, I've had extremely bad treatment from them, and then I've had the pharmacist kind of save that. They've really been informative and told me what to look out for. Things that are really important that the doctor doesn't share because they're almost like, 'Okay, here you go. Get out.'

This story focuses on the lack of time that doctors spent talking with P12 about their medications. This lack of time and attention has left P12 feeling uncared for when visiting the doctor.

P12 did note that many of their Indigenous friends aren't as vocal as they are when it comes to interacting with community pharmacies and that many of them do not understand what is being said but they don't have the social power to let the pharmacists know that. This puts these people in a situation where they do not know exactly what is going on with their health, and it also creates an environment in which their health isn't given as much attention because they aren't as demanding as other groups of people. P12 highlighted the importance of power dynamics and how social status plays into health. This topic of white privilege, social location, and health will be discussed in the discussion section.

### Mihko Kihêw

Mihko Kihêw shared their name, where their family is from, where they were born, and where they currently live. They jumped right into the topic by sharing that they generally avoid the medical system because of the varying intersections that make up who they are. They told us that they are Indigenous, queer, trans, and fat, and said that "having brown skin and being fat is like a crime. Even in Indigenous spaces." Mihko Kihêw highlighted the important fact that fatphobia is deeply ingrained in society. They said that just because they are fat, people have very little respect for them, and they often feel invisible. It was at this point in their storytelling that Mihko Kihêw began to weep, overcome with frustration and grief.

They said that avoiding pharmacies is not necessarily a direct reflection on community

pharmacies alone but rather a reflection of the entire flawed system. Mihko Kihêw gave us an example of an "outstanding" pharmacist. They said that he is white and queer, so he does understand what it means to be queer while trying to access healthcare. They said that he doesn't know what it means to be Two Spirit as he is not Indigenous, but he holds space for that conversation and for the Two Spirit Peoples. Due to his welcoming nature, a lot of Two Spirit folx choose to access services from his pharmacy. Mihko Kihêw shared some of the factors that make this pharmacist and community pharmacy welcoming:

> He wears his pronouns on his [shirt] and has more than just the rainbow sticker in the window. It's the way he talks to the people that he works with, the attention he provides them, and the love that he provides them. And the answers. So, being able to ask questions about 'Is testosterone for me? What is it gonna do to my body?' We need to have places where we can go and ask these questions. And pharmacies should be that space.

Mihko Kihêw stressed the importance of having community pharmacists that are like this pharmacist because it creates an environment in which people are willing to go and feel comfortable asking questions. They see the potential for pharmacies to be working with community organizations in terms of carrying HIV self-testing kits and PrEP and offering other services to reduce interactions with doctors and nurses. This sentiment of avoiding nurses and doctors was also shared by P5 when they discussed having traumatic experiences with these particular healthcare providers. The idea of having minority groups, such as Two Spirit Peoples, interact less with nurses and doctors seems to be an intervention that would save frustration, time, and trauma.

As previously discussed by Mihko Kihêw, they said that doctors and nurses exclusively attribute any health issues they have to being fat. Their Indigeneity, Two Spiritedness, non-binary identity is not acknowledged because they feel that healthcare providers can only see them as a fat person. And this fatness is what trumps their healthcare experiences. They shared that they are not ashamed to be fat, but "it's shameful to feel like I don't have a right to my health because I'm fat. And [being fat] limits the way that people perceive and receive me." Mihko Kihêw is not sure what role pharmacists may have in helping fat, queer, Indigenous Peoples with this situation, but they know that they want to avoid the healthcare providers that are causing them this harm.

P14

P14 wasted no time introducing themself and immediately started sharing their stories and experiences with community pharmacies when it was their turn to speak. P14 said that their interactions with pharmacists have been very rare because they tend to only seek out medical care in emergency situations. They have had poor experiences with physicians and nurses in the past which results in them avoiding healthcare altogether. However, they did state that the few interactions they have had with pharmacists have been unmemorable, which P14 views as a good thing. Yet, they said that they have felt at times like they weren't allowed to ask questions and weren't given the time to fully understand their medications.

P14 ended their story by emphasizing the importance of pharmacists as "medicine holders" and "medicine keepers." They discussed how important and honourable that role is. P14 also noted that pharmacists are often witnesses, supporters, and knowledge sources for a lot of changes that people go through in their lives, whether it be transitioning genders, coming off substances, or improving their sleep schedule. P14 talked about the transition photos that people take after each month on HRT and suggested that the pharmacist could be the one to take these photos. P14 strongly emphasized the need for pharmacists to know that the role they hold in society is a sacred one and one that is very person-centred. They also want pharmacists to realize how reciprocal the relationship between patient and pharmacist is as there is care that goes both ways; the pharmacist ensures that the patient is taken care of with their medications and the patient, in part, provides a job and income for the pharmacist.

This last point that P14 brought up really emphasizes the contradictory nature of healthcare and capitalism. They clarify that the reciprocal relationship between patient and healthcare provider is what it is because of capitalism, but at the time same time, it is not possible under capitalism. Money as the motivation for healthcare providers to care for patients cannot work to have a meaningful relationship between both parties. This topic of capitalism and community pharmacy will be elaborated in the discussion section.

P15

When it was P15's turn to share, they said that they were not planning to attend the focus group and may have to leave soon to do a few things. However, once P15 began talking, they continued sharing their stories and ideas for 30 minutes. P15 described themself as a middle-

being with 16 chronic conditions who use 28 prescription medications in addition to traditional medicines. Because of this, they had a lot to share about their experiences in the healthcare system.

P15 told a story about a passionate pharmacist whom they interacted with a few times and whom they felt lucky to interact with because the pharmacist was accepting of the traditional medicines they used and had a lot of respect for their culture. P15 said that this pharmacist took the time to look up interactions between Western medicines and traditional medicines that they use. One important factor to keep in mind here is that this pharmacist was based out of a clinic rather than a community pharmacy. This could potentially be a factor as to why this pharmacist had the time to investigate these interactions, as many other stories focused on community pharmacists not having enough time to look into drug interactions or counsel patients. Prior to finding this pharmacist, P15 said that they had a lot of negative experiences with community pharmacies due to the complex nature of their multiple conditions and the inability of community pharmacists to take the time to manage and consider these issues. They described feeling like a customer, rather than a patient, in a healthcare system that strips them of individuality and autonomy over their own health.

P15 shared that they asked some of their pharmacist friends about the training that they receive in pharmacy school when it comes to Two Spirit health education. They said that their pharmacist friends told them that this is a huge gap in their education. I am also familiar with this gap in pharmacy education as I went through four years of pharmacy school. During my entire education, the term Two Spirit was not brought up once. Aside from these anecdotal examples, there is clearly a lack of focus and attention paid to this group of individuals in the pharmacy curriculum (Gahagan & Subirana-Malaret, 2018; Mandap et al., 2014).

P15 expressed their frustration about Two Spirit individuals not knowing the pharmacies well enough to know which ones will do delivery, which ones have free delivery, or how to go about setting up delivery for medications. They emphasized that this is especially important for people that have disabilities that limit their transportation options. P15 suggested that there needs to be a pharmacy health information day where pharmacists explain what they can offer to the community. This suggestion by P15 is a simple possible solution to the issue discussed above. Having pharmacy outreach days would be a low-resource project that could result in greatly improved care for many individuals.

They concluded their stories by saying that pharmacists need to be more knowledgeable when it comes to traditional medicines so that when patients ask about them, there is information that can be given. However, they did say that they know that not a lot of research money goes into looking at traditional medicines. The frustration of pharmacists not knowing a lot, if anything, about traditional medicines, stems from the societal idea that traditional medicines are not worthy of spending money on researching these topics. This ties in directly with white supremacy and the societal belief that Western medicine is the only real medicine. The deeply engrained white supremacy values in healthcare and pharmacy will also be elaborated further in the discussion section.

P16 (Elder)

P16 started off by sharing that she was born in her grandmother's house who is a midwife. She said that her grandmother is the only doctor that she knows, and when she passed away, P16 became her own medicine keeper. She stated that she has been her own doctor for almost all her life up until recently.

P16 told a story about feeling numbness in her feet which prompted her first visit to a doctor in a Western setting. At this appointment, it was determined that she had peripheral neuropathy due to pre-diabetes. She said that they were trying to force her to take metformin, which is a medication used to lower blood glucose levels. P16 explained that she doesn't want prescriptions and thinks that pharmacists are "pill pushers." When speaking about Western medicines and traditional medicines, she had this to say:

> We need a place where our medicines are trusted. Where our bodies are respected. Our body doesn't lie. I think Western medicine and traditional medicine can work together; I've seen that too. I'm not against Western medicine, but I see that we're not treated with respect. And dismissed. They don't see you. You're invisible. And they just have these conclusions.

P16 described feeling patronized by this system that judges a person based on stereotypes. It was at this point in her sharing that P16's tone changed from critical to understanding. She acknowledged that if healthcare professionals are not taught about Two Spirit health, Indigenous health, queer health, etc., then that is all those people know. P16 was simultaneously critiquing the pharmaceutical side of healthcare while realizing that there is a

systemic mindset shift that must occur to create meaningful change. P16 hopes that their way of healing becomes honoured by the Western healthcare system.

### 4.4 Edmonton

The last circle that was held was for the Edmonton area. This was a virtual focus group that followed the same protocols and procedures as the Toronto and Vancouver focus groups. Six participants said that they would attend, and a total of five made it to the session. The Elder at the Edmonton focus group was also Two Spirit and participated in the focus group by gifting stories about their experiences in community pharmacies. Some of the participants had a previous relationship with each other, so they spoke fondly amongst each other while we waited for the virtual focus group to officially start. The gifted stories from the Edmonton participants can be found below.

P17

P17 described themselves as a non-binary person who was just recently diagnosed with a precancerous condition. They said that their grandmother is a Residential School survivor, and they themself are a survivor of human trafficking.

When P17 started sharing their experiences with community pharmacies, they described the difficulty of navigating through the healthcare system and feeling like healthcare professionals are not willing to talk to them about sexual healthcare. They describe not knowing about a vaccine that could prevent this type of cancer that they are at risk of developing. This highlighted the lack of sexual education given in our education system and how there was a lack of health education given to P17. They had this to say:

> In general, the healthcare system has always been a struggle for me, as I do tell my doctors and the pharmacist that I am Two Spirited. A lot of times they don't know how to help me with any sexual healthcare.

P17 also talked about being shamed and made to feel like a burden when they needed to access healthcare services. They said that they "would get like shunned by [their] doctor and everybody, because [they] were putting the healthcare cost up by just getting simple tests done to protect [themself] and other people." They shared that if they were given more information and provided appropriate care, they could have avoided their current condition and could have avoided passing on infections to other individuals.

P18

P18 introduced themselves by letting the group know where he is from and where they live now. He said that does a lot of work with the Two Spirit community and Indigenous People living with HIV and AIDS. P18 started sharing by describing the feeling of being in a community pharmacy as uncomfortable and somewhat unsafe. This has resulted in them generally avoiding the pharmacy. P18 said:

> I really really haven't been in a community pharmacy in a long time. Well, I actually recently [went] to pick up the good old PrEP. But before that, like honestly, it's been years. I think that a big reason for that is when it comes to spaces like that, I honestly don't really feel.. I don't want to say I don't feel safe. That's not the right wording.

This particular feeling that P18 was trying to describe was immediately known to me. I have experienced this same feeling many times in my life. P18 attributed this feeling to the colonial and binary environment that community pharmacy encompasses. P18 explained that these rigid systems create a space in which dead-naming and misgendering are common. P18 described working with 2SLGBTQQIA+ youth and hearing them being addressed as what is written on their identification card rather than what they truly are. P18 expressed his frustration over having things like that not being implemented or used in the pharmacy to create a safe space for individuals. He explained that this type of intervention is simple in the sense that no money or resources need to be invested to put this into action, but what is needed is a change in mindset and effort to start using inclusive language to create safer spaces for 2SLGBTQQIA+ individuals. Focussing on the youth, he said:

> Constant misgendering, constant dead-naming. And at the mindset of the youth at that time. It's like that's just something that, well, I don't want to say simple. But something a mistake that small makes a big big impact on them mentally.

P18 went on to explain that there is an intersectionality of queerness and Indigeneity in being a Two Spirit person. They talked about systemic racism and how assumptions are made based on a person's skin colour or whether they are status. In addition to systemic racism, P18 talked about the barriers that trans individuals face when it comes to accessing gender-affirming care. P18 expressed frustration when they discussed how every encounter one must have with a healthcare provider should be inclusive and safe. They talked about how OUTSaskatoon ("Saskatoon and area's 2SLGBTQ community centre and service provider") has a list of

supports that are queer-friendly yet discussed how in an ideal world, there wouldn't have to be a list for this; everyone you go to would be a safe person. He had this to say:

> If you're a queer person and you wanted to make sure that you're going to a service provider where you know you were going to be treated like a human being, you can go to an organization like OUTSaskatoon, and they'll be able to guide you in the right direction. But that shouldn't be the case. We shouldn't have to keep a list of 'avoid this pharmacy, avoid this doctor.' It should be 'go to a service provider and they provide you service as a human being,' despite not being cisgender, despite your skin colour.

P19

P19 first introduced themself by identifying the land that their ancestors came from. They also let the group know where they are from and where they are currently situated. They shared that their "gender and sexuality fall outside of the binaries that are colonially imposed." P19 also said that they are a registered nurse. They said that they were excited to be a part of the focus group and excited to share their stories.

When P19 first started talking about their experiences with community pharmacies, they spoke about having mostly really positive experiences and described their community pharmacists as amazing. They shared that they are perceived as a male and use the name that they were given at birth, and they attribute their positive experiences to this. In other healthcare settings, where their gender marker does show up all the time, they experience the discomfort of having the healthcare provider trying to "figure out" what gender they are. P19, being a nurse, has also had experiences with community pharmacies from a professional standpoint. In their work, they said that they have seen the way that some of their patients who are trans or gender non-conforming are treated. Quite similarly to P18's stories, P19 has seen their patients being dead-named, misgendered, questioned about hormones, and questioned about their identity. They shared the important reflection that "the further a person gets from the expected binary definitions that are often in our health records, the more difficult it becomes for them to access care from the community."

On further discussing the barriers that exist for Two Spirit individuals in the community pharmacy setting, P19 talked about the accessibility of certain medications. They note that there are only two pharmacies in Edmonton that carry HIV medications, and this makes it difficult for

individuals to access medications when they have to drive to various pharmacies to pick up all of their medications. P19 told a story about speaking to a community pharmacist about the issue of many community pharmacies not carrying HIV medications. The pharmacist told them, "It costs too much money for us to go to pick up those meds. Like we'd have to drive over there and get them, and you know we don't get a dispensing fee for this med. So, we lose money by giving it." P19 responded by saying, "But the person will die if they don't get it. And you're their pharmacist." P19 pointed out the very obvious question: when did community pharmacy turn into a for-profit business instead of a place to seek care? They said that the lack of person-oriented care is prevalent in community pharmacies. When speaking about the conversations they had to have with community pharmacists around this issue, P19 stated:

> I had to have a very stern professional conversation with another professional about their inability to deliver high-quality person-centred care. It's often for our Two Spirit, trans, and other Indigenous relatives. Because the privileges that I have as a cis-passing, white-passing person are not extended at all to many of my relatives.

P19 said that they see the need for pharmacists to play a role in the systemic issues that Two Spirit Peoples face in community pharmacies. They brought up the issue of pharmacists not knowing how to apply for exemptions under the Non-Insured Health Benefits (NIHB) program and discussed how this is a barrier to accessing care in community pharmacies. In addition to the complications that pharmacists have with NIHB, P19 felt the frustration of not all medications being covered by this program, meanwhile, pharmacies are benefitting from this. They strongly suggested that pharmacists need to be advocating for systemic changes, such as getting all medications covered by NIHB, as this will increase the level of care that Two Spirit Peoples receive. While explaining this, P19 made this important statement that "every pharmacy exists on mostly stolen Indigenous land. All of the money they make is directly related to the wealth that's extracted from Indigenous People."

A suggestion that was given by P19 to improve care and to increase awareness in pharmacies was to incorporate gender theory and the meaning of Two Spirit in pharmacy education. P19 suggested that "it would be good if pharmacists just knew what Two Spirit was." They have pointed to the notion that increased visibility and awareness of Two Spirit Peoples in everyday life will increase the understanding and quality of care received. Lastly, P19 described how useful it is when a pharmacist will find an alternative therapy for one that they were

prescribed but wasn't covered by their insurance. They found that their pharmacist has provided good suggestions on this matter and found this to be an extremely positive aspect of their experiences with community pharmacies.

P20

P20 started their turn speaking by letting everyone know who they are, where they are from, and that they are currently living in a rural setting in Alberta. They also informed the group that their child is also Two Spirit which has been an "interesting journey" for both of them.

When asked to share about their experiences with community pharmacies, P20 started off by saying that they personally have had all positive experiences with community pharmacies because "they assume that I am straight, and I do look white-passing." However, P20 went on to tell us a story about being frustrated that not many pharmacies in Lethbridge carry methadone or HIV medications and asking the pharmacist why. The response from the pharmacist was that they "don't want people like that in here because they steal." They said that they asked the pharmacist to explain what he meant by that, but they said he would not elaborate because he knew what he said was wrong. P20 said that they find that the community pharmacies that they go to are not very accepting because they are located in a small rural town in Alberta.

P20 described feeling judged and scared to go into pharmacies because they are not sure if pharmacists would understand what Two Spirit is, and they feel that "[pharmacists] do not want to understand it" either. P20 remarked that they do not feel that is it their job to explain what Two Spirit is, saying that "[pharmacists] don't need straight people to explain what [heterosexuality] is to them." The last comment P20 made was around assumptions that community pharmacies have when it comes to being able to afford medications. They explained how frustrating it is when pharmacies assume that they cannot afford a medication if it is not covered by their insurance, so they do not order the medication or fill it.

P21 (Elder)

P21 introduced themself as an 82-year-old Metis man who is very young at heart. He went on to describe where his mother, father, and grandmother are from. P21 said that he is involved in the Two Spirit movement. He said that he wants to find out why "white people and their bible go against Two Spirit Peoples and gays." He said that Two Spirit Peoples have always

played an important role in society, and he wants to change the viewpoint of people who think that gay or Two Spirit People are not "normal." P21 said he was looking forward to the session and thanked us for asking him to be a part of it.

P21 described a very positive relationship with his pharmacist. He has been seeing the same pharmacist for the last 30 years which has created a trusting and loyal relationship between the two, and he even described them as "friends." He joked, "Every Christmas she gives me a real nice Christmas present cause of the amount of business I give her." P21 said that he has been relatively healthy his whole life up until 30 years ago, so he didn't need to access pharmacy services up until then. The experiences he has had in the pharmacy have been satisfying and there have been no issues for him. P21 also said that it is handy to have a status card at a pharmacy to get prescriptions covered, and he has never had any difficulties using his status card at his pharmacy and other community pharmacies.

A barrier that P21 described was the language barrier that exists between people who speak different languages. He told a story about an Elder being prescribed the wrong medication but not being able to explain this to the pharmacist because the pharmacist did not speak their language. He said that it should be the job of the pharmacy to reconcile language barriers for patients. In addition to that barrier, P21 suggested that it would be interesting to see what the youth have to say about their experiences. The younger generation of people, specifically young trans people, have been sharing their experiences in pharmacies with him; the stories that are told are "harrowing."

One recommendation that P21 made was to have consultations between traditional medicine keepers and Western healthcare people. He said that there needs to be a collaboration between these groups of people and that this would greatly improve the care that Indigenous Peoples receive.

# CHAPTER 5: DISCUSSION

Three structural systems, namely white supremacy, heteronormativity, and capitalism were produced as the major themes throughout the participants' stories during the focus groups. There were various ways that these three themes presented themselves in the stories. All stories that were shared had a connection to at least one of the following: racism, homophobia and/or transphobia, lack of knowledge, and lack of time and greed. These four examples were recurring themes during the stories that participants gifted. Using the Voice Centred Relational Method, I listened to the various voices that the participants brought to the focus group. From this, I was able to identify the three major systems in place that are creating positive and negative experiences for Two Spirit Peoples in community pharmacies. The fourth time while listening to the stories/reading the transcripts, I listened for the various voices and how they connected back to the research topic of "Two Spirit Peoples' experiences accessing and receiving care in community pharmacies." In addition to listening to the stories by reading the transcripts, I re-listened to the stories by replaying the audio recordings. I wanted to do this as I remembered pieces of stories that had various emotions in them that I wanted to revisit. I wanted to listen to the volume changes, tones, inflections, and other nuances that aren't readily obvious from reading the transcript. I concluded that systemic issues are the roots of these stories by listening to the ways that participants talked about their experiences throughout their lives. When participants shared stories from their youth, the voices were sure about the injustices that were occurring. The rhythm of these stories was smooth and uninterrupted. They spoke with certainty and a strong sense of the unfairness of their experiences. Later in life, during early adulthood, the stories shared also depicted the injustices faced. However, during this stage of many participants' lives, the strong feelings about the injustices seemed to fade away, and those feelings were replaced by acceptance. The "I" poems had lines such as "I kinda think," "I don't know," and "I'm just guessing." The rhythm seemed to slow down and have frequent interruptions, possibly due to participants trying to put the current feelings they have into words. I interpreted this as an acceptance of the structural systems that dictate how community pharmacies are run because one of the tones expressed during these stories was one of defeat. In the older participants, the stories about their experiences seemed to divert away from acceptance of oppressive systems and moved towards fighting and advocating for Two Spirit rights. The tone of the "I" poems changed

here and lines such as “I know,” “I need,” and “I feel” were heard. The rhythm became smooth again, and the volume was louder than other stories shared. It was in this later stage of adulthood that participants (re)found and used their voices to critique the systemic nature of these injustices and were conscious of the necessity of needing to change systems rather than individuals to achieve more equitable outcomes. Examples of how I used the VCR method can be found in Appendix D.

In this section, I will discuss and analyze stories that participants told and what they mean in terms of areas that community pharmacies can focus on to create safe and accessible spaces for Two Spirit Peoples. I have chosen to discuss the four recurring themes and the structural processes of white supremacy, heteronormativity, and capitalism in the broader categories of Relationships, Knowledge, and Accessibility. I will discuss how each of these aspects helped and/or harmed Two Spirit Peoples’ experiences in community pharmacies.

### 5.1 Knowledge

Knowledge, or lack thereof, was a major contributing factor to the experiences that the research participants had while accessing care in community pharmacies. Many negative experiences in pharmacies stemmed from pharmacists not being knowledgeable about traditional medicines, Two Spirit, or 2SLGBTQQIA+ healthcare. Participants spoke of positive experiences in pharmacies when pharmacists were knowledgeable about aspects of traditional medicines, such as P15’s story about their former pharmacist. Knowledge around queer health, or a general openness to learn about Two Spirit and queer health also resulted in positive experiences. I will discuss the ways that knowledge level can determine a Two Spirit individual’s experience in community pharmacies.

#### 5.1.1 Upholding White Supremacy

Unfortunately, traditional medicines are not thoroughly taught in pharmacy schools in Canada (Swidrovich, 2020). Any information that a pharmacist has about traditional medicines would have to be because that pharmacist took the time to learn that information. Two Spirit health is not covered at all in pharmacy curricula, and even education on what Two Spirit means is not covered (Swidrovich, 2020). There needs to be an increased focus on this in pharmacy education to break down stigmas and stereotypes that exist among healthcare professionals in Canada (Curtis et al., 2019). In addition to learning about traditional medicines, pharmacy

students should be exposed to Indigenous worldviews. This points to the failures of the pharmacy education system, but more broadly, it points to the ways that white supremacy dictates what is taught and valued and how this creates great disparities for those who are not benefitting from this structural system.

Another major point that several participants talked about was the ways that pharmacists were racist towards them due to stereotypes and assumptions. Racism was a prominent theme in almost every single story shared during the four focus groups. There were two types of stories about racism that occurred in every focus group. The one type of story that emerged was that of blatant racism based on what the participants look like, and the other story is that of the way they notice how they are treated when they are white-passing. The latter stories came in the forms of either the participant themselves looking white or noticing how white-looking people are treated in comparison to themselves. These types of interactions caused participants to avoid care due to the stress caused by previous experiences. This is aligned with the distal stress processes that occur for gender and sexual minority groups in pharmacy settings (Villemure et al., 2022). It has been shown that these stressors have a significant impact on the health and well-being of minority communities.

Another way that white supremacy impacts pharmacists' knowledge is through the mindset that is ingrained into pharmacy students during their education. In the edited book *White Benevolence,* Swidrovich examines the ways in which Western medicine has forced itself to the "top" of worthiness and left Indigenous medicine as "less than" (Swidrovich, 2022). This is because Western medicine only views Western methods and methodologies to be valid and worthy, and because of this, Western medicine is what is taught to healthcare professionals in Canada. The evidence-based medicine that Western medicine prides itself on was created to benefit white people, and it continues to do this while simultaneously creating health inequities for Indigenous Peoples (Swidrovich, 2022). One participant stated that the piece of interacting with pharmacists that bothers them the most is the condescending way that they are treated and the stereotypical assumptions that they make about Indigenous Peoples, such as "all Indigenous Peoples use narcotics." A few participants described the lack of respect they feel when pharmacy professionals do not value their outlook on health. There is room for both Western and traditional medicines in community pharmacy practice; these two (and other ways of healing) can work together (Redvers, 2019). However, it is difficult to implement and work with traditional

medicines within a Western healthcare setting. Unknown interactions between traditional medicines and Western medicines, Western bureaucratic policies and procedures, and the Western medicine superiority complex all hinder the implementation of traditional medicines in Canadian institutions (Redvers et al., 2019). And, on top of that, the ways in which traditional medicines are known to be effective, such as through generations of using them, are not considered "valid" by the scientific system that Canada runs on (Swidrovich, 2020).

In many of the scenarios described above, changing the language would not help, but in some cases, it would. There are ways to be more inclusive of Two Spirit Peoples by changing the words used or the phrasing of sentences. For example, pharmacists should ask open-ended questions that do not have any assumptions tied to them, and they should talk to patients in a respectful manner that isn't patronizing. These two language considerations do not need to be taught in a course, but rather they can be implemented immediately without needing additional resources.

### 5.1.2 Upholding Heteronormativity

It was clear from the focus groups that pharmacists' knowledge of what Two Spirit is needs to be improved. Several participants called for pharmacists to just know what Two Spirit is. There were many examples of pharmacists, upon learning that someone is Two Spirit, assuming that Two Spirit means that the patient is trans, non-binary, has HIV or AIDS, or is on hormone replacement therapy. This points to the lack of knowledge around Two Spirit and queer health, but it also points to the deeply ingrained homophobia and transphobia that is rampant in Canada. Situations like this create awkward, uncomfortable, unsafe, and stressful situations for Two Spirit participants, and on top of that, put Two Spirit patients in the position to teach pharmacists what Two Spirit is when that is not their duty or responsibility. One participant said that the pharmacist wasn't able to provide comprehensive education when it came to hormones and other medications for trans health. It is clear that this type of education is lacking in healthcare and pharmacy school education (Gahagan & Subirana-Malaret, 2018; Mandap et al., 2014). Trans-inclusive health education should be a part of pharmacy professionals' education to serve all members of the community.

The other common grievance of deadnaming and misgendering could be overcome partly by using inclusive language. Instead of using gendered pronouns when speaking to a patient, pharmacists and pharmacy team members should be using gender-neutral pronouns. Also, asking

patients what name they would like to be called, saving that preferred name on their file, and then using that name when interacting with the patient can have significant effects on one's health (Pollitt et al., 2021). This is another intervention that does not require money to implement; it is something that can be started immediately in community pharmacies to foster safer environments for Two Spirit and other queer individuals.

A general lack of comfort among healthcare professionals and pharmacy professionals when it comes to providing education about sexual health to gender-diverse and sexually diverse individuals has resulted in poor health outcomes for Two Spirit patients (see P17 from Edmonton). Further than the individual discomfort of Two Spirit and 2SLGBTQQIA+ individuals is the societal discomfort of this group of individuals and their health needs. Pharmacy schools need to include 2SLGBTQQIA+ education in their curricula and it doesn't have to be a specific course that is only on this topic; it could be including 2SLGBTQQIA+ individuals in case studies during therapeutic classes, for example (Wilby, 2022; Wilby et al., 2022). As P20 from Edmonton stated, there is discomfort when seeking care from healthcare professionals who are not knowledgeable about your identity. I can attest to this feeling as well. It is a feeling of being judged and seen as less than which results in literally feeling scared to be in that environment. Similarly to increasing LGBTQ+ patient cases in pharmacy education, increasing Two Spirit patient cases may lead to pharmacy professionals feeling more confident when it comes to Two Spirit care (Anson et al., 2021). By making mandatory courses or modules for pharmacy students, the level of sensitivity towards and competence with marginalized groups increases (Anson et al., 2021). In addition to increased sensitivity, education interventions have been shown to increase knowledge and confidence when attending to queer health and well-being (Anson et al., 2021). It should also be noted that interventions such as these are positively reviewed by pharmacy students (Anson et al., 2021).

### 5.1.3 Looking Forward

As one participant explained, pharmacists who are inclusive and open-minded, even if they aren't fully knowledgeable about Indigenous culture, can create a very positive experience for Two Spirit Peoples. When Mihko Kihêw from the Prairies shared that their pharmacist is white and queer and creates a welcoming environment for Two Spirit folx, it demonstrates how white pharmacists can foster safe and beneficial environments for Two Spirit Peoples. This suggests that it is not entirely necessary for pharmacists to be Two Spirit to create a positive

experience for other Two Spirit Peoples. A few participants suggested that they felt safe and cared for when pharmacists took the time to investigate drug interactions between traditional medicines and Western medicines rather than simply encouraging the participant to stop using their traditional medicines. One participant also noted that they were grateful to talk to a pharmacist after receiving a prescription for a new medication because they felt that the pharmacist was very informative and helpful in relation to starting a new medication.

Healthcare in so-called Canada is built on hetero- and binary systems. When participants spoke of interacting with a physician or a nurse, the ones who did not ascribe to the ways in which society wants them to with their sex marker on their health card faced poor treatment. Meanwhile, in community pharmacies when a patient picks up a medication, the sex marker is not always something that is the focal point of that interaction. This provided comfort to some patients. Unless the biological sex of a person influences the ways that a medication will work, perhaps it is time to remove sex markers on patient profiles in pharmacies. Or possibly replace these with patient gender markers.

### 5.2 Accessibility

Pharmacists are one of the most accessible healthcare professionals (Murphy, 2020). One does not need to make an appointment, pay a fee, or have a prescription to talk to a pharmacist. Despite this, there are some rules that make it hard to provide optimal care to individuals such as fixed time intervals between filling medications and restrictions on how many pharmacist-initiated extensions can be made on a prescription. Some participants expressed frustration with these rules and regulations that impede timely and patient-centred care. Aside from these general rules that apply to everyone, there were additional barriers that prevented Two Spirit Peoples from accessing or receiving care in community pharmacy settings.

#### 5.2.1 Upholding White Supremacy

Another common racist story that was shared multiple times was about community pharmacies not carrying certain medications that may be beneficial to the Two Spirit community. This type of racism is not as overt as the previous example. This type of racism is able to thrive behind the corporate entities that make these decisions. It does not require a pharmacist or a pharmacy team member to say or do anything; it can exist as a looming force that one cannot simply point to and say “this is the person who is being racist” because it is a system that is

racist. Another example of this pervasive racism in community pharmacies is the non-entitlement of people covered under NIHB to receive annual comprehensive medication reviews as discussed by Swidrovich in *White Benevolence* (Swidrovich, 2022). I will not regurgitate Jaris's discussion in their chapter of *White Benevolence*, but I will briefly list the main points of the chapter. They discuss how some Indigenous Peoples in Canada (not all as Métis and non-status First Nations Peoples are not covered) are covered through NIHB for medications, which requires extensive work to get medications covered versus the process involved for other drug coverage plans such as the Saskatchewan Drug Plan. He states that this has resulted in pharmacists "resenting" working with individuals covered under NIHB (Swidrovich, 2022). I urge the reader to read Jaris's Chapter 13: The Whiteness of Medicine in *White Benevolence*. In addition to this service that is excluded by NIHB, there are many medications that are not covered by NIHB. One participant called for all medications to be covered by NIHB. It is the duty of policymakers and decision-makers to advocate for all medications to be covered under NIHB to allow for increased accessibility to medications.

Several participants shared their frustration with having to go to multiple pharmacies to get all of their medications. Many community pharmacies do not carry methadone, and the reasoning behind this is not clear. It has been postulated that pharmacists, similar to many Canadians, hold a stigmatized view of people who use methadone. This creates increased barriers for individuals who need to access this medication. It requires extra time out of a patient's day and extra commuting which can increase the cost to access the medication as well. This bears similarity to community pharmacies not stocking HIV medications which I will discuss in the next section.

The end result of many of these experiences is avoiding healthcare, which is a major theme that was produced from this research. This came up consistently throughout every focus group. The avoidance of community pharmacies stemmed from either poor experiences in community pharmacies themselves or poor experiences with other healthcare professionals that deterred patients from going to the pharmacy. Some participants said that negative experiences and interactions with pharmacists caused them to become anxious when they had to go back to the pharmacy for refills or other prescriptions. The feeling of anxiousness and advocating for oneself resulted in participants going days without their medications for fear of pharmacists patronizing them or questioning their intentions for picking up a particular medication or getting

refills early or late. Other participants discussed how interacting with nurses and physicians was a negative experience that caused them to opt out of going to the pharmacy to fill their prescriptions; they felt tired, frustrated, and hopeless by their other interactions that they could not see the prospect of a pharmacist being any better. There were many reasons that participants made the conscious decision to avoid pharmacies. As discussed in the Results chapter, participants had experienced racism, discrimination, transphobia, homophobia, deadnaming, misgendering, lack of privacy, and lack of respect from healthcare providers in either pharmacies or other healthcare settings. This made participants avoid healthcare settings, including pharmacies, for fear of experiencing similar situations. Similar findings for gender diverse and sexual minorities were found in Villemure and colleagues' scoping review on minority stress in pharmacy settings (Villemure et al., 2022).

### 5.2.2 Upholding Heteronormativity

Similar to pharmacies not carrying methadone, many pharmacies do not carry HIV medications (Providence Health Care, 2023). The participants from Vancouver shared that there is only one pharmacy in Vancouver that dispenses HIV medications, so they have no choice but to go to that pharmacy to access that medication. Again, the reasoning behind this is not clear. However, it is suspected by the patients that pharmacists and pharmacy professionals do not want people with HIV in their stores. This systemic discomfort with people who have HIV is causing inequitable access for these individuals.

### 5.2.3 Upholding Capitalism

The structural systems of capitalism and heteronormativity are, at times, hard to untangle as they are so intertwined and rely upon and benefit from one another to a great degree. However, in some stories that were gifted, participants shared that the reason pharmacies do not stock HIV medications is that it is not profitable for community pharmacies to do so. In addition to these stories, P19 from Edmonton noted, in their healthcare professional-to-healthcare professional conversation, the pharmacist said that they do not carry HIV medications due to cost. Participants spoke of the extra burden it is to have to go to multiple pharmacies to get all their medications; This takes extra time, money, and energy on the patient's part. This further demonstrates the ways in which community pharmacies are not set up or designed to make accessibility a priority for marginalized people.

Another way in which capitalism showed itself in terms of accessibility to pharmacies is by shaming individuals about the price of their medications. Multiple Two Spirit participants described being shamed by pharmacists who tell them how much their medications are with the intention to try to guilt them into taking the medication or being "adherent." It is not beneficial to try to guilt a patient into taking medications. The role of a healthcare provider is to provide information to patients, and they can make their own decisions. Yet, much of Western healthcare is paternalistic in nature whereby the healthcare provider "knows best" and the patient is expected to follow every order. It is also not the patient's fault the medication is priced the way it is. Many community pharmacies are pieces of larger multi-million-dollar operations, such as Loblaws and Empire Company, that run off a capitalistic business model in which the entire point of their existence is to make money for the rich and not to serve those in the community which is what they should be used for.

Long wait times in pharmacies also add to unwanted experiences by Two Spirit Peoples. Some participants spoke of the anxiety they feel while in community pharmacies and added that waiting for their medications increased their stress levels. This is another downfall of having pharmacy practice outside of universal healthcare in Canada; it creates a business model out of healthcare where the pharmacy is trying to gather as many 'customers' as possible to make the biggest profit.

### 5.2.4 Looking Forward

Many participants who shared positive experiences within community pharmacy settings spoke of timely service for their medications or the high accessibility of receiving care from a pharmacist. Two Spirit folx shared that they have had better experiences in smaller, independently owned pharmacies than with the big corporate pharmacies. The independently owned pharmacies gave participants a sense of ease and comfort which made them more likely to visit the pharmacy and ask questions to the pharmacist. Participants also spoke of the ways that pharmacists help them have seamless care within the system by either offering services they offer or helping to direct them to where they need to be. They talked about pharmacists faxing physicians for refills on their medications which saves time and resources for everyone involved. However, there were participants who did not know that pharmacists could do this and only just learned about it during the focus groups from the other participants. Community pharmacies should be offering and promoting this service. Ideally, community pharmacy professionals

should make an effort to make known what services they can offer to patients. There are many pharmacy services and programs that community pharmacies currently can offer, but the patients need to know that these services exist to be able to access them. Some examples of services that pharmacists in Saskatchewan (and many other provinces) can perform include prescribing for some minor ailments, immunizing patients, and renewing/continuing existing prescriptions (National Association of Pharmacy Regulatory Authorities, 2021). Please refer to NAPRA's Pharmacist's Scope of Practice in Canadian Jurisdictions for the full list of services that pharmacists can offer.

The last point I will touch on is the aspect of avoidance which was discussed in section 5.2.1. Although some participants consciously avoided community pharmacies and pharmacists because of poor experiences with physicians, nurses, or other pharmacists, some participants described feeling comforted by pharmacists after a sequence of poor experiences. This is a very important point as pharmacists are typically the last stop in the succession of healthcare visits for many people. Pharmacists are perfectly poised to encourage or discourage individuals from seeking out healthcare in the future. If a patient had a safe and positive experience with a pharmacist then they perhaps would be more likely to seek out care in the future, whereas a poor experience with pharmacists may deter patients from seeking care when they need it for fear of a similar experience.

### 5.3 Relationships

Relationships are foundational to Indigenous ways of being. Key pieces to creating a healthy relationship include dedicating time to that relationship and respecting everyone and everything in the relationship. As discussed in Chapter 3, relationships are the basis for Indigenous Methodologies, and methodologies are comprised of one's worldview and values. It is vital that meaningful and positive relationships are maintained in all areas of an Indigenous person's life. There needs to be a relationship between a Two Spirit individual and their community pharmacist, and that relationship needs to be a reciprocal and helpful one. In this section, I will discuss the ways that both time given to a relationship and respect in that relationship influence the experiences that Two Spirit Peoples have within community pharmacy settings.

### 5.3.1 Time

A major recurring theme that was produced was the benefit of having a relationship with a pharmacist. When participants spoke of their relationship with their pharmacist it was due to the quantity of time spent with the same pharmacist, the quality of time spent with the same pharmacist, and/or the nature of interactions they had with the pharmacist. Two Spirit individuals who had the same pharmacist for multiple years felt comfortable and welcome in the pharmacy. After spending years with the same pharmacist, participants felt trust within that relationship. Some participants had to spend time finding the right pharmacist for them, and once they found them, they formed a trusting relationship that they continued to nurture. There is a comfort that is felt in consistency.

Another aspect of time that was discussed was the amount of time that the pharmacist spent talking to participants about their medications or looking into drug information questions. The more time spent with the participant, the safer, more informed, and more valued the participant felt. When pharmacists did not take the time to talk to patients about their medications then they felt that their health was not being valued. The lack of time that pharmacists spend with patients may be intentional or unintentional or both. The ever-increasing capitalistic nature of community pharmacy creates an environment in which the pharmacy team must work at an unreasonably quick pace to churn out as many scripts as possible to make the most money for the corporate entity. Many times, when pharmacists slow down to spend time with the patient, the workload piles up and other patients are left waiting for their prescriptions. This is not the fault of the pharmacy team; it is the result of capitalism being a part of healthcare. When healthcare turns into a business then the result is profit over people.

Time is needed to create a lifelong healthy relationship. However, when capitalism forces pharmacists to reduce time spent interacting with patients, it harms the existing relationship, makes it harder for a relationship to be formed, and/or prevents a meaningful relationship from forming altogether. Capitalism does not foster an environment in which meaningful relationships can flourish, and unfortunately, pharmacy, and other sectors of healthcare, do function off this political ideology.

### 5.3.2 Respect

"Relationship as a verb infers the *intentional quality* of connection that is *experienced* and remembered."- Meyer (2013)

Aside from the quantity of time spent within a relationship, we must also look at the quality of the relationship. Two Spirit participants stressed that the way that pharmacists interact with them can create either a good relationship or a "toxic" relationship. Participants who felt that their pharmacist respected them tended to ask more questions about their health than other healthcare professionals whom they felt uncomfortable with. When patients feel comfortable with pharmacists and community pharmacies, they are more likely to engage in their health which can help increase health outcomes for these individuals, as they will be more likely to get care when they need it as opposed to avoiding care until it is a dire situation (Villemure et al., 2022). Pharmacists were viewed as caring and accessible when they greeted participants, used participant names, asked them how they are doing, or had a conversation of some sort with the participants. Participants also reported that when pharmacists used inclusive language, displayed rainbow flags, or wore pronoun pins their experiences were very positive. In addition to these more concrete ways to respect individuals, pharmacists need to show the same love and attention to Two Spirit patients as they do to the other patients. For example, one participant described the respect and passion they felt when a pharmacist openly valued their traditional medicines and approaches to health. The use of traditional medicines by some Indigenous Peoples provides them with a connection with their culture and community, in addition to treating ailments (Redvers et al., 2019). This acknowledgement and acceptance of another's culture is a way to show respect and strengthen relationships.

In terms of the treatment of participants by pharmacists, the most recurring theme produced was that the Two Spirit participants just wanted to be treated like anyone else. When a participant described not being treated differently because of who they are, they said they felt respected and described the pharmacist positively. Participants also noted that they could see the difference in the way they were treated compared to their friends or family who may have darker skin or stray further from the colonial binary and were treated more poorly. There was an agreeance that respect was given to those who were more white, more hetero, and more cis. As P18 from Edmonton stated, Two Spirit individuals simply want to be provided service and treated as if they were human beings.

### 5.3.3 Intersectionality

It has been shown that when people hold multiple marginalized characteristics simultaneously, they experience greater discrimination and inequities than they would with one

marginalized identity (Crenshaw, 1989). This concept was first illustrated by Kimberlé Crenshaw when she illustrated that black women faced increased discrimination in hiring practices due to race *and* gender (Crenshaw, 1989). When individuals face multiple forms of oppression simultaneously, it is easy to see how those individuals' existence is harder than those not facing oppression daily. A recent article published by Statistics Canada put this concept into quantifiable numbers showing that 33% of Indigenous Peoples experienced discrimination in the years the survey was conducted (2014-2019) (Cotter, 2022). This number increased to 70% when looking at Indigenous Peoples who are sexual minorities (Cotter, 2022). The intersectional nature of Two Spirit Peoples' being contributes to poorer health outcomes and wellness compared to the societally dominant person.

Although no two Two Spirit individuals are the same, there are some identities that they have in common that create some common experiences amongst the community. However, there are additional identities or characteristics on top of being Two Spirit that contributes to their experiences in community pharmacies. For example, Mihko Kihêw spoke about being fat and how that trumps their experiences in healthcare. Daniel spoke about living without a house and how that made it difficult to access healthcare. This illustrates the need to examine the social determinants of health and to consider intersectionality when looking to improve the health and wellbeing of individuals and populations.

### 5.4 Implications

Many participants shared their suggestions and aspirations for community pharmacists during the focus groups. Participants made suggestions in the realms of pharmacy education, programs, services, queering the physical space, language use, and treatment of individuals. Below I will discuss the various suggestions that participants shared.

One of the recurring suggestions that the participants called for was an increase in Indigenous healthcare education in pharmacy school training. There was a call for more education about traditional medicines so that pharmacists are better prepared to address questions about these medicines. Although this piece is important, there should be better collaboration between Western medicines and traditional medicines. Ideally, a Western-trained pharmacist would be able to refer an Indigenous patient to an Indigenous healthcare professional so that they can be cared for and served in an appropriate manner (Redvers et al., 2019). This also raises the issue of Indigenous Peoples not having self-governance and self-determination; Indigenous

Peoples need to be in control of their money and resource allocation to make meaningful change (Redvers et al., 2019). The idea of trying to fit traditional medicines into a Western healthcare system is similar to trying to fit Indigenous methods into a Western worldview which was discussed in Chapter 3. Ideally, there would be "traditional medicine chests and greenhouses" where Two Spirit folx could go to access traditional medicines (Lezard et al., 2021).

There was also a discussion about the need for pharmacists to rectify language barriers that may exist between patients and pharmacists. Pharmacists should know where to find a translator app or service to address any questions that individuals of other languages may have. On the same note, there needs to be cultural safety training for pharmacy professionals. Cultural safety results when an individual's culture, community, and identity are respected and valued in a space (Curtis et al., 2019). To realize this cultural safety piece, in a pharmacy or within an individual, there must be an ongoing conscious effort to overcome the biases and power structures already in place. Some steps to get there are achieving cultural awareness, cultural sensitivity, and cultural humility (Curtis et al., 2019). These steps are not easy to achieve. Right now, to be licensed as a pharmacist in Saskatchewan for the 2023-2024 year, one must take a course on Equity, Diversity, and Inclusion (Continuing Professional Development for Pharmacy Professionals, 2023). The course takes about four hours in total, with one of those four hours dedicated to Indigenous cultural safety (Continuing Professional Development for Pharmacy Professionals, 2023). Although this is a step in the right direction, this is not nearly enough training to become culturally safe. Additionally, this is a recorded Zoom lecture from a cis and hetero Indigenous male who is not a healthcare professional. There needs to be ongoing education in pharmacy schools to start to achieve this. However, I do not know if it is possible to achieve cultural safety in a society such as Canada which is built on the structural systems that have been discussed in this thesis; a complete shift in pharmacy practice is only possible once there is a shift in society. As discussed previously, a shift towards using queer and "Indigiqueer" pedagogy in education would be one way to start moving towards a safer and more inclusive society (RISE, 2022).

In addition to education around Indigenous health and wellness, there was a call for increased queer and Two Spirit education. This call stemmed from participants feeling uncomfortable and harmed by deadnaming, misgendering, and lack of knowledge about what Two Spirit is. At the recommendation of one participant, there should be gender and queer

theory incorporated into the pharmacy curriculum. This could be in the form of a required course in addition to incorporating queer content throughout training. For example, including gender queer individuals in case examples, using gender-neutral language, and discussing the unique healthcare needs of queer and Two Spirit patients are all ways in which queer content can be implemented throughout courses. Anson and colleagues (2021) discuss the various ways that pharmacy schools can and should change and/or add to their programs to improve LGBTQ+ outcomes. Although this work does not include Two Spirit considerations, this may be one place to start. One of the findings from this paper shows that increasing pharmacy students' exposure to the realities and experiences of queer patients results in an increased level of care for this group (Anson et al., 2021). It may be wise to increase the exposure of Two Spirit cases and patients in pharmacy education to increase the visibility of this group with the aim of increasing health and well-being and decreasing biases. It is necessary to increase the frequency in which Two Spirit patients appear in cases, but one must be diligent to include Two Spirit patients in a ubiquitous way. If race, sexual orientation, or other marginalized identity is only included in cases that are focused on HIV for example, then the curriculum is subconsciously (re)creating biases in pharmacy students (Wilby et al., 2022). Additionally, patient cases that do not include identities results in students automatically assuming the dominant characteristics of white, heterosexual, and cis-gender (Wilby et al., 2022). This is something the students, and eventually pharmacists, will carry with them as they begin to practice in the community.

The next topic that was brought up by participants was the need for more services and programs that are already in place to be made known to them. This aligns well with the recommendation from the 2SLGTQQIA+ sub-committee of the NIMMIWG to "expand services, increased use and improved outcomes" within the health and wellness realm (Lezard et al., 2021). In one of the focus groups, a participant discussed how they appreciate the ability for themselves to talk to a pharmacist even if they do not have a prescription. One of the participants later in the focus group explained that they did not know you could do this. Another similar example was when a participant spoke of a pharmacist faxing their doctor for refills for medications and how convenient that was, and a participant later said that they did not know pharmacists could fax doctors for refills. This demonstrates the need for pharmacists and the profession to promote the services they can already offer to Two Spirit individuals to make receiving healthcare more accessible. In addition to promoting existing services, there should be

an increase in 2SLGBTQQIA+ services as well (Lezard et al., 2021).

An issue that was brought up a few times in various focus groups was the need to have all medications covered by NIHB. A couple of participants spoke of being prescribed medications that are not covered by NIHB and having to opt for other medications that may not necessarily be the best therapy for them. One participant, speaking from their professional role, discussed the need for pharmacists to advocate for Two Spirit individuals to get all medications covered under NIHB and how it is the job of white people to advocate on behalf of the individuals who need these medications.

The last suggestion that participants had was about the nature of how they are treated in pharmacies. Some participants spoke of the way they are not treated with love or respect when they access healthcare from a pharmacy. One example that came up in multiple focus groups was the ways that pharmacists assume the Two Spirit patients have no bodily autonomy. A simple request of *asking* rather than *telling* was made. There needs to be a shift in the way some pharmacists treat patients. There is an obvious power dynamic differential between a pharmacist and a patient, and that only becomes more gross and obvious when the patient is a Two Spirit individual. A shift in the mindset of who is more important and valuable than others need to be made. Although the above suggestions may improve the health and well-being of Two Spirit individuals, there needs to be more focus on systemic changes rather than changes within the existing system. It is not enough to be 'culturally competent;' one must practice cultural safety (Curtis et al., 2019). In this reflective practice, one needs to look beyond knowing about another culture and their health needs; one needs to look at the systems that are creating the health needs (Curtis et al., 2019).

### 5.5 Limitations

There are various limitations to this study. The first is that all the focus groups took place in urban centres. Because of this, we do not have any voices from rural or remote settings. It is likely that the experiences of Two Spirit Peoples from rural and remote settings may differ from their urban relatives. Another limitation is that there were only people 18 years of age or older involved in the focus groups. This was done to avoid having to navigate guardian/parental consent for the youth. However, this did mean that youth voices were not heard. This piece was brought up by participants in two of the focus groups. One participant discussed how differently they acted in their youth versus the present day. They brought up that they would have not felt

like they could speak up or advocate for themselves when they were younger in age. However, now they feel like they have the right to have a voice. Another participant suggested that it would be interesting to hear from the youth because of the stories that they have heard from them regarding accessing healthcare. It is also important to note the shift in queerness amongst youth today versus in the past. Youth are more likely to acknowledge and state their queerness today than in previous generations (Statistics Canada, 2021).

In addition to participant demographic limitations, there is also the limitation that this study did not explore participant voices from the territories, the maritime provinces, or Quebec. Listening to Two Spirit voices from all these locations is ideal, but reaching this mark was beyond the timeframe and scope for this project. However, this may be a good place to start for future projects around this topic.

The biggest limitation yet may be my whiteness and how that potentially, and likely, impacted participants' willingness to share openly. Participants may have felt uncomfortable and uneasy about critiquing whiteness in front of a white person who is non-Indigenous. Jaris is Two Spirit, and all Elders were Two Spirit as well, so that may have provided comfort and created an open environment in which they felt safe to share. However, the power dynamics between an Indigenous person and a non-Indigenous researcher cannot be overlooked. Research involving Indigenous Peoples has historically been exploitive in nature, so a white researcher would almost certainly elicit a more filtered response from Two Spirit participants versus an Indigenous researcher.

# CHAPTER 6: CONCLUSION

In this final chapter, I will recap the findings of this project, reiterate the implications of the findings, and discuss potential next steps. As discussed previously, there is a clear gap in the literature when it comes to Two Spirit Peoples' experiences in community pharmacies. This project, the first of its kind, helps to gain some insight into the experiences that Two Spirit Peoples have when accessing and receiving care in community pharmacies.

Research has shown that Two Spirit Peoples face increased barriers when it comes to accessing and receiving healthcare in what is known today as Canada (Czyzewski, 2011; Greenwood, De Leeuw, Lindsay, et al., 2018; Hunt, 2016, 2018; National Aboriginal Health Organization, 2021; Reading & Wien, 2009). There are a number of determinants of health that affect Two Spirit Peoples, and the intersectional nature of a Two Spirit person's being contributes to the inequitable health outcomes that they face in Canada (Hunt, 2016, 2018; Lyons et al., 2016; Reading & Wien, 2009) What we know today to be "Canada" is a colonial state that views the white, hetero, cis man as a superior being. It is important to note that Two Spirit individuals are in fact individuals and have their own unique characteristics that make each person their own person. Although this is true, there are some key identities that Two Spirit individuals hold that align with other Two Spirit individuals that create similar experiences amongst each other. It is not the intent of this project to reduce each individual person into a joint identity and assume that everyone has the same experience, but rather, the project aims to show the ways in which some of those similar identities can result in similar experiences.

During the four focus groups out of Vancouver, Edmonton, the Prairies area, and Toronto, 21 Two Spirit participants gifted stories about their experiences in community pharmacies. The findings from these stories suggest that the participants faced white supremacy, heteronormativity, and capitalism in community pharmacy settings which impeded the level of care they received. The recurring themes that were spoke of were racism, homophobia, and transphobia in community pharmacy settings, as well as pharmacists' lack of time spent with patients and lack of knowledge about Two Spirit, queer, and/or Indigenous healthcare. These result in increased difficulty accessing and receiving care in community pharmacies for Two Spirit Peoples. When participants spoke of positive experiences in community pharmacies, they spoke of strong relationships with the pharmacist. There was trust and respect built between

individuals when participants had the same pharmacist for an extended period of time or when the pharmacist treated the participant with love, care, and attention. The findings from this project are consistent with other findings in the literature around Two Spirit health and wellness when it comes to accessing healthcare in Canada (Czyzewski, 2011; Hunt, 2016, 2018; Ristock et al., 2019).

The stories told suggest that Two Spirit Peoples face barriers when it comes to accessing and receiving care in community pharmacies due to various structural and other processes that exist in this country. This has resulted in many Two Spirit individuals from this project avoiding healthcare to save themselves from unsafe and uncomfortable interactions. This aligns with previous research that found that some Indigenous Peoples and queer people avoid seeking healthcare (Browne et al., 2011; Tang & Browne, 2008; Villemure et al., 2022). Many suggestions to improve experiences in pharmacies were shared such as using inclusive language, adding pronouns and preferred names to patient files, and displaying rainbow flags in community pharmacies' windows. Participants also called for pharmacists to increase their knowledge and awareness in a variety of areas such as queer health, Indigenous health, Two Spirit health, and Two Spirit-related content. Two Spirit participants also suggested increased promotion of community pharmacy services and programs that are currently in place so that they are aware of the various ways pharmacists can help provide seamless and accessible care. Additionally, there was a general call for pharmacists to use their positions of power to advocate for Two Spirit Peoples when it comes to NIHB matters and beyond. Lastly, participants called for pharmacists to treat them with respect and dignity. These suggestions, coupled with the recommendations from the NIMMIWG 2SLGBTQQIA+ sub-committee, are starting points to work from to create more equitable access to healthcare for Two Spirit folx (Lezard et al., 2021).

This project serves as a starting point for future research and projects in the realm of Two Spirit Peoples and community pharmacies. Some potential projects may include listening to more stories from Two Spirit individuals in other cities such as Montreal, Ottawa, Iqaluit, Whitehorse, and Halifax for example. There is also the possibility of gathering stories from Two Spirit Peoples in rural and remote settings. The other area yet to be explored is the experiences of Two Spirit youth in community pharmacy settings. This is an important addition to the study as the youth are the future. Other potential research could look at community pharmacists' current knowledge about Two Spirit health, and they could identify gaps in their knowledge that need

improvement. There is also the opportunity for Two Spirit Peoples and community pharmacists to design, build, and implement programs in community pharmacies that aim to serve the needs of Two Spirit Peoples.

Pharmacists need to be consciously aware of the ways in which Two Spirit Peoples' health is unique compared to the white, cis, hetero population. Reducing stigma, unlearning previously taught biases, and normalizing diversity are starting points that pharmacists can work from. As the pharmacy profession continues to grow and improve the health of communities, we need to ensure that the Two Spirit community is a part of that improvement. Although personal-level change is needed, it is imperative that systemic change happens as well. The capitalistic, white supremacist, heteronormative society that we live in is not designed to heal Two Spirit Peoples; we must work towards dismantling these nefarious structural systems to achieve equitable health and wellbeing for all.

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# College of Pharmacy and Nutrition
# University of Saskatchewan

**PARTICIPANTS NEEDED FOR**
**RESEARCH IN TWO SPIRIT PEOPLES' HEALTH**

We are looking for volunteers who identify as Two Spirit to take part in a study of
**Two Spirit peoples' experiences accessing and receiving care from community pharmacies.**

As a participant in this study, you would be asked to participate in a virtual talking circle (group setting of approximately six participants) led by a Two Spirit person and Elder.

Your participation would involve one talking circle session, which is anticipated to last approximately 60-90 minutes in total.

You will receive an honorarium for your time and participation.

For more information about this study, or to volunteer for this study, please contact:

Marissa Pirlot
College of Pharmacy and Nutrition
at
Email: marissa.pirlot@usask.ca

**This study has been approved by the University of Saskatchewan Behavioural Research Ethics Board**

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APPENDIX B- Consent Form

UNIVERSITY OF SASKATCHEWAN

# *Participant Consent Form*

***You are invited to participate in a research study entitled:***

**Two Spirit peoples' experiences accessing and receiving care from community pharmacies**

**Student Researcher:**
Marissa Pirlot, BSP, MSc Student
College of Pharmacy and Nutrition
Division of Pharmacy
University of Saskatchewan
marissa.pirlot@usask.ca

**Supervisor and Principal Researcher:**
Jaris Swidrovich, BSP, PharmD, PhD(c)
Assistant Professor
College of Pharmacy and Nutrition
Division of Pharmacy
University of Saskatchewan
jaris.swidrovich@usask.ca

**Purpose and Objective of the Research:**

- The purpose of this study is to learn about the experiences of Two Spirit people accessing and receiving care from community pharmacies.
- The objective of this research is to listen to Two Spirit peoples' lived experiences of accessing and receiving care in community pharmacies and to then provide education to pharmacy professionals across the country to improve care and services provided to Two Spirit peoples.

**Procedures:**

- A group talking circle will take place virtually over Zoom. This link will take you to Zoom's privacy statement: https://explore.zoom.us/en/privacy/. We will be used the Zoom service that is provided through the University of Saskatchewan. No data will be stored outside of Canada. No guarantee of privacy of data can be made with any of the virtual meeting platforms currently in use.

- A graduate student will be taking notes during the talking circle and it will be audio-recorded; however, you may request at any time to not have notes be written down or for the recording to stop.
- Please agree to not making any recordings of the content of the talking circle. As a reminder, we cannot guarantee that all participants will refrain from recording the session.
- The talking circle is expected to take approximately 60-90 minutes; however, talking circles "end whenever they end" to ensure each participant has a chance to share, although you are welcome to leave whenever you wish.
- Please feel free to ask any questions regarding the procedures and goals of the study or your role.

**Funded by:**

- Canadian Institutes for Health Research (CIHR)

**Potential Risks:**

- There are no known or anticipated risks to you by participating in this research; however, it is recognized that some stories shared may cause discomfort – especially if such experiences caused trauma. An Elder will be present to assist should anyone become distressed.
- You do not have to answer any questions you don't want to. There will be no penalty or negative consequence for not answering a question or for ending your sharing prematurely.

**Potential Benefits:**

- There is no guarantee of a personal benefit to your participation in this study; however, Two Spirit persons are anticipated to benefit from the stories you share as your stories will inform the research team's efforts to provide education to pharmacy professionals across the country.

**Compensation**:

- Elders and Two Spirit talking circle guides will receive an offering of tobacco and a small gift for your participation in this project, as well as an honorarium of $500. (A Social Insurance Number may be required for this honorarium.)
- Two Spirit talking circle participants will receive a $50 honorarium. The honorarium will still be given even if withdrawal during data collection occurs.

**Confidentiality:**

- Individual names will not be recorded in the notes taken during the talking circles.
- Your name will not be used in any of the data collection or data sharing.
- This consent form will be stored separately from the data we collect.
- All participants of the talking circle will be present and hear what is shared; however, all participants will be asked to honour confidentiality of what is shared in the talking circle.

The researcher will undertake to safeguard the confidentiality of the discussion but cannot guarantee that other members of the group will do so. Please respect the confidentiality of the other members of the group by not disclosing the content of this discussion or the other participants' identities outside the groups and be aware that others may not respect your confidentiality.

- Data from this study will be used for the graduate student's (Marissa) Master's Degree dissertation and will be submitted for publication in journal articles or other academic media; however, no identifying information about you will be included. Once the five-year post-publication retention period has passed, we will destroy all data beyond recovery.
- If there are any possibly identifying features related to your stories and/or participation during publication, we will mutually work out a plan for how you would like to be represented in the work.
- The videoconference will be conducted in a private area of the home that is not accessible by individuals outside of the research team. It is recommended that participants also find a private area to have the talking circle.
- Data may be temporarily stored in a home due to COVID-19. All data will be stored on the password-protected University managed device in OneDrive. This device will not be accessible by anyone outside of the research team.

**Storage of Data:**

- Data will be stored behind two locks (locked cabinet in locked office or locked home). Electronic data will be stored on a password-protected University of Saskatchewan managed computer (under the care of Marissa Pirlot) during analysis and then moved to a USask system (OneDrive on both Marissa Pirlot and Jaris Swidrovich's accounts) for long-term storage.
- Data will be stored for five years post-publication and then will be destroyed.
- Findings from this research are anticipated to be presented at conference poster presentations, conference presentations at local, provincial, and national conferences, in addition to a manuscript submission to the Canadian Pharmacists Journal and Pharmacy Practice + Magazine. We also hope to develop the findings into national online webinar(s) for pharmacists, pharmacy professionals, and pharmacy educators.

**Right to Withdraw:**

- Your participation is voluntary, and you can participate in only those discussions that you are comfortable with. You may withdraw from the research project for any reason, without explanation or penalty of any sort. Should you wish to withdraw, you may leave the sharing circle at any time; however, data that have already been collected cannot be withdrawn as it forms part of the context for information provided by other participants.

**Follow up:**

- We will share the results (in the form of journal articles, posters from poster presentations, and educational materials developed for pharmacy professionals) from the study with you via email, unless you choose otherwise.

**Questions or Concerns:**

- Contact us using the information at the top of page 1.
- This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office: ethics.office@usask.ca; 306-966-2975; out of town participants may call toll free 1-888-966-2975.

**Signed Consent:**

Your signature below indicates that you have read and understand the description provided.

I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this consent form has been given to me for my records.

| | | |
|---|---|---|
| *Name of Participant* | *Signature* | *Date* |

| | |
|---|---|
| *Researcher's Signature* | *Date* |

***A copy of this consent will be emailed to you, and a copy will be stored the researcher.***

**Oral Consent:**

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

☐

| | | |
|---|---|---|
| *Name of Participant* | *Researcher's Signature* | *Date* |

APPENDIX C- Focus Group Questions

1. The first question is designed so that anyone can answer it. It establishes a relationship and draws on lived experiences.

    a. Two Spirit is a term that not everyone is familiar with. Are you willing to share what being Two-Spirit means to you?
2. The next question focuses on past experiences.

    a. Do you have a story about a time you felt comfortable or welcomed while receiving or seeking care in a community pharmacy?
    b. Do you have a story about a time you felt that there were barriers to you while receiving or seeking care in a community pharmacy?

3. The third question focuses on current programs or systems in place.

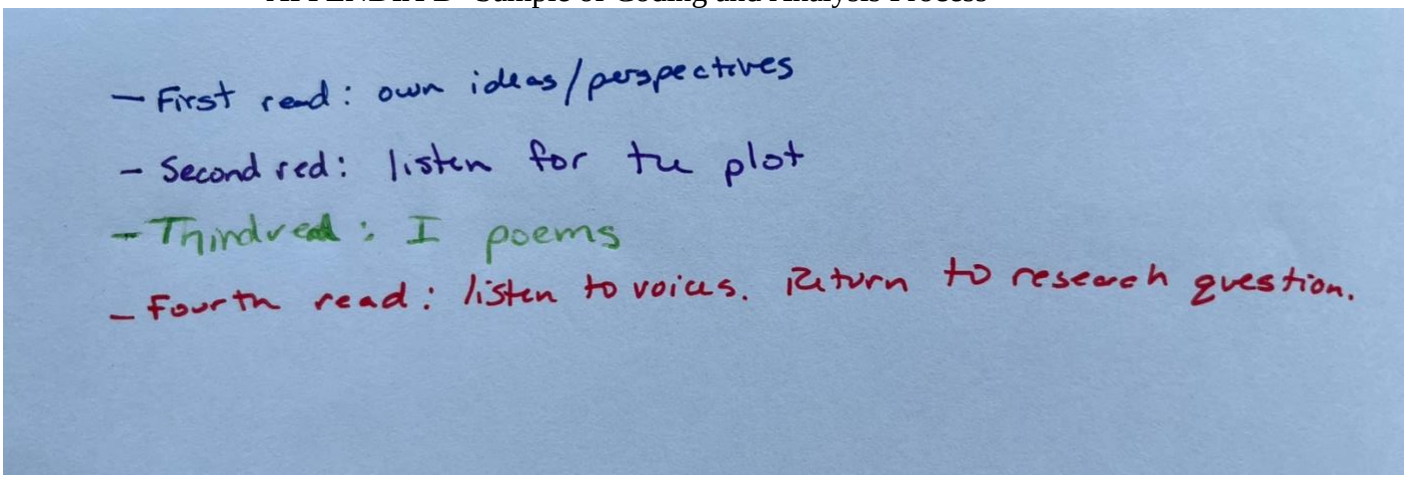
    a. What services or programs are you aware of that are currently in place, in community pharmacies, to help serve and make Two Spirit peoples feel welcome and comfortable?

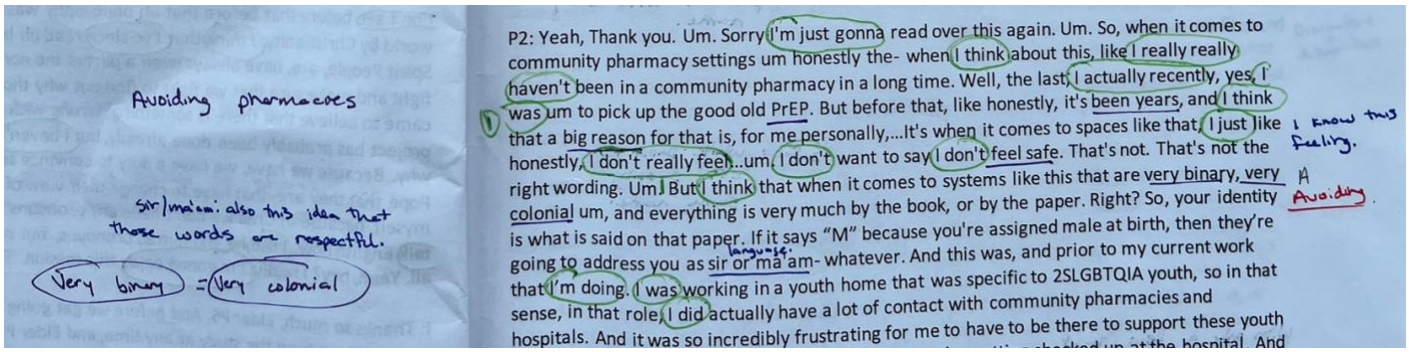
4. The fourth question looks to the future and potential policies that would be beneficial.

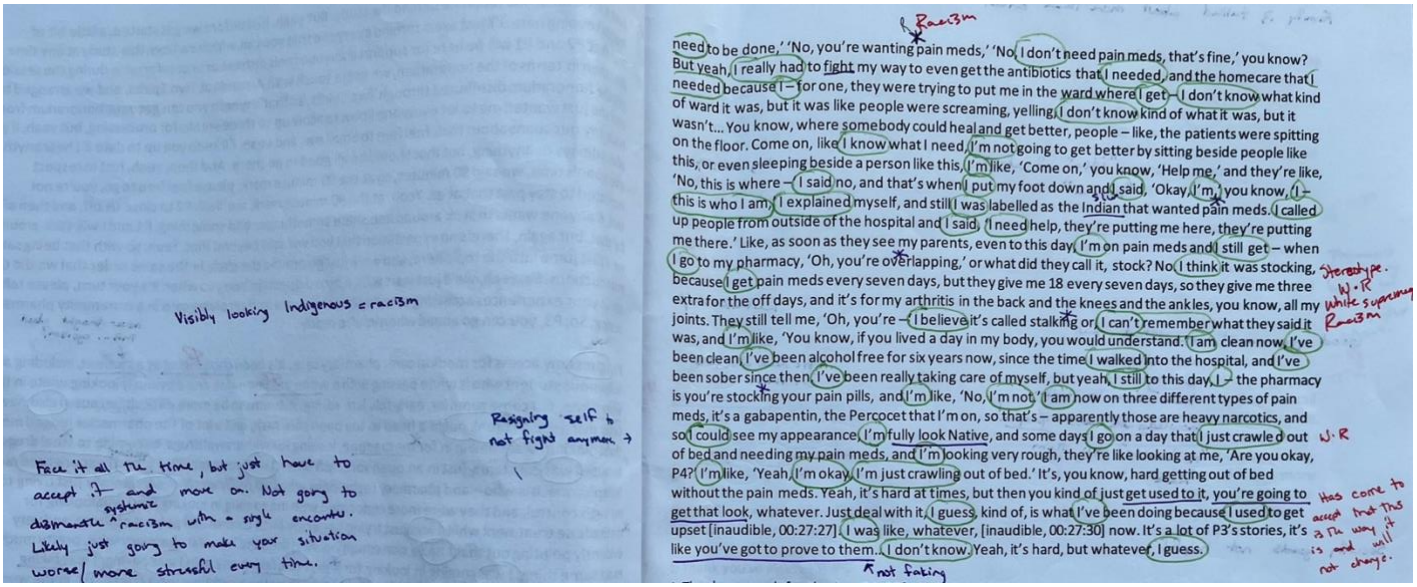
    a. What do you think needs to be implemented or changed to improve Two Spirit peoples' experiences with community pharmacies?

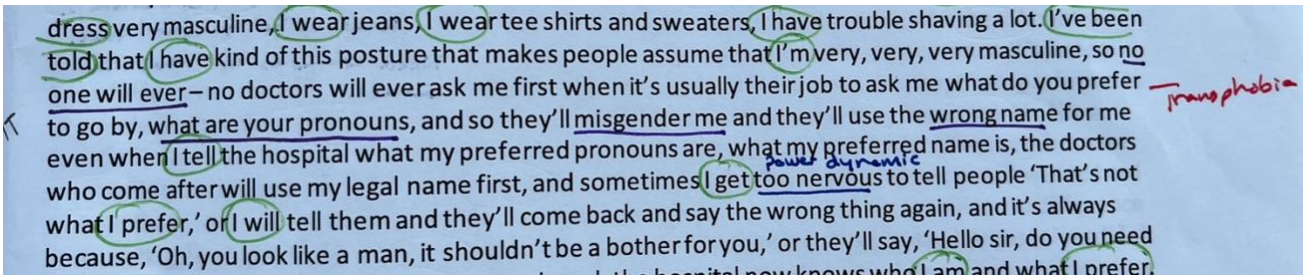
5. Do you have any questions, or do you have anything you would like to add?

APPENDIX D- Sample of Coding and Analysis Process





dress very masculine, I wear jeans, I wear tee shirts and sweaters, I have trouble shaving a lot. I've been told that I have kind of this posture that makes people assume that I'm very, very, very masculine, so no one will ever – no doctors will ever ask me first when it's usually their job to ask me what do you prefer to go by, what are your pronouns, and so they'll misgender me and they'll use the wrong name for me even when I tell the hospital what my preferred pronouns are, what my preferred name is, the doctors who come after will use my legal name first, and sometimes I get too nervous to tell people 'That's not what I prefer,' or I will tell them and they'll come back and say the wrong thing again, and it's always because, 'Oh, you look like a man, it shouldn't be a bother for you,' or they'll say, 'Hello sir, do you need

Transphobia

power dynamic

Mission. Growing up in the north we didn't have a pharmacy on the res, it was just kind of the nurses and doctors would just kind of give you the medication as you needed it. It wasn't until I moved to La Ronge that I had to engage with pharmacists. And it was a pretty good experience, but I honestly thing

Past influences the current.

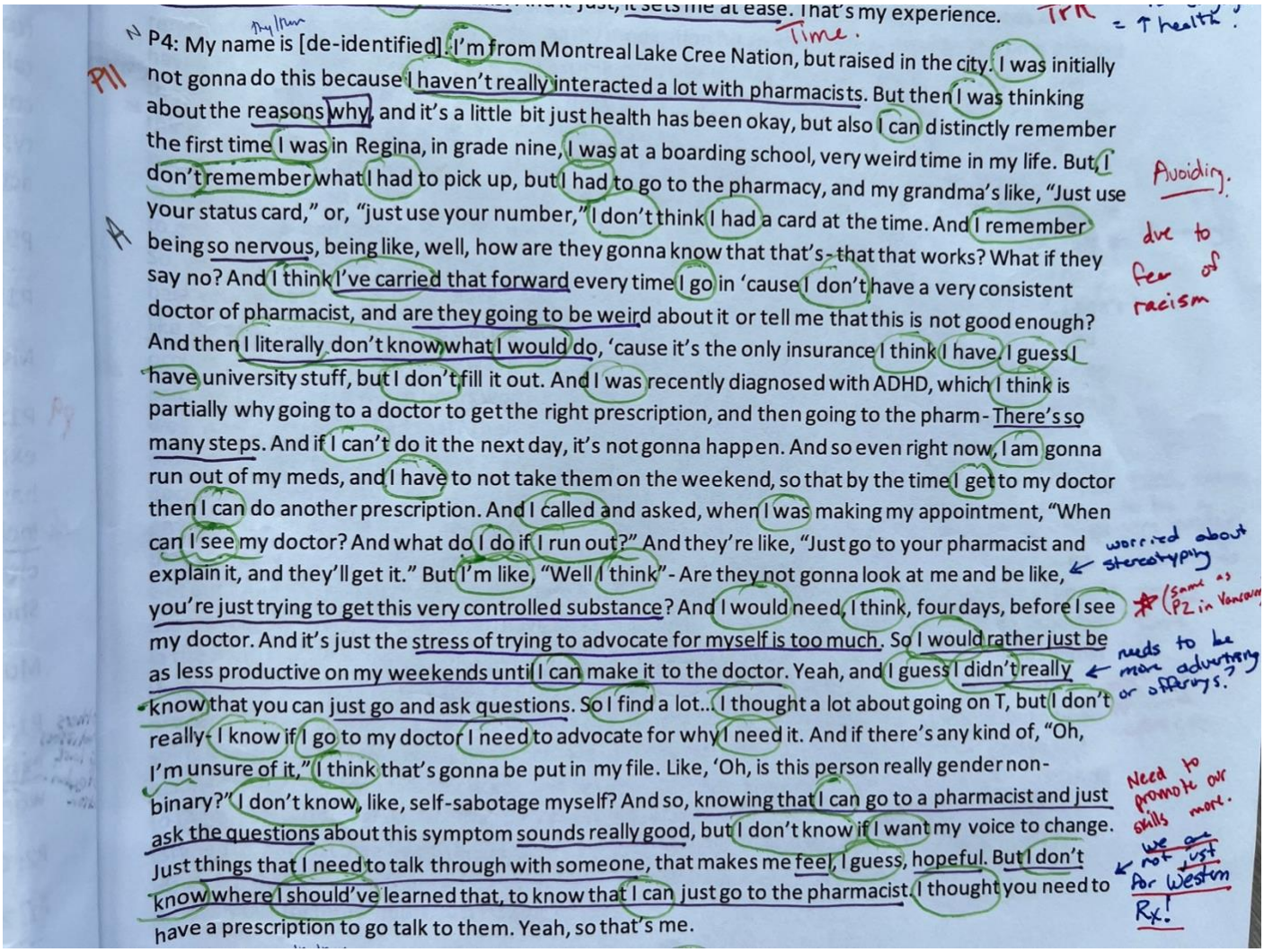
racism

weird assumption

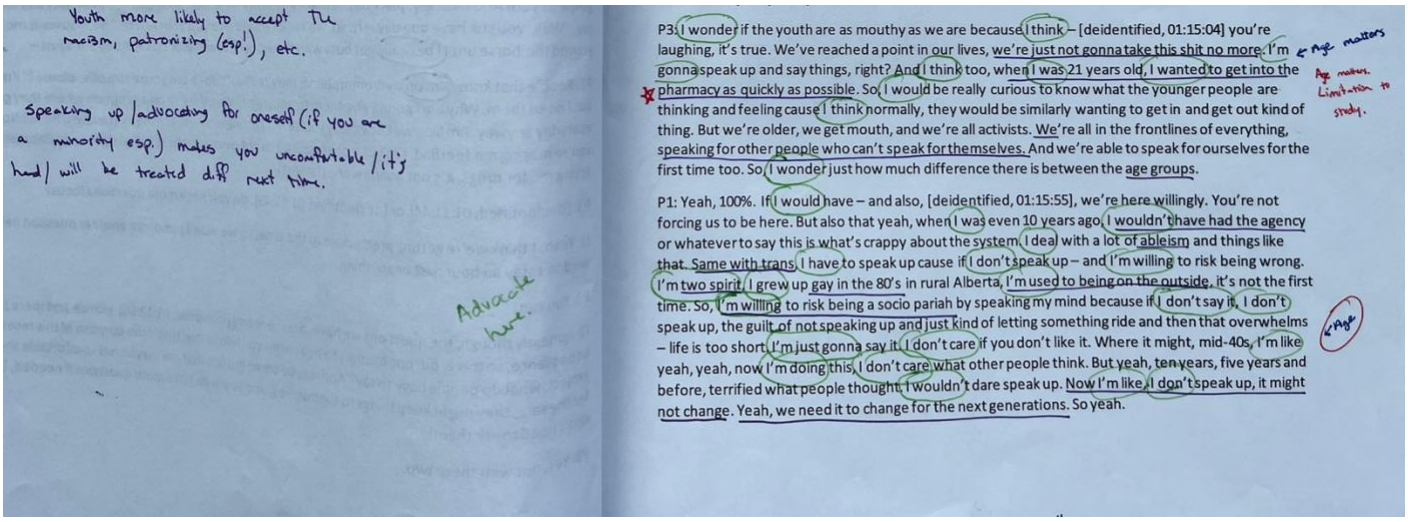
Knowledgeable

that's from seeing my mom advocate for me growing up, because I had really bad asthma growing up. And I remember one time we went to a pharmacy, and there was a big inhalant problem in the north, and they thought I was going through my puffer so fast because I was providing them to other kids. And that was, my mom took care of that. But that lives in you. But I also find the pharmacists are also very - I feel like they're more informed than the doctors that are prescribing things. I've had very traumatic experiences with doctors and nurses, less so with pharmacists, because I think they understand what they're - I don't want to say understand what they're doing more, 'cause I think it's just different sides of the coin, I guess. But I think that's why it's so important that we have trans health navigators and people that can advocate for us, because it is very scary. And I've felt - I have ADHD too, and my meds are renewed on - now, because I've been taking my medication for so long, I go six months at a time without

A?



P4: My name is [de-identified]. I'm from Montreal Lake Cree Nation, but raised in the city. I was initially not gonna do this because I haven't really interacted a lot with pharmacists. But then I was thinking about the reasons why, and it's a little bit just health has been okay, but also I can distinctly remember the first time I was in Regina, in grade nine, I was at a boarding school, very weird time in my life. But, I don't remember what I had to pick up, but I had to go to the pharmacy, and my grandma's like, "Just use your status card," or, "just use your number," I don't think I had a card at the time. And I remember being so nervous, being like, well, how are they gonna know that that's - that that works? What if they say no? And I think I've carried that forward every time I go in 'cause I don't have a very consistent doctor of pharmacist, and are they going to be weird about it or tell me that this is not good enough? And then I literally don't know what I would do, 'cause it's the only insurance I think I have, I guess I have university stuff, but I don't fill it out. And I was recently diagnosed with ADHD, which I think is partially why going to a doctor to get the right prescription, and then going to the pharm - There's so many steps. And if I can't do it the next day, it's not gonna happen. And so even right now, I am gonna run out of my meds, and I have to not take them on the weekend, so that by the time I get to my doctor then I can do another prescription. And I called and asked, when I was making my appointment, "When can I see my doctor? And what do I do if I run out?" And they're like, "Just go to your pharmacist and explain it, and they'll get it." But I'm like, "Well I think" - Are they not gonna look at me and be like, you're just trying to get this very controlled substance? And I would need, I think, four days, before I see my doctor. And it's just the stress of trying to advocate for myself is too much. So I would rather just be as less productive on my weekends until I can make it to the doctor. Yeah, and I guess I didn't really know that you can just go and ask questions. So I find a lot... I thought a lot about going on T, but I don't really - I know if I go to my doctor I need to advocate for why I need it. And if there's any kind of, "Oh, I'm unsure of it," I think that's gonna be put in my file. Like, 'Oh, is this person really gender non-binary?' I don't know, like, self-sabotage myself? And so, knowing that I can go to a pharmacist and just ask the questions about this symptom sounds really good, but I don't know if I want my voice to change. Just things that I need to talk through with someone, that makes me feel, I guess, hopeful. But I don't know where I should've learned that, to know that I can just go to the pharmacist. I thought you need to have a prescription to go talk to them. Yeah, so that's me.



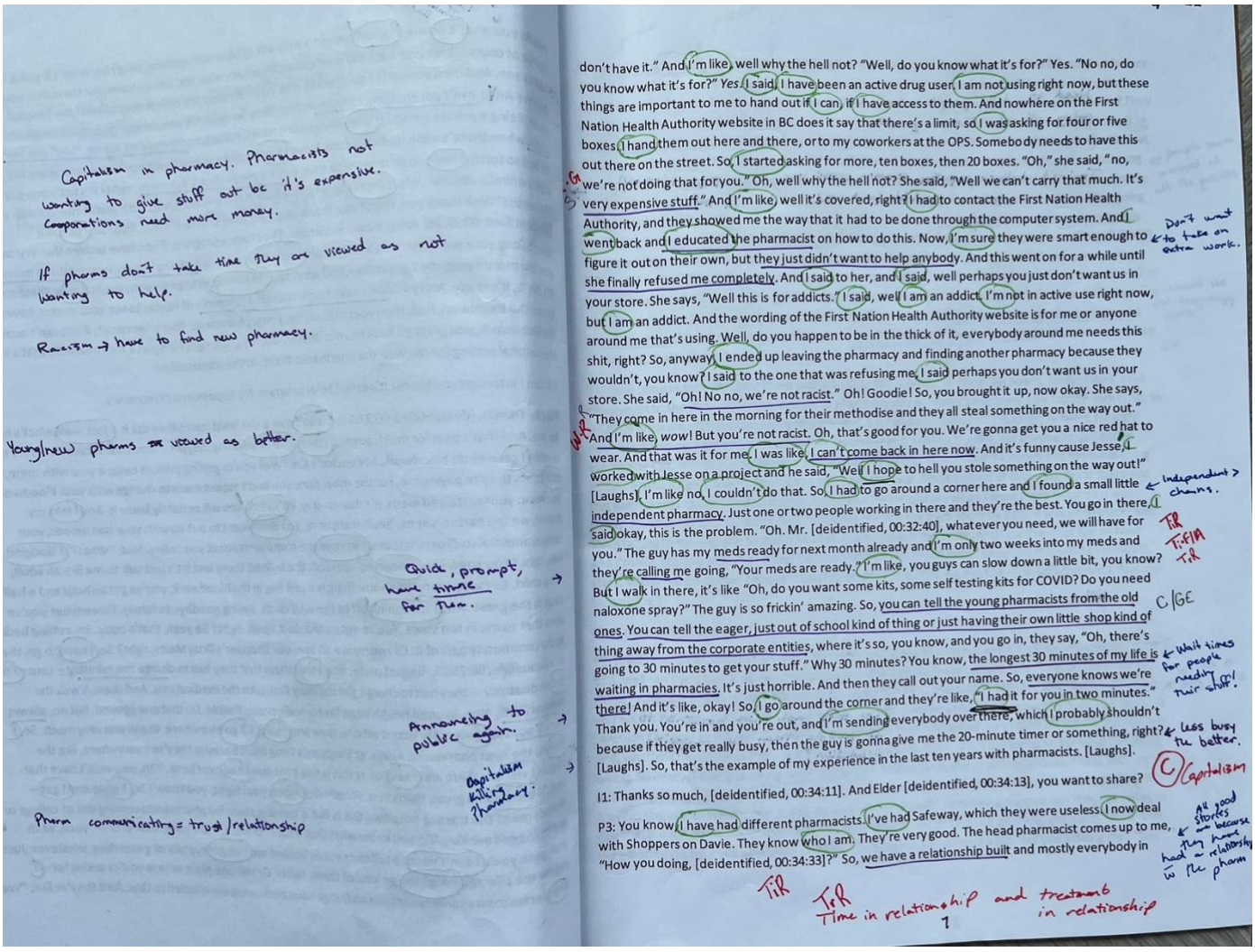
Youth more likely to accept TL racism, patronizing (esp!), etc.

Speaking up / advocating for oneself (if you are a minority esp.) makes you uncomfortable / it'll hard / will be treated diff next time.

Advocate here.

P3: I wonder if the youth are as mouthy as we are because I think – [deidentified, 01:15:04] you're laughing, it's true. We've reached a point in our lives, we're just not gonna take this shit no more. I'm gonna speak up and say things, right? And I think too, when I was 21 years old, I wanted to get into the pharmacy as quickly as possible. So, I would be really curious to know what the younger people are thinking and feeling cause I think normally, they would be similarly wanting to get in and get out kind of thing. But we're older, we get mouth, and we're all activists. We're all in the frontlines of everything, speaking for other people who can't speak for themselves. And we're able to speak for ourselves for the first time too. So, I wonder just how much difference there is between the age groups.

P1: Yeah, 100%. If I would have – and also, [deidentified, 01:15:55], we're here willingly. You're not forcing us to be here. But also that yeah, when I was even 10 years ago, I wouldn't have had the agency or whatever to say this is what's crappy about the system. I deal with a lot of ableism and things like that. Same with trans. I have to speak up cause if I don't speak up – and I'm willing to risk being wrong. I'm two spirit, I grew up gay in the 80's in rural Alberta, I'm used to being on the outside, it's not the first time. So, I'm willing to risk being a socio pariah by speaking my mind because if I don't say it, I don't speak up, the guilt of not speaking up and just kind of letting something ride and then that overwhelms – life is too short, I'm just gonna say it, I don't care if you don't like it. Where it might, mid-40s, I'm like yeah, yeah, now I'm doing this, I don't care what other people think. But yeah, ten years, five years and before, terrified what people thought, I wouldn't dare speak up. Now I'm like, I don't speak up, it might not change. Yeah, we need it to change for the next generations. So yeah.



don't have it." And I'm like, well why the hell not? "Well, do you know what it's for?" Yes. "No no, do you know what it's for?" *Yes*, I said, I have been an active drug user, I am not using right now, but these things are important to me to hand out if I can, if I have access to them. And nowhere on the First Nation Health Authority website in BC does it say that there's a limit, so I was asking for four or five boxes, I hand them out here and there, or to my coworkers at the OPS. Somebody needs to have this out there on the street. So, I started asking for more, ten boxes, then 20 boxes. "Oh," she said, "no, we're not doing that for you." Oh, well why the hell not? She said, "Well we can't carry that much. It's very expensive stuff." And I'm like, well it's covered, right? I had to contact the First Nation Health Authority, and they showed me the way that it had to be done through the computer system. And I went back and I educated the pharmacist on how to do this. Now, I'm sure they were smart enough to figure it out on their own, but they just didn't want to help anybody. And this went on for a while until she finally refused me completely. And I said to her, and I said, well perhaps you just don't want us in your store. She says, "Well this is for addicts." I said, well I am an addict, I'm not in active use right now, but I am an addict. And the wording of the First Nation Health Authority website is for me or anyone around me that's using. Well, do you happen to be in the thick of it, everybody around me needs this shit, right? So, anyway, I ended up leaving the pharmacy and finding another pharmacy because they wouldn't, you know? I said to the one that was refusing me, I said perhaps you don't want us in your store. She said, "Oh! No no, we're not racist." Oh! Goodie! So, you brought it up, now okay. She says, "They come in here in the morning for their methodise and they all steal something on the way out." And I'm like, *wow*! But you're not racist. Oh, that's good for you. We're gonna get you a nice red hat to wear. And that was it for me, I was like, I can't come back in here now. And it's funny cause Jesse, I worked with Jesse on a project and he said, "Well I hope to hell you stole something on the way out!" [Laughs]. I'm like no, I couldn't do that. So, I had to go around a corner here and I found a small little independent pharmacy. Just one or two people working in there and they're the best. You go in there, I said okay, this is the problem. "Oh. Mr. [deidentified, 00:32:40], whatever you need, we will have for you." The guy has my meds ready for next month already and I'm only two weeks into my meds and they're calling me going, "Your meds are ready." I'm like, you guys can slow down a little bit, you know? But I walk in there, it's like "Oh, do you want some kits, some self testing kits for COVID? Do you need naloxone spray?" The guy is so frickin' amazing. So, you can tell the young pharmacists from the old ones. You can tell the eager, just out of school kind of thing or just having their own little shop kind of thing away from the corporate entities, where it's so, you know, and you go in, they say, "Oh, there's going to 30 minutes to get your stuff." Why 30 minutes? You know, the longest 30 minutes of my life is waiting in pharmacies. It's just horrible. And then they call out your name. So, everyone knows we're there! And it's like, okay! So, I go around the corner and they're like, "I had it for you in two minutes." Thank you. You're in and you're out, and I'm sending everybody over there, which I probably shouldn't because if they get really busy, then the guy is gonna give me the 20-minute timer or something, right? [Laughs]. So, that's the example of my experience in the last ten years with pharmacists. [Laughs].

I1: Thanks so much, [deidentified, 00:34:11]. And Elder [deidentified, 00:34:13], you want to share?

P3: You know, I have had different pharmacists. I've had Safeway, which they were useless. I now deal with Shoppers on Davie. They know who I am. They're very good. The head pharmacist comes up to me, "How you doing, [deidentified, 00:34:33]?" So, we have a relationship built and mostly everybody in

Capitalism in pharmacy. Pharmacists not wanting to give stuff out bc it's expensive. Cooperations need more money.

If pharms don't take time they are viewed as not wanting to help.

Racism → have to find new pharmacy.

Young/new pharms ≠ viewed as better.

Quick, prompt, have time for them.

Announcing to public again.

Capitalism killing pharmacy.

Pharm communicating = trust/relationship

Don't want to take on extra work.

Independent > chains.

Wait times for people needing their stuff!

Less busy the better.

All good stories are because they have a relationship in the pharm