WORKING THROUGH STIGMA: A CONSTRUCTIVIST GROUNDED THEORY OF DELIVERING HEALTH SERVICES TO 2SLGBTQ POPULATIONS IN NOVA SCOTIA

by

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DEDICATION PAGE

This dissertation is dedicated to those who participated in this research because none of this would have been possible without your generosity and wisdom. The authenticity in which your contributions were made, and experiences shared, was humbling and inspiring. It is with the deepest gratitude that I dedicate this to all of you. This work is also dedicated to my sisters, the Lesbians who forged the path along which I travel. Without your bravery and perseverance, the life I live would not be possible.

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ABSTRACT

This study was designed to generate theory that works to further understandings of the processes and factors influencing the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. This Constructivist Grounded Theory study employed Intersectional and Critical lenses, complicated the notion of identity in a broadly inclusive manner, and gained insight into socio-structural factors that influence access to health services in primary care settings across Nova Scotia. By conducting a preliminary literature review, stigma was identified as significant to the health outcomes of 2SLGBTQ populations, justifying its use as a starting point for the investigation.

Upon REB approval, a diverse sample population was recruited; variation was maximized across categories of identity (sexual orientation, gender, race, (dis)ability, and citizenship), geographies, and professional scope of practice/role. Sampling purposively from historically underrepresented groups so they were overrepresented in the sample population created points of comparison for the purpose of enhancing data analysis and generation of a robust grounded theory. The sample population (n=30) was comprised of three subgroups: 2SLGBTQ health service users (HSUs) (n=10), 2SLGBTQ health service providers (HSPs) (n=10), and non-2SLGBTQ HSPs (n=10). Semi-structured interviews lasting up to 90 minutes were conducted with each participant using video-conferencing software.

Participants confirmed that stigma was a meaningful construct; its significance was substantiated throughout the data collection process. Conceiving stigma as a socio-structural process that determines health outcomes allowed for an exploration of 2SLGBTQ stigmatization in health care by investigating the delivery of primary care services to 2SLGBTQ populations across a provincial health system. Data analysis started with its collection by way of constant comparison, and continued through coding methods, memo-writing, diagramming, and writing this dissertation. As such, the level of abstraction was raised and a substantive theory of Working Through Stigma was co-created. The main concern of participants was that stigma causes individuals to experience power relations differently and the experiences of those with relatively less power are often disproportionately negative. The theory depicts what participants are doing about their concerns and involves three interrelated processes: depending on context, resolving histories, and surviving the situation.

LIST OF ABBREVIATIONS USED

2SLGBTQ	Two Spirit, Lesbian, Gay, Bisexual, Trans, and Queer
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Disorder
ANCA	Adornian Negative Case Analysis
BRIC NS	Building Research for Integrated Primary Healthcare in Nova Scotia
CCA	Continuing Care Assistants
CGT	Constructivist Grounded Theory
CINAHL	Cumulative Index to Nursing and Allied Health Literature
COVID-19	Coronavirus Disease 2019
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBSCO	Elton B. Stephens Company
EMR	Electronic Medical Record
EMS	Emergency Medical Services
GAC	Gender Affirming Care
GAH	Gender Affirming Hormones
GAS	Gender Affirming Surgeries
GBMSM	Gay, Bisexual, and Other Men Who Have Sex with Men
HIV	Human Immunodeficiency Virus
HSP	Health Service Provider
HSU	Health Service User
ID	Identification
IV	Intravenous

LPN	Licensed Practical Nurse
MSI	Medical Services Insurance
MSM	Men Who Have Sex with Men
MST	Minority Stress Theory
NSH	Nova Scotia Health
PrEP	Pre-Exposure Prophylaxis
PTSD	Post-traumatic stress disorder
REB	Research Ethics Board
REDCap	Research Electronic Data Capture
SOGI	Sexual Orientation and Gender Identity
TV	Television
US	United States
VON	Victorian Order of Nurses
WPATH	World Professional Association of Transgender Health

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CHAPTER ONE – INTRODUCTION

By way of Constructivist Grounded Theory (CGT) methodology and methods, I grappled with stigma in two ways: 1) the societal stigmatization of Two Spirit, Lesbian, Gay, Bisexual, Trans, and Queer (2SLGBTQ) identities in the public domain, and 2) the institutionalization of stigma in health care that shapes university curricula, the health system, and how health services are delivered to 2SLGBTQ health service users (HSUs). It was necessary to recruit a sample that includes both health service providers (HSPs) and 2SLGBTQ HSUs. This allowed for an exploration of HSPs' learning experiences of delivering primary care services to, and the care recipient experiences of, diverse 2SLGBTQ populations in Nova Scotia.

This study is critical of clinical knowledge because it represents a narrow perspective on health that coincides with the values of dominant cultures and their principles of conduct. When health-related behaviour is situated within broader social contexts (whereby dominant cultures influence the opportunities of groups and individuals through socially constructed differences), socio-structural determinants of health can illuminate the constraints that are placed on the health-seeking strategies employed by populations historically underserved in health care (Metzl & Hansen, 2014). Using CGT methodology and methods, this study sought to expand upon existing perspectives on health by exploring stigma, a social construct that is historically verifiable. Historical context was important from the onset of the study because social histories shape how the world is perceived and experienced (Haraway, 1988). Social histories precede individuals who are then socialized to existing norms and the latter shapes the former accordingly (Razack, 1998). The historical precedence for the ongoing exclusion and invisibility of 2SLGBTQ populations in medical and health professions curricula and training complicate how stigmatization is experienced by individuals within health care and society more broadly

(Donald et al., 2017). Distress felt across generations of stigmatized groups connects individuals across time; at their expense, those with relatively more power are afforded better choices (Collins & Bilge, 2020; Haraway, 2016; McGovern & Vinjamuri, 2016).

The potential for diversity within the 2SLGBTQ communities is exponential when social categories of identity beyond sexual orientation and gender are considered, such as, race, (dis)ability, and citizenship. Using maximum variation sampling, persons at the intersections of sexual orientation, gender, race, (dis)ability, and citizenship were purposively recruited to complicate the exploration of delivering health service to diverse 2SLGBTQ populations in primary care settings in Nova Scotia. The proposed study was designed to generate new theory that works to further understanding of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. The Two Spirit identity is specific to Indigenous cultures whereby distinct cultural beliefs with particular histories of colonialism exist (Carrier et al., 2020). Two Spirit is thus a term that describes the tradition of diversity and fluidity of gender and sexual identity within Indigenous cultures (Hunt, n.d.). Lesbian, Gay, and Bisexual are sexual orientations; Lesbians have same-sex attraction to Woman-identified persons, Gays have same-sex attraction (typically between Man-identified persons), and Bisexuals show no preference in sexual attraction. Trans and Queer are both umbrella terms, the former referring to those who do not identify with the gender they were assigned at birth, including gender Queer and Non-Binary, and the latter is defined here as persons who do not feel represented by the aforementioned social categories.

Stigma served as a point of entry for the investigation because it is is a socio-structural process that is embedded in practices across cultures (Donald et al., 2017; Kleinman & Hall-Clifford, 2009). Stigma thus afforded an exploration of health-related practices that are influenced by socially constructed differences between (eg. 2SLGBTQ versus non-2SLGBTQ) and within groups (eg. depending on characteristics, such as sexual orientation, gender, race, (dis)ability, and citizenship) and shape access to resources (eg. health services). Findings will be translated and disseminated with an aim to inform changes in how medical and health programs deliver education on diverse 2SLGBTQ populations so that HSPs can be better prepared to work through stigma (as a socio-structural process that determines health outcomes), learn how to avoid constructions that negatively influence health outcomes, advance 2SLGBTQ health equity within Nova Scotia and beyond through practice, and transform health service delivery for historically underserved populations who experience stigmatization.

The barriers to bringing about change in health care reach beyond the health system itself because they are embedded in practices that give rise to social structures. By extending application of Bourdieu's (1977) understanding of social structures (Metzl & Hansen, 2014), I used stigma as it relates to 2LSGBTQ populations within healthcare settings as a starting point for my investigation. A legacy of homophobia and heterosexism can be objectively verified by tracing the pathologization of 2SLGBTQ populations in the Diagnostic and Statistical Manual of Mental Disorders (DSM), highlighting its institutionalization in health care. This history exposes a past that underlines the need to analyze the conditions within which health services are delivered to 2SLGBTQ populations in relation to a stigmatizing broader social context.

It was clear from the beginning of data collection that stigma was significant to participants. The overall process described by participants co-created from the data as "Working Through Stigma". Participants were aware of the impact of stigma on how health services are delivered to 2SLGBTQ populations within primary care settings in Nova Scotia and findings demonstrate the scale of stigma that individuals are working through. Participants who were

2SLGBTQ-identified experienced stigma differently than those who were non-2SLGBTQ identified; however, through power relations, participants were contrained by stigma in various aspects of their lives. All participants described ways of negotiating power relations (by) working through stigma. HSPs stated intentions to avoid reproducing negative constructions in their individual practice, but there was evidence of power relations working through stigma in ways that were beyond the control of individuals, including those belonging to dominant groups.

1.1 Background

The literature review is contested among Grounded Theorists; some suggest delaying the literature review until after the data analysis is complete while others suggest a preliminary review to outline the path of investigation (Charmaz, 2014). By locating a starting point for the proposed study, the preliminary literature review intended to achieve the latter. This allowed me to avoid forcing data into preconceived sub concepts, but still make connections between my study and existing knowledge (Charmaz, 2014). As such, the preliminary literature reviewed merely intended to verify and explore the ways that 2SLGBTQ populations uniquely and negatively experience stigma within the broader context of society, the situated context of health service delivery, and in relation to social norms around gender.

I wish to begin by offering a concrete scenario to provide context for the study and foster an appreciation of how stigma influences the ways in which health services are delivered to 2LSGBTQ populations. This is important for the reader to fully appreciate the research problem, rationale, and purpose, as well as the research questions and objectives. It is important to note that this example highlights access to gender-affirming care in Nova Scotia and does not broadly represent barriers to health services experienced by members of the 2SLGBTQ communities. Funding for gender-affirming surgeries (GAS) was approved as an insured benefit for Nova

Scotians in 2014 if they had a diagnosis of gender dysphoria (CBC News, 2014; Government of Nova Scotia, n.d.). I worked for prideHealth and became knowledgeable about the (limited and complicated) pathways to gender-affirming care across the province. I am thus speaking to the breadth of experience I gained as patient navigator working to diminish barriers to health services for Trans patients in Nova Scotia. PrideHealth is a program in the primary healthcare portfolio at Nova Scotia Health (NSH), the Canadian province's publicly funded health authority, that aims to diminish barriers to accessing health services experienced by 2SLGBTQ populations. I received as many calls from HSPs as I did HSUs looking for assistance in navigating a system that was fraught with barriers to access services for a population on which they received little to no training.

There are two pathways to accessing gender-affirming hormones (GAH) in Nova Scotia (McLean, n.d.). One pathway requires a letter of readiness from a person whose practice is informed by the World Professional Association for Transgender Health (WPATH) standards of care, which were last released in 2011 (the new version's release has been delayed and is currently expected in the Spring of 2022). This means that HSUs must have a psychosocial assessment conducted by a trained professional, many of which charge for the assessment in addition to a fee for writing the letter itself. The assessment itself consists of confirming gender dysphoria, that the HSU is competent to consent to treatment, and that they will benefit from GAH (WPATH, 2011). The other pathway does not require a letter of readiness (McLean, n.d.). HSPs who provide GAH without a letter operate under what is commonly referred to as an informed consent model. Unfortunately, the lack of education that HSPs receive on GAH in their formal (and mandatory) training results in many refusing to offer these services. In the rare circumstances that an HSP was willing to provide GAH to their own patients, it was my experience that they often chose to operate under the first pathway because WPATH Standards of Care (that are now over a decade old) recommends a letter of readiness prior to initiating GAH.

Stigma does not just place limitations on HSUs; HSPs are impacted differently in how they practice, which can indirectly negatively impact HSUs. The example of GAH pathways illustrates how stigma converges upon individuals to place limitations on what options are available to them and what barriers must be overcome to access health services, some of which are lifesaving. Also illustrated is the necessity for collaboration between governments, HSPs, HSUs, and other stakeholders so that barriers experienced by populations historically underserved in health care, such as the lack of information for HSPs on how to deliver GAH that results in the refusal of health services to HSUs seeking gender-affirming care (GAC), can be addressed in ways that benefit service users.

While at prideHealth, I was involved in a collaborative initiative that aimed to work through the stigma that placed disproportionate barriers on Trans and gender diverse HSUs seeking GAH. Education modules were created, accredited, and made available at no cost to anyone who wished to take them. Those who registered for the course were asked if they would take on patients for GAH. I called or emailed those who agreed, and they became part of a province-wide referral network. When HSUs contacted me seeking GAH, I could refer them to the HSP in my referral network who was closest to them. Prior to this initiative, it took approximately 8-12 months to gain access to GAH. The average wait time for HSUs who accessed GAH through the referral network I helped to established waited an average of 30 days. During a follow-up interview with one of the participants in this study, I was delighted to hear that they accessed GAH through my referral network and was faced with the impact of intervening upon stigma upstream and how the downstream benefits impact the lives of individuals. Having provided an example of how stigma can influence access to health services, it is my hope that the reader has developed an appreciation for the importance of working through stigma by providing educational opportunities that formally address the needs of 2SLGBTQ populations for learners within the medical and health professions.

1.1.1 Defining Culture and Power

Within the context of this study, culture is defined as the knowledge, skills, and behaviour that serve to create, maintain, reinforce, and reproduce social divisions between groups and individuals (Bourdieu, 1977). An important and related concept to culture, power is conceived as mutually constructed systems of relationships between groups and individuals whose cultural differences are reduced and reified into social categories of identity for the purpose of domination (Adorno, 1973; Bourdieu, 1989; Collins & Bilge, 2020; Nader, 1972). Relations of power are complex, contested, negotiated, exercised, and perpetuated by way of daily struggles that highlight the organization and positioning of groups and individuals according to social inequalities that shape interactions intrapersonally (within the self), interpersonally (between and among individuals) and contextually (cultural, economic, historical, political, and social contexts that shape individuals' ability to act at intrapersonal and interpersonal levels) (Bourdieu, 1989; Collins & Bilge, 2020; Doane & Varcoe, 2015). Power relations can then be explored according to context to appreciate how differences in status and outcomes promote and justify social inequalities that work to normalize the advantages that some gain at the expense of others (Castro & Farmer, 2005; Collins & Bilge, 2020). Cultures can then be understood with respect to what they "do" and how groups and individuals construct cultural differences to organize themselves by way of social divisions that underpin inequalities through intersecting power relations (Collins & Bilge, 2020; Nader, 1972). In terms of reproducing socially constructed differences that shape relations of power, culture has been (and continues to be) an important factor in how social realities are constructed (Bourdieu, 1989; Nader, 1972).

Cultural differences shape relations of power and social inequalities that have different consequences for groups and individuals within and across cultural contexts; social differences are reified into social categories of identity, which can be used to create standards by which groups and individuals can be objectified (Adorno, 1973; Bourdieu, 1989; Collins & Bilge, 2020; Razack, 1998; Robertson, 2002). Groups and indivduals with the capacity to objectify another person can exercise power over those who have relatively less contextual power in ways that are symbolic, such as media portrayal (Bourdieu, 1989; Salzman, 2002; Tyler & Slater, 2018). Such objectification involves situating subjects in ways that fail to acknowledge broader social processes that shape the distribution of resources and contextual power relations, which work to restrict access to services, such as those in health care (Castro & Farmer, 2005; Kleinman & Hall-Clifford, 2009; Marcus, 1994; Narayan, 1993). The assertion that Heterosexual bonds were organized by and for Men by distinguishing themselves from Women due to biological differences demonstrates my point; Men justify their superiority by limiting access to social privileges, thus revealing the reproduction of dominance through power relations that makes it possible to naturalize their domination across cultures (Rosaldo, 1980). This example illustrates how distinctions can be used by groups and individuals to assume a position of dominance and reproduce power relations that justify cultural supremacies and social inequalities, which naturalize the advantages that Men can then gain at the expense of Women (Rosaldo, 1980). Objectification is thus a symbolic act of power that is contextually determined by powerful groups and individuals to reproduce hegemonic power relations, which are those that are grounded in and thus rely upon keeping dominant cultural norms in place (Castro & Farmer, 2005; Razack, 1998; Rosaldo, 1980).

Culture is broadly defined in this study to be inclusive of the broad range of meaning that diverse 2SLGBTQ populations give to their experiences and to avoid the creation of objectifying standards. In this sense, what culture "does" is important to exploring how groups and individuals are organized by way of intersecting power relations that perpetuate social inequalities. As such, Donna Haraway's (2016) conceptualization of culture in *Staying with the Trouble* helps to capture the complexity of culture so that interconnections and mutually constituted power relations can be explored. Haraway (2016) presents a perspective on the current state of the human world whereby she argues that domination in all its forms characterizes a fundamental flaw in human relationships because these forms too often fail to account for the shared responsibility that all living things have to one another through mutual pasts, presents, and futures. As such, cultures do not exist in isolation from one another, nor do they pre-exist their interconnected relationalities whereby knowledge, skills, and behaviours are used to create, maintain, reinforce, and reproduce divisions between groups and individuals (Bourdieu, 1977; Haraway, 2016). Haraway (2016) asserts that cultures do not pre-exist their mutually constituted realities. I would add, however, that cultures often pre-exist the groups and individuals that take up their practices. When social realities are "characterized by partial connections" (p. 104), cultures are falsely separated from one another, as if they are not all parts of sustained processes of social reproduction, and the power relations that arise from interconnected relationalities can obscure shared responsibilities, allowing for priorities to be set in ways that fail to account for collective interconnectedness (Haraway, 2016). Under such conditions, interconnected relationalities are created within, instead of also across, different cultures. Haraway’s (2016) conceptualization of culture therefore allows me to be inclusive of diverse perspectives and explore collective interconnectedness while also avoiding reproducing power relations that work to promote the prioritization of the experiences of certain groups or individuals over others.

I should clarify that I am not arguing that essentializing differences is a superior approach or one that would necessarily disrupt dominating power relations; what social categories of identity represent in terms of intersecting categories of power depends on the cultural context and relations of power therein. Minimizing differences within or between groups can work to reproduce power relations in ways that dominant groups and individuals can maintain their position(s) of power (Razack, 1998). As such, non-dominating groups and individuals, which are those with relatively less contextual power, can be objectified and judgements as to whether the standard for a social category of identity has been met can be made by those with relatively more power (i.e. dominant groups and individuals) (Razack, 1998). Those in non-dominant positions can then be oppositionally constructed according to prevailing power relations by way of those occupying dominating positions. As such, socially constructed differences must be acknowledged so that power relations can be explored without reproducing them. Differences among non-dominant groups and individuals are thus broadly defined in this study because essentialization can be strategic if the intent is to avoid creating distinctions that can be used by dominant groups and individuals to conceive an objectifying standard (Agger, 2006; Razack, 1998). Power relations and what underpins contextual social inequalities can then be explored by way of social categories of identity that are broadly defined for strategic purposes (Agger, 2006; Collins & Bilge, 2020; Razack, 1998). In other words, oppositional social categories (i.e., dominant versus non-dominant groups) can be repurposed as analytic tools, not because they are "real", but because their social consequences are.

1.1.2 Structural Stigma

Bourdieu's (1977) framework informs my understanding of structural stigma. His conceptualization of social structures is central to this study because it helps me to explore power relations within health systems and with respect to cultural norms, whereby individuals come to understand their social worlds through experiences therein. Bourdieu (1977) helps me to understand how social structures are practices that inform policies and decisions that impact people negatively or positively, thus mutually constituting power relations by way of patterns of behaviour in which we all engage (Metzl & Hansen, 2014). When something is said to be structural, cultural, economic, historical, political, and social factors are thought to be influencing "local, state, and global political economies, globalization, racialization, and institutions such as health legal, educational, and government systems" (p. 55), which shape social interactions at intrapersonal, interpersonal, and contextual levels (Doane & Varcoe, 2015). The interplay between these systems and social interactions are impacted by power relations (Doane & Varcoe, 2015). It is important to understand social structures as fluid and under construction (Bourdieu, 1977); policies (or lack thereof) shape individuals' ability to act, their health, how health services are distributed/accessed, and how health is even constructed (Doane & Varcoe, 2015). As such, policies and decisions impact people and what social services are available to them (educational policy, health policy, criminal justice policy, etc.) (Metzl & Hansen, 2014). This understanding allows me to see practice (the means by which health services are delivered within health systems) as structured actions that represent an externalization of subjective understandings of the social world, and reflective of an individual's perceived ability to respond within a given context (Bourdieu, 1977).

Stigma is a structural process that disqualifies individuals from being members from groups they once belonged, is embedded in power relations, and persists across cultures with varying consequences (Castro & Farmer, 2005; Link & Phelan, 2014, 2001; Metzl & Hansen, 2014). Relations of power work through stigma in different ways; separating the self from the non-self using labels that link individuals with undesirable characteristics and uphold cultural norms that benefit members of dominating groups results in losses in status and unequal outcomes among members of non-dominating groups, which serves to outline a general process by which stigma persists across cultures (Castro & Farmer, 2005). Stigmatization is rooted in relationships that reproduce power relations that promote "the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (Link & Phelan, 2001, p. 367). Social differences can then be negatively constructed, which is necessary for the creation and maintenance of opposition categories or binaries whereby stigma can be used to uphold.

The stigmatization of 2SLGBTQ populations is verifiable across cultures and shown to carry disadvantages for those who experience stigma in relation to their sexuality or gender (United Nations, 2011). Applying Bourdieu's (1977) framework suggests that individuals internalize stigma, which is then externalized through various practices. The historical legacy of stigma means that it pre-exists sexual and gender minorities, and so their identities are constructed as unnatural, abnormal, and/or bad, often before they gain awareness of their own sexual and/or gender identities (Lane, 2020b).

Bourdieu (1977) explains that individuals interact with others, gain or lose advantage(s), and find their structured position(s) in accordance with mutually constitutive social hierarchies and contextual power relations, whereby “those who are in a dominant position [are given] the right to profess the veneration of the past which is best suited to legitimate their present interests” (Bourdieu, 1977, p. 36). Histories predispose those who have relatively more contextual power to assume a dominant position and as a result, they perceive a greater ability to influence their social worlds. Individuals act within a given context, by way of how they perceive others’ subject positions (relative social positions of individuals), and interact according to practices that produce and reproduce the social world (Bourdieu, 1977; Törrönen, 2001). Stigma is a dynamic construct that has been extensively researched (Friedman et al., 2022); stigma is used to negatively constructs individuals who are then rendered vulnerable by (often unknowing) others who engage in practices (externalizations of how they internalized structural stigma) that reproduce hegemonic power relations and uphold cultural supremacies. In health care, that means that practices have consequences and can be seen as not only shaping practice, but health outcomes. It also means that power relations are reproduced through stigma by way of policy and decision-making without necessarily actively engaging in practices that carry direct advantages. At the interpersonal level, an individual may not intentionally reproduce hegemonic power relations, but if they are afforded legal protections that are not available to others, then they may be benefiting from another’s disadvantages at a contextual level. Stigma thus operates on multiple levels simultaneously, which makes its impacts complex and far-reaching.

Socio-structural determinants of health are conceptualized here as factors that emanate from social structures and influence health outcomes (Metzl & Hansen, 2014). Stigma is a socio-structural determinant of health that reflects “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2). Structural stigma reinforces social distinctions and disadvantages at various levels; stigmatization can be carried out and have negative impacts without intention when privileges are afforded in a discriminatory manner by way of institutional policies and practices that re-create the stigmatizing conditions found within broader social contexts (Hatzenbuehler, 2016). Such settings trigger chronic psychological and physiological stress responses of individuals who experience stigma in broader society, causing them to anticipate rejection and fear exclusion when disclosing stigmatized aspects of their identity (Hatzenbuehler et al., 2017). There are factors (social policies, community-level attitudes, and neighborhood-level hate crimes, among others) that operate at intrapersonal, interpersonal, and contextual levels that influence health outcomes; the relationship between stigma and the increased risk of negative health outcomes among populations as a result of the social stress they experience is a matter of being made vulnerable by structural level factors (Hatzenbuehler & Link, 2014; Luna, 2009). These factors carry an increased risk of mortality for individuals who hold membership in socially stigmatized groups (Flores et al., 2018; Hatzenbuehler, 2014). Structurally stigmatizing conditions promote psychiatric morbidities; where protective policies are lacking for sexual minorities, negative psychiatric outcomes were 2.5 times higher as compared to their Heterosexual counterparts in the same American states (Hatzenbuehler, 2014). Moreover, one study found that once sex-sex marriage bans were passed, there was an increase of 37% in mood disorders, 42% increase in disordered alcohol use, and a staggering 248% increase in generalized anxiety disorder among respondents after same-sex marriage bans were passed as compared to before the laws were put in place (Hatzenbuehler, 2014). When discriminatory laws were passed, stigmatized individuals and groups experienced poorer health outcomes, not only as compared to those who are not stigmatized individuals, but also in comparison to their own health prior to the laws being passed. Studies in and beyond the American context support these findings; legislation and policies that promote equality for sexual and gender minorities may mitigate risk and deleterious outcomes (Aivadyan et al., 2021; Bränström & Pachankis, 2021; Hatzenbuehler et al., 2020; Pachankis et al., 2017, 2021). Stigma is thus depicted in the literature as a multilevel construct that has deleterious impacts on individuals, groups, and communities who fail to conform with cultural norms.

1.1.3 Minority Stress Theory

There are physiological processes that are impacted by stress. Cortisol - a hormone that is released by the hypothalamic-pituitary-adrenal axis - is found to be elevated among minority groups in response to social stress and is implicated in an increased risk for negative health outcomes that are associated with compromised physiological functioning, such as hypertension and diabetes (Cohen et al., 2007; Lick et al., 2013). The concealment of identity, which is central to having a stigmatized identity (Goffman, 1963), is a shared, yet diverse, experience for all members of the 2SLGBTQ communities because their differences are negatively constructed in opposition to gender norms by members of dominant groups. What is meant by this is that the practices and behaviours of 2SLGBTQ populations are different from what dominant groups "do" with their gender; through stigma, the latter is opposed to the former. There is evidence that shows cortisol levels were increased when individuals had not disclosed their sexual minority status within their workplace as compared to those who had (Huebner & Davis, 2005). A study conducted by Cole et al. (1997) looked at the cortisol levels among participants who were known to conceal their sexual identities. They determined that concealing one's sexual identity was associated with increased cortisol levels, immune function dysregulation, and negative health outcomes. They found that Gay Men who were HIV positive and concealed their sexual identity had faster disease progression than those who disclosed their sexuality, even when age, ethnicity, and socio-economic status were taken into account (Cole et al., 1997). Cortisol was also found to be increased among groups beyond that of sexual minorities, particularly racialized populations, underlining the higher risk for negative health outcomes among those who comprise their identities from multiple minority groups (Parra & Hastings, 2018). There is substantial additional evidence that supports the idea that there is a strong relationship between minority stress and biological outcomes (Flentje et al., 2019). Taken together, there is ample evidence to support that social stress causes physiological changes that lead to specific chronic illnesses, which establishes that stigma is a valid socio-structural determinant of health that negatively impacts diverse 2SLGBTQ populations.

Reinforced and responded to by individuals through interpersonal interaction, stigma is a structural process that causes stigmatized individuals to experience stress (Meyer, 2003). Minority Stress Theory (MST) has been shown to be useful in conceptualizing the unique, chronic, and socially-based stigma-related stress that negatively impacts sexual minorities (Meyer, 2003). MST has been expanded to include Trans populations (Lefevor, Boyd-Rogers, et al., 2019), illustrating the value in considering multiple social categories of identity to understand stigma-related stress (Shangani et al., 2020). In a large-scale national study in the United States, racialized sexual minorities were found to have a greater pre-occupation with the perceived risk of being discriminated against as compared to their White counterparts; specific to Black sexual minorities of higher socioeconomic status was an increase in enacted stigma, which is when discrimination is actually experienced (thus confirming its perceived risk) (Shangani et al., 2020). White sexual minorities in the sample were found to experience relatively less stigma with higher socioeconomic status (Shangani et al., 2020). This suggests that within the context of American culture and among the participants in this study, higher socioeconomic status is not necessarily protective for Black sexual minorities as compared to their White counterparts (Shangani et al., 2020). MST teases out important differences within and between groups who experience disadvantages as a result of engaging in behaviour that is constructed in opposition to gender norms. In addition to sexual minority status, MST has been used to identify unique stressors in relation to gender identity, race, age, (dis)ability, religion, and socioeconomic status (Abbruzzese & Simon, 2018; Lefevor, Blaber, et al., 2019). MST is thus relevant to understanding stigma as a source of stress that negatively influences health outcomes and is useful in establishing a common starting point for research that captures the diversity that exists within and between 2SLGBTQ populations.

Stigma-related stress in 2SLGBTQ populations. If stigma is regarded as “a dynamic process enacted through structures and individuals, and mediated by relationships of power, control, and domination that are continuously produced and reproduced” (Jackson-Best & Edwards, 2018, p. 1), then there are variations in how individuals experience stigmatization within and between groups, particularly contained in the lived realities of diverse 2SLGBTQ populations. There are pathways along which minority stress travels that diverse 2SLGBTQ populations experience because of stigma. Minority stress travels on pathways that include rejection expectation, internalized homophobia, identity concealment, rumination, emotional dysregulation, unassertiveness, and impulsivity (Pachankis et al., 2019). These pathways connect individuals to broader stigmatizing social conditions by way of the stress they experience. In so far as sexual orientation and gender cut across other intersections of identity, including race, Indigeneity, ethnicity, religion, age, (dis)ability, and culture, addressing minority stress pathways may be a means by which health disparities can be broadly appreciated to avoid the impossible task of addressing population-based health problems separately (Pachankis et al., 2019).

Turan et al. (2019) describe the issue of stigma as intersectional; when stigmatized identities intersect, stigma converges upon individuals, groups, or communities, making their experiences more negative than those with identities that are singly stigmatized or non-stigmatized. Guidelines on how to characterize, analyze, or design interventions that address the complexity of intersectional stigma and the stress it causes are lacking (Turan et al., 2019). Diverse 2SLGBTQ populations are ideal for conducting intersectional research that seeks to understand the processes and factors that contribute to stigma-related stress in healthcare settings. The various versions of the DSM reveal a historical account of the conditions under which health services have been delivered to 2SLGBTQ populations that have legitimated and contributed to the pathologization of multiple 2SLGBTQ identities, spanning decades (Drescher, 2015a; Spurlin, 2019). Since 1952, the distress that 2SLGBTQ individuals experience as a result of the societal stigma they face in relation to their sexual orientation or gender identity has been classified as a mental disorder in some way or another (Drescher, 2015a). Distress has and continues to be medicalized by way of psychiatric diagnoses, and by default, distressed individuals are pathologized because diagnostic criteria fail to address the social causes of the stress that they experience. Metzl & Hansen (2016) challenge this historical legacy by arguing health outcomes are determined by "the pathologies of social systems" (p. 179), meaning the social causes of illness need to be addressed in societally as well as individually (Sercu & Bracke, 2017).

In nursing, there is a lack of content on 2SLGBTQ populations, which translates into a lack of nursing scholarship on 2SLGBTQ issues (Lim et al., 2013). Depending on how

2SLGBTQ-related content is introduced to learners, stigmatization can be reinforced, and negative stereotypes confirmed. For example, an end-of-life simulation about a Gay Man dying of AIDS because he contracted HIV from a contaminated needle during intravenous (IV) drug use was being used in the undergraduate nursing program at Dalhousie University. When content such as this confirms negative stereotypes (i.e., high-risk sexual and substance-use behaviour among Gay men) without exploring the socio-structural causes of health-related behaviour, educational opportunities for learners to explore how stigma adversely impacts 2SLGBTQ populations are missed. This not only underprepares medical and health professionals to provide equitable care to 2SLGBTQ populations, but it also fails to teach learners the importance of examining (personal, social, and institutional) biases and assumptions that contribute to the stigmatization of 2SLGBTQ populations (Greene et al., 2018; Knight et al., 2014; Murphy, 2019). This issue is not limited to nursing and highlights the socio-structural nature of stigma; it has an impact on individuals (future HSPs) by way of a lack of content on stigmatized populations in formal training and education. There is a paucity of training on 2SLGBTQ in medical schools across Canada and the United States and physicians are frustrated by their lack of training on the social causes of illness (Donald et al., 2017; Hansen & Metzl, 2017). One study found that there was a median of five hours dedicated to 2SLGBTQ-related content and one-third of the schools reportedly failed to include any training whatsoever (Obedin-Maliver et al., 2011).

The Standing Committee on Health created the *Health of LGBTQIA2 Communities in Canada* report (House of Commons of Canada, 2019), which demonstrates an awareness on the part of the Government of Canada surrounding the health issues that 2SLGBTQ populations experience. Their report outlines that Bisexuals and those with same-sex attraction are two to four times more likely to report fair or poor mental health status as compared to their Heterosexual counterparts. One survey found that 60% of Trans people had high levels of depression, 65% of Trans youth reported suicidal ideation, and 10% of the overall sample had attempted suicide (House of Commons of Canada, 2019). In terms of other chronic diseases, the prevalence of asthma among Lesbians and Bisexual Women was found to be 16% (Heterosexuals were nine percent) and anal cancer among Gay/Bisexual/Menwho have sex with Men(GBMSM) has a prevalence of 45 per 100,000 persons (general population being 1.5-2 per 100,000) (House of Commons of Canada, 2019). Addictions are also more prevalent among 2SLGBTQ populations; Lesbian and Bisexual Women were found to engage in heavy alcohol use at a rate of 1.64 times more than their Heterosexual counterparts, tobacco use was 24-45% higher within 2SLGBTQ populations as compared to the general population (16% in 2012), and Menwho are Gay, Bisexual, and/or have sex with Menwere noted to be more likely to use drugs illegally than their Heterosexual counterparts (House of Commons of Canada, 2019). Negative health outcomes are disproportionately experienced by 2SLGBTQ populations, but as noted above, they are too often separated from the social issues that cause, exacerbate, and reinforce 2SLGBTQ health disparities (Meyer, 2003; Spurlin, 2019). Obscuring these socio-structural factors, which include discrimination in the workplace and education system, food and housing insecurity, rurality, and legal factors, results in unequal treatment under the law and a failure to appreciate the broader social context of negative health outcomes.

We know that health disparities are disproportionately experienced by 2SLGBTQ communities and not inherent to sexual or gender minority groups, rather their adverse health outcomes are determined by socio-structural processes, such as stigma, that also shape the conditions under which health services are delivered (Donald et al., 2017; Luna, 2009). This is because broader social contexts shape the conditions (and lived realities of individuals) therein. For example, sexual and gender minorities are subject to various human rights violations globally and across cultures, including persecution, torture, corrective rape, discrimination in the workplace and school, fewer legal rights and protections than their normative counterparts, conversion therapy even though it has been disproven as an effective treatment, and being murdered, targeted by religious and political extremists, and mutilated (United Nations, 2011). Impacts on individual experiences are contextual, including but not limited to where a person lives and the resources available to them; community, national affiliations, and individual factors including personal wealth all matter in addition to countless other factors. Where there is tension between the cultural norms of dominant groups and those of minority/non-dominant groups, the former can assume a dominant position over the latter and the conditions under which social interactions take place are shaped accordingly. Power thus works through stigma to justify the organization of groups and individuals and how subjects are positioned according to social inequalities that shape interactions at intrapersonal, interpersonal, and contextual levels. As such, the need for sexual and gender minorities to disclose their identities in order to access care that addresses their health needs (Griffin et al., 2020; Ruben & Fullerton, 2018; Whitehead et al., 2016) illustrates the need to explore how health service delivery constructs and perpetuates the stigmatization of diverse 2SLGBTQ populations.

1.1.4 Cultural Dominance and Heteronormativity

Dominant cultures are being broadly conceived for the purpose of this study because defining them as such is inclusive to the range of cultural domination that diverse 2SLGBTQ populations experience. The 2SLGBTQ communities are not universally impacted by stigma, rather there is domination between and within populations, complicating relations of power therein. Reducing differences to sexual and gender minority populations is insufficient in being broadly inclusive to the racial, ethnic, socioeconomic, age-related, cultural, citizenship, ability-related, use/mastery of language, and religiously motivated domination that diverse 2SLGBTQ populations experience, both within and between various subject positions. It is intended to be a "catch-all phrase" so that the differences within what is "caught" can promote a dynamic and nuanced understanding of the phenomenon under investigation. I cannot look at intersecting identities separately; to be truly intersectional in my approach and capture the potential for diverse experiences, I need to be broadly inclusive and thus open to the wide range of cultural dominance constituted by sustained processes of social reproduction within, between, and upon diverse 2SLGBTQ populations. Broad inclusion as such promotes the exploration of subjective experience in relation to social categories of identity in ways that account for cultural differences without objectifying them (Collins & Bilge, 2020; Razack, 1998). Sexual and gender minorities are more than "just" their sexual orientation and gender; identities can be complicated by way of race, ethnicity, socioeconomic status, age, culture, citizenship, ability, use/master of language, and affiliations religious and otherwise, to be broadly inclusive of the subjective differences within and between members of the non-dominant group that are categorized as "2SLGBTQ". As such, there are important differences within and between diverse 2SLGBTQ populations that this study explored in relation to the conditions under which primary health services are delivered.

Within the context of this study, dominant cultures refer to any culture that de-naturalizes, negates, denies, or devalues other cultures in such a way that their members are denied equal access to resources within a given social context (Rosa et al., 2018). Cultures can be dominating when their members can reproduce power relations through intersecting social categories of identity, including sexual orientation, gender identity, race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation (among others). Dominant cultures are not necessarily Western, although that is yet another example of a culture whose members can assume dominating positions. Dominant cultures are those whose members can assume positions that come with advantages that place others at a disadvantage (Horkeimer, 2002). Adorno & Horkeimer (1997) narrowly conceptualized dominant cultures as those that uphold the status quo within Westernized contexts. They understood dominant cultures to be normative in so far as they “remain unquestioned, unanalyzed and undialectically presupposed, even if they no longer have any substance for those who accept them” (Adorno, 1973, p. 17). While Horkeimer & Adorno did not conceive dominant cultures in relation to 2SLGBTQ populations, they saw dominant cultures as inherently ideological and grounded in conformity (Adorno, 1973). Cultural dominance is thus not about one dominant view, but the ways in which social structures create hierarchies of power that organize groups and individuals within societies, upholding the status quo. This makes the work of the Frankfurt School a relevant philosophical starting point to understanding how culture can be used to place limitations on groups and individuals whose autonomy could challenge the status quo and threaten power relations that position members of dominant groups in ways that they can reproduce power relations upholding cultural supremacies at the expense of members of non-dominant groups (Adorno, 1973).

Despite the fact that they were only referring to Western culture, I am complicating the School’s conceptualization of cultural domination to think about 2SLGBTQ populations. This is possible because *diverse* 2SLGBTQ populations are constructed as “other”: unnatural, abnormal, or bad because they are understood in relation to the values and principles of conduct belonging to dominant cultural supremacies that construct Heterosexuality, gender conformation, Whiteness, able-bodiedness, and other normative social identities as superior. Standards by which members of diverse 2SLGBTQ communities can be objectified are thus constructed in opposition to that which they are not. Without being opposed to the other, dominant groups cannot construct themselves as good, natural, or normal, nor would they be positioned to interpret history in ways that serve their own interests. This is what dominant cultures "do" for their members. They work to sustain cultural supremacies and hegemonic power relations, uphold the status quo, and legitimate the interests of their members who can then derive advantages at the expense of non-members (Adorno & Horkeimer, 1997; Bourdieu, 1977).

Dominant cultures are routinely tied to characteristics that are socially constructed as superior, and can serve as a means by which power structures can be understood in relation to subjective understandings of social worlds (Adorno & Horkeimer, 1997; Bourdieu, 1989; Cho et al., 2013; Groff, 2014; Nietzsche, 2003; Röndahl, 2005). Heterosexuals are a dominant group that derives power by way of the systems, institutions, and practices (Röndahl, 2005) that disadvantage those who are not Heterosexual. Heteronormativity relies on the cultural dominance of Heterosexual structures and refers to cultural norms around gender that are grounded in a "symbolically, discursively, psychically, psychologically and materially violent form of social regulation and control" (Rondähl, 2005, p. 12). In this sense, heteronormative cultures are dominant because their members gain benefits from negatively constructing non-Heterosexuality and positioning non-members as unnatural, which illustrates how power relations are reproduced through stigma to justify Heterosexuals' greater access to resources at the expense of 2SLGBTQ populations. The consequences of these power relations are that those who conform to Heterosexual standards, values, and principles of conduct can assume a dominant position over those who do not.

Within situated contexts, dominant cultures can be studied so as to make connections with broader social contexts whereby humans produce and reproduce power relations through social interaction (Yan & Hyman, 2018). This study sees heteronormativity as an outcome of dominant Heterosexual cultures that use stigma to justify their superiority, dominating subject positions of their members, regulate and control what is constructed as acceptable expressions of gender, and reproduce power relations that underpin social inequalities that shape interactions at intrapersonal, interpersonal, and contextual levels. The concept of subject position is defined within the context of this study as the construction of multiple identities that make possible locating another in relation to the self and takes into account relations of power that are historically embedded (Razack, 1998; Törrönen, 2001). By way of regarding Heterosexuality as the correct version of human sexuality, heteronormativity has been used to construct boundaries around sexuality and gender expression that devalue those who express their gender in ways that are beyond the limitations of cultural norms. The values and principles of conduct set a standard for membership within dominant cultures that cannot be achieved by non-members, which serves as a "cohesive force for holding together a social structure" (Horkeimer, 2002, p. 219).

The stigmatization of 2SLGBTQ populations is a symbolic representation of power that can be contextually exercised according to social inequalities that shape interactions at intrapersonal, interpersonal, and contextual levels (Bourdieu, 1989; Doane & Varcoe, 2015; Donald et al., 2017; Link & Phelan, 2014; Tyler & Slater, 2018). The pathologization of 2SLGBTQ populations in the DSM has evolved from explicit to implicit over time; "homosexuality" attributed the cause of illness to individuals who failed to conform with the prevailing heteronormative cultural milieu while "gender dysphoria" attributes the cause of illness to the distress an individual experiences due to an incongruence between their gender and the sex they were assigned at birth (American Psychiatric Association, 2013; Drescher, 2015a). This underscores the power of the DSM in so far as it has reproduced cultural norms that construct Heterosexuality as superior and has upheld heteronormativity in health care by way of the pathologization of 2SLGBTQ populations. One can see the institutionalization of heteronormativity within health care, embedded in health practices, and perpetuated by stigmatizing 2SLGBTQ populations and unequal consideration in service delivery, policy development, and decision-making (Eliason & Chinn, 2018). The institutionalization of heteronormativity in health care thus shapes social interactions at intrapersonal (avoiding access to health services), interpersonal (denial of health services), and contextual (discriminatory policies) levels.

The historical construction of "homosexuality" and the institutionalization of heteronormativity in health care serve to highlight an entry point to further understanding on how to interact with others in contexts where stigma is structurally embedded. Conceptualizations of "homosexuality" reveal a dialectical process that has relied on scientific theories that worked to legitimate and thus uphold heteronormative belief systems (Drescher, 2015a; Haraway, 1988). Medical and health professionals describing "homosexuals" in theories of pathology as "sick people requiring medical help" (Bergler in Drescher, 2015, p. 566) gained notoriety during the Cold War when there was intense pressure to conform to cultural norms out of fears that non-conformity would place national security at risk (Fodey, 2018; Spurlin, 2019). During this time in Canada, there was an initiative undertaken by the Government of Canada that targeted public servants who were suspected of "homosexuality" due to a perceived threat to national security

(Fodey, 2018). Referred to as “The Purge”, this initiative continued until 1967 when until Justice Minister Pierre Elliot Trudeau challenged the government’s discriminatory practices and famously said, “there’s no place for the state in the bedrooms of the nation” (CBC Archives, 1967). This eventually led to a federal apology, but not until 2017 did the Government of Canada begin to make reparations to those who lost their jobs, a great number of whom died by suicide because they were unable to live with the shameful treatment they experienced from the inquiry (Fodey, 2018; Trudeau, 2017).

The historical context for constructing 2SLGBTQ populations in opposition to gender norms allows for the reproduction of dominant cultures in the health system to be situated within their broader social contexts. This can provide insight into how cultural dominance works through stigma by way of gender norms that have been taken up into the health system. The symbolic expression of the power (Bourdieu, 1989) that dominant cultures derive from gender norms is illustrated by the ways in which “homosexuality” was constructed and reconstructed as pathological within healthcare settings and their broader social contexts. In 1952, the DSM-I classified “homosexuality” as a personality disorder that was characterized by a sociopathic personality disturbance (Drescher, 2015a). While “homosexuality” was removed from the DSM in 1973, 2SLGBTQ populations were hardly emancipated from stigma. In fact, the pathologization of “homosexuality” seemingly evolved and adapted to society’s changing views on sexuality and gender. It was not until 1987 in the DSM-III-R that the APA finally conceptualized “homosexuality” as a normal variant of human sexuality (Drescher, 2015a). In 1994, and after the fall of the Soviet Union, psychiatric diagnoses shifted once again (Drescher, 2015a). The DSM-IV included a diagnosis of “sexual disorder not otherwise specified” as well as “gender identity disorders” in children, adolescents, or adults (Drescher, 2015a, 2015b).

Gender identity disorders in children alleged that gender-atypical children were pre-disposed to "homosexuality" and in need of discouragement from becoming "transgender" adults (Drescher, 2015b; Spurlin, 2019). The field of psychiatry rationalized this by saying that their intent was to have these children avoid growing up to experience the distress of having same-sex attraction, but Trans communities regarded this as a form of conversion therapy (Spurlin, 2019). The language of "transgender" is in quotations to acknowledge a shift in language I recognized in my work with Trans populations who prefer "Trans" over "transgender" because the latter is pathologizing and the former is more inclusive to identities falling under the Trans umbrella, including, but not limited to Trans masculine and Trans feminine. Quotations are used around "homosexuality" for a similar reason; while some members of the 2SLGBTQ communities identify with this language, I do not because I see it as stigmatizing, given its history.

It appears that psychiatrists perceived same-sex attraction to be the cause of distress experienced by children who grew up to be "homosexuals" because the DSM, in its multiple iterations, found different ways to attribute mental illnesses found among 2SLGBTQ populations to sexuality, rather than seeing the stigmatization made possible by gender norms as the cause of mental health disparities. The DSM-V is the version currently being used in psychiatric practice, and while the language of "gender identity disorder" has been replaced with "gender dysphoria", the diagnosis mirrors the language used to pathologize homosexuality in the DSM-III-R through DSM-IV-TR. Similar to the positioning of the diagnosis of sexual orientation disturbance disorder (as a source of conflict that could be alleviated by changing one's sexual orientation), a diagnosis of gender dysphoria "refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (American Psychiatric Association, 2013, p. 451). To alleviate the distress that Trans individuals may experience due to an incongruence between biological sex and gender identity, physical interventions are recommended in the form of hormones and/or surgery are recommended (American Psychiatric Association, 2013). It will be interesting to see how this evolution in the pathologization of 2SLGBTQ populations persist as society's views on gender continue to shift and social tensions are resolved at the expense of those who are perceived to threaten the interests of dominant cultures. Either way, by tracing the DSM, we can see how gender norms have been taken up into healthcare settings from the broader context of society and how the former shapes the latter by way of historical circumstances.

1.1.5 2SLGBTQ Stigmatization

A secondary literature review was conducted once data analysis was near completion. The literature review entailed a search of Scopus, CINAHL, EBSCOhost, and Academic Search Premier databases. The search was limited to studies that involved enacting stigma upon or stigmatization of sexual or gender minorities because enacting stigma upon individuals (who are thus stigmatized) from multiple levels had emerged as significant in shaping the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Through later data analysis as I revised this dissertation, enacted stigma was revealed to be a negative consequence of power relations working through stigma. Thinking about enacting stigma at intrapersonal, interpersonal, and contextual levels revealed opportunities to intervene upon structural inequalities by way of anticipating stigmas in practice, policy, and legislation to mediate its impact. As such, literature on enacted stigma and sexual and gender minorities informed my understanding of how power relations work through stigma at multiple levels, not just intrapersonal and interpersonal levels, but also contextually, to shape contextual factors that impact individuals differently (Black et al., 2019; Candrian & Hinrichs, 2021; Ghabrial, 2017; Hatzenbuehler, 2014; Jen & Paceley, 2021; Streed et al., 2021).

Sholeye et al. (2018) explored views of HSPs towards sexual and gender minorities and partially attributed higher rates of HIV among Nigerian sexual minorities to "judgmental, heteronormative attitudes among health workers" (p. 347). Health workers with negative views of stigmatized groups who practice in stigmatizing healthcare settings, such as HIV clinics, have experienced and internalized stigma themselves, otherwise they would not carry such beliefs. A group of students in the last year of the medical program were found to have limited knowledge (60.4% of Women who participated in study were aware of the concept of homosexuality as compared to 70% of men; 62.3% of Women conflated MSM with homosexuality as compared to 76% of men) of sexual minorities (Sholeye et al., 2018). In terms of negative attitudes, about half of all participants in the Sholeye et al. (2018) study were opposed to hiring Gay physicians at public hospitals and that 94% of Menand 100% of Women in the sample population believed homosexuality was unnatural. For these medical students, power relations were working through stigma in ways that reproduced normative views on sexuality and gender. Negative views held at the intrapersonal level became negative attitudes at the interpersonal level, which have implications for accessing HIV care at the contextual level.

Burgess et al. (2019) found that political views of medical students became more strongly aligned with normative values and principles as they progressed through their program. Normative values and principles at year four included increased implicit bias against Black and sexual minority populations as well as "more negative explicit attitudes toward stigmatized groups, lower internal motivation to control racial prejudice, lower levels of trait empathy and empathy toward patients, and lower levels of patient-centred attitudes" (Burgess et al., 2019, p.

114). This suggests that medical training (contextual) is failing to create opportunities to work through personal biases (intrapersonal) that are grounded in stigmatizing frames of reference, which underprepares HSPs in obtaining the knowledge and skills that are necessary to engage in compassionate, patient-centred care with populations who need it the most (interpersonal). Furthermore, it highlights how values and beliefs that benefit members of dominant cultures (that cannot be achieved by non-members) can be used to create normative standards against which non-members can be judged, thus reproducing power relations in broader social structures within the health system.

Furukawa et al. (2020), Oldenburg et al. (2015), and Owens et al. (2020) conducted research on MSM in the US. They found that Gay, Bisexual, and other MSM who disclosed their sexual orientation to their HSPs were more likely to experience enacted stigma, but less likely to be denied PrEP as compared to those who were closeted to their provider (Furukawa et al., 2020). Health service providers that deliver health services to Gay people without prejudice may pose less of a risk of enacting stigma upon HSUs, but this does not necessarily translate to fewer barriers during the delivery of those services. Structural stigma was found to negatively impact MSM's use of antiretroviral-based HIV-prevention strategies (Oldenburg et al., 2015), access to PrEP for MSM who lived in the American Midwest was further complicated by rurality, and addressing the barriers to obtaining this medication in all practice settings was found to be important (Owens et al., 2020). There was an abdundance of research with persons from sexual and gender minorities and how they experience enacted stigma in healthcare settings (Algarin et al., 2019; Alzahrani et al., 2019; Aurpibul et al., 2021; Colombini et al., 2014; Fields et al., 2020; Hedge et al., 2021; Hoffman et al., 2017; Kemnitz et al., 2017; Levy et al., 2021; Li et al., 2016; Luo et al., 2021; Madiba et al., 2021; Norberg et al., 2019; Oldenburg et al., 2015; Owens et al., 2020; Schroeder et al., 2019; Varni et al., 2012). This highlighted a trend to conduct research in such a way that knowledge is produced by way of a stigmatizing connection between MSM and HIV/AIDS. While there is much to be learned from how persons from sexual and gender minorities experience stigma in health care, the overrepresentation of MSM living with HIV/AIDS in the reviewed literature suggests that stigma is being enacted by way of research that further establishes the connection between HIV/AIDS and MSM, which may carry benefits for HSUs at risk for or living with HIV in some parts of the world due to the sheer volume of research on HIV/AIDS.

Lyons et al. (2021) used qualitative methods to explore healthcare experiences of Queer Women living in Vancouver, Canada, who engaged in sex work. Interviews with 56 participants revealed various ways that stigma was enacted, including housing insecurity, judgement from HSPs with regards to substance (mis)use, and demonstrated "the intersecting dimensions of stigma and structural oppressions in the lives of the Queer Women sex workers" (Lyons et al., 2021, p. 957). These studies illustrate the complexity with which power works through stigma, particularly the Lyons et al. (2021) study because it explored the impact of structural inequalities (housing) on individuals and that stigmas enacted by way of substance (mis)use and participation in the sex industry further complicate access to health services.

The majority of literature reviewed that pertained to 2SLGBTQ populations and enacted stigma in primary care was conducted in the US (Burgess et al., 2019; Goldenberg et al., 2019, 2021; Shangani et al., 2020; Whitehead et al., 2016), aside from one study in India (Chakrapani et al., 2017). Two literature reviews on sexual and gender minorities (Kuzma et al., 2019; Rowe et al., 2019) were included because their recommendations highlight the significance of conceptualizing stigma beyond the interpersonal level if the structural embeddedness of stigma is to be meaningfully addressed within the health system. Kuzma et al. (2019) searched the literature for theoretical and empirical work that was concerned with the health needs of persons from sexual and gender minorities and found that their underservicing in health care could be attributed to HSPs' "inadequate education and preparation" (p. 167). Rowe et al. (2019) also searched the literature to identify strategies for creating welcoming environments for persons from sexual and gender minorities because they recognize that this is a first step to addressing health disparities and like Kuzma et al. (2019), they attributed this to a lack of training for HSPs on how to do so. These literature reviews reflect a substantial body of research with persons from sexual and gender minorities that often cite a lack of or inadequate training of HSPs as the barrier to addressing the underservicing of these populations. This highlights a need to expand upon recommendations that would suggest more education and training by exploring contextual power relations that work through stigma and omit 2SLGBTQ populations from HSP education/training in the first place.

Goldenberg et al. (2019) found that stigma influences access to healthcare by examining the impact of providing GAC to gender diverse Black youth. Affirming the gender of Black Trans and gender diverse youth was found to be an important intervention for diminishing the barriers that this population experiences, but only in relation to anticipated stigma (Goldenberg et al., 2019). They found that the interaction between GAC and enacted stigma was not significant and hypothesized that it may be "possible that experiencing stigma in healthcare may be a stronger deterrent for delaying/not using care" (p. 487) and that experiencing enacted stigma (as compared to anticipated stigma) may require interventions beyond gender affirmation if the intent is to increase use of health services among stigmatized individuals (Goldenberg et al., 2019). This suggests that power works through stigma at contextual levels and so interventions beyond affirming gender at interpersonal levels may have a greater impact. Intervening at contextual levels could mediate the negative impacts of stigma, thus highlighting a need to employ upstream approaches to impact how and the conditions under which health services are delivered. Goldenberg et al. (2021) sought to further examine gender affirmation and found that participants experienced more enacted stigma in Southern and Midwestern areas of the US, where there are fewer protections for sexual and gender minorities. In so far as there are fewer upstream interventions in these areas, such as anti-discrimination laws, there is little being done to influence the reproduction of hegemonic power relations at interpersonal levels.

Shangani et al. (2020) took an intersectional approach to understanding the experiences of sexual minority adults and found that racialized participants had more anticipated stigma, but when socioeconomic status was considered, White participants experienced less enacted stigma while African American participants experienced relatively more. They discuss "minority stress processes" as operating differently for sexual minorities when intersections of race and socioeconomic status are considered. Their insights are however limited in terms of conceptualizing strategies on how to intervene upon stigma to mitigate its negative impacts on 2SLGBTQ health outcomes.

Whitehead et al. (2016) introduced the intersection of rurality, an aspect of social identity that is relevant to the Nova Scotian context. The geographical barriers to accessing health services that rural populations experience is often overlooked in research on sexual and gender minorities (Whitehead et al., 2016), which complicates the challenges faced by participants who hold multiple stigmatized identities. The Whitehead et al. (2016) study sought to explore the utilization of primary care of rural dwelling persons from sexual and gender minorities and found that higher stigma scale scores were associated with lower levels of accessing care for gender minorities and for sexual minorities who were Cisgender Men, the disclosure of their sexual orientation was associated with higher levels of accessing health services in primary care settings. They concluded that there is a need to intervene upon stigma because it shapes access to primary care among rural sexual and gender minorities and that doing so could increase utilization of primary care services (Whitehead et al., 2016). As such, rural 2SLGBTQ populations in Nova Scotia experience unique barriers to accessing health services that could be mitigated if stigma was intervened upon in ways that disrupted the reproduction of hegemonic power relations that influence access to health services.

The literature is clear in its messaging: improving the education/training of HSPs is necessary so that the negative impacts of stigma can be mitigated when delivering health services but is narrow in terms of recommendations on *how* this might be done, particularly at the contextual level. Chakrapani et al. (2017) point out that stigma reduction programming may be informed by research that teases out the differences in how stigma is experienced among diverse groups of Trans Women in India, but offer a narrow perspective on stigma that represents only part of 2SLGBTQ populations. Research on how 2SLGBTQ populations experience stigma across the health system is limited, particularly in primary care settings, and that which does exist is often focused on the experiences of parts of the 2SLGBTQ communities, or subgroups therein. The failure to explore the interplay between stigmatized identities and the structures that make it possible for hegemonic power relations to work through stigma is thus an omission in existing research that the theory generated in this study addresses.

Specific and/or practical recommendations on how to work under these structurally stigmatizing contexts or mitigate the impact of enacted stigmas are lacking. Implications for practice and research involved reducing the negative impacts of stigma at intrapersonal, interpersonal, and contextual levels. Furthermore, research failed to account for the differences in how racialized minorities experience enacted stigmas due to reductive operationalizations of race, illustrating how hegemonic power relations can be inadvertently reproduced when non-dominant populations are defined in relation to dominant populations without the strategic purpose of exploring underlying power relations. Solutions provided are thus superficial because they are based upon reductively conceived populations. While findings offer insight on how stigmas overlap in health care and in relation to sexual and gender minorities, they expose a possible reproduction of hegemonic power relations to which researchers may be unaware of their contributions. The literature reviewed addressed the ways in which stigmatized identities and health service areas mutually reinforce one another, but few presented practical recommendations for how HSPs can work with persons from sexual and gender minorities to diminish the negative impacts of stigma, which may reinforce barriers to care at interpersonal levels, between HSUs and HSPs. Each social category of identity tells us something different about how power relations are working through stigma in health care, but none examine the barriers in a way that is inclusive of all 2SLGBTQ populations, let alone other intersections of identity, such as race, citizenship, and ability in the ways that this study did.

1.2 Research Problem and Rationale

The exclusion of 2SLGBTQ populations in the formal education of HSPs can inadvertently lead to exclusionary health practices that indirectly influence the health outcomes of individuals. This underprepares HSPs to consider how to provide equitable health services to 2SLGBTQ populations. The health of 2SLGBTQ populations is of international concern; the United Nations (2011) called attention to the obligation that nations must address the human rights violations that 2SLGBTQ populations experience globally. While attention is brought to the current version of WPATH's Standards of Care for Trans and gender diverse populations, these are nearly a decade old. The final document for the updated version is anticipated for release in spring of 2022 (World Professional Association for Transgender Health, n.d.). The Government of Canada has recognized that 2SLGBTQ populations experience social inequalities differently than their Heterosexual counterparts, and that this contributes to their disproportionately high health disparities (House of Commons of Canada, 2019), but the Government of Nova Scotia continues to use standards of care that were released in 2011 to inform health policy on Trans and gender diverse HSUs. For 2SLGBTQ populations in Nova Scotia, access to primary care that is equitable is further complicated by a lack of consistency with regards to research that could inform practice in such a way that the negative impacts of stigma can be mediated by medical and health professionals, rather than (inadvertently) reproducing hegemonic power relations due to a lack of training.

1.3 Purpose and Research Questions/Objectives

The purpose of the proposed research was to generate theory that works to further understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. When there is a lack of training about stigmatized populations, pre-conceived notions, ideals, and beliefs can influence social interactions, often without an awareness of doing so. In exploring this, insight was gained into the role that stigma plays in perpetuating inadequate training about 2SLGBTQ populations and how this shapes the delivery of health services in primary care settings in Nova Scotia.

The research questions/objectives were as follows:

- Describe the learning experiences (formal, personal, professional, societal) of HSPs in delivering primary care services to diverse 2SLGBTQ populations in Nova Scotia.
- Describe the experiences of diverse 2SLGBTQ populations in receiving primary care services in Nova Scotia.
- Identify how health-related educational and institutional structures, systems, processes, and decision-making can support positive change within the primary care system and influence the conditions under which health services are delivered to diverse 2SLGBTQ populations in Nova Scotia.

1.3.1 Invitation for Reflection

The lens through which this study was conducted needs to be addressed and an invitation to reflect upon what drove the study extended to the reader. I must situate myself and disclose that my intersectional identity and professional designation of registered nurse allowed me to use myself as an instrument to conduct research. The stigma that I experience as a Lesbian with chronic depression (a disabling health condition) allows me to appreciate stigmas that I do not experience in relation my race and Canadian citizenship. Gender is more complicated; I feel congruence between the sex I was assigned at birth and my gender, and yet as a Lesbian, my sexual orientation challenges gender norms that often define Women's sexuality in relation to that of men. Distinctions made, such as those between overrepresented and underrepresented, are not fixed, but are social processes that are contextual and shifting (Narayan, 1993; Robertson, 2002). Advantages thus depend on contextual power relations. This study conceptualizes identity as complex and power relations as contextual; I may be stigmatized by way of my sexual orientation, mental illness, and perhaps my gender, but I can offset the disadvantages I experience through the advantages I derive from my White skin, able body, and citizenship. The reader is thus invited to identify the advantages and disadvantages that they experience and reflect upon how cultural context can cause a shift in how the different strands of identification impact relationships within and across contexts (Narayan, 1993).

1.4 Significance

The scholarly significance of this study is revealed in how stigma has been reframed as an opportunity for multilevel intervention within the health system and beyond. This study departs from the research canon on stigma in so far as it recasts the multilevel construct as something that individuals can leverage within contexts whereby it is institutionalized. As such, medical and health professions curricula can support the development of skills among HSPs so that they are better prepared to engage in broadly inclusive practices that intervene upon stigma in ways that positively impact stigmatized groups and individuals. There is a plethora of research on stigma, including the quantification of its deleterious impacts at multiple levels (Friedman et al., 2022), but this study flouts this tradition to uncover unrealized opportunities (Adorno, 1973) that would transform the conditions under which primary care is delivered to diverse 2SLGBTQ populations and other historically stigmatized populations in Nova Scotia and beyond.

This study is important because the studied context is primary care, a key site for promoting the health and wellbeing of individuals, groups, and communities and bringing about transformational change within Nova Scotia (Primary Health Care NSH, 2019). COVID-19 has underscored the urgency of the need for change in the NS health system and the opportunity that increasing access to primary care services offers to support said change (Henderson, 2022). The 2SLGBTQ communities comprise parts of every community within Nova Scotia because their identities intersect with other social categories of identity, including race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation. This means that the 2SLGBTQ communities are a diverse population that can be recruited from across various geographic regions within Nova Scotia so that the social causes of illness that affect Nova Scotians can be broadly explored. In so far as there are unique socio-structural factors in Nova Scotia, such as the environmental racism that adversely impacts Black and Indigenous communities across the province (Waldron, 2020), barriers to inclusion faced by Immigrant populations (Weerasinghe & Numer, 2010), 41% of the population residing in rural areas, and smaller percentages of French-speaking communities than the national average (S. C. Government of Canada, 2012, 2022b), this study is particularly well-suited to further understandings surrounding stigma as a socio-structural determinant of the health within the context of primary care in Nova Scotia.

This study's significance is also one of timeliness; it comes at a time when the gaps in 2SLGBTQ health knowledge are being widely acknowledged and inconsistently implemented (Tamtik & Guenter, 2019). Medical schools, health professions, and health administrators are all thinking about how to be inclusive of diversity because it has been acknowledged that the barriers to providing equitable care to underserved patient populations negatively influence health outcomes (Nova Scotia Health Authority, 2017). New priority groups are being identified by dominant groups that have been historically prioritized, which does little to address the underlying power relations shaping conditions and might contribute to social inequalities of groups who are not being prioritized. There are no theories that broadly conceive equity, diversity, and inclusion by way of differences so that common experiences can be identified to promote positive change.

The inseparability of the health system from the broader context of society is important. By generating theory that furthers understanding of the processes and factors that influence the conditions under which primary health services are delivered to diverse 2SLGBTQ populations in Nova Scotia, recommendations aim to provide a theoretical understanding of how “power structures such as culture, politics, race, gender, class, and the mass media” (Ryan, 2018, p. 11) can be disrupted and transformed across systems and disciplines. This is because perceptions and experiences will be explored in relation to stigma, a structural process that is perpetuated at various levels (intrapersonal, interpersonal, contextual) within various social systems.

This study’s significance is furthered by its intent to generate theory that can be used to inform institutional changes that will not only promote the delivery of equitable health services to diverse 2SLGBTQ populations, but support HSPs to accomplish what they set out to do within their roles. For example, foundational to the Code of Ethics for Registered Nurses in Canada is “endeavouring to address broad aspects of social justice that are associated with health and well-being” (Canadian Nurses Association, 2017, p. 3). Is it possible to do so when there is a lack of knowledge surrounding the populations who experience disproportionately high health disparities because of converging socio-structural determinants of health? If there is no formal education to support them in this task, then how are nurses going to be able to achieve this in practice? This is an example of the negative impacts of stigmatizing 2SLGBTQ populations by omission and highlights the challenges that providers face in providing equitable care to patients from stigmatized populations.

1.5 Summary

This concludes the first chapter of this thesis, which provided the background information that frames this study, research problem and rationale, purpose of the study, research questions, and the significance of the project. Stigmatization of 2SLGBTQ populations in health care was verified by way of tracing the psychiatric legacy of pathologizing diverse expressions of sexuality and gender in the DSM and the negative impacts of stigma-related stress were established by way of preliminary and secondary literature reviews. The research questions/objectives that aimed to serve this study's purpose of generating new theory that works to further understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia were stated. The second chapter explains the philosophical and methodological underpinnings of the study, which included a critical relativist ontology and constructivist epistemology to justify the use of CGT. Chapter three outlines the research design and methods used by the researcher to conduct this study. Chapter four presents the findings of the study; data illustrate how power works through stigma under structurally stigmatizing conditions and by way of delivering primary care to 2SLGBTQ populations in Nova Scotia. Chapter five will make distinctions between this study and others, describe unique contributions to the literature, and make recommendations for education and research that can inform future practice so that stigma can be intervened upon, and hegemonic power relations disrupted and transformed to change the conditions under which primary care is delivered to 2SLGBTQ populations in Nova Scotia.

CHAPTER TWO – PHILOSOPHICAL AND METHODOLOGICAL UNDERPINNINGS

This chapter explains the philosophical and methodological approaches that I used to generate theory that works to further understanding of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Intersectional and Critical Theories informed CGT methodology and methods and supported theory generation. Using Intesectionality and Critical Theories, different points of comparison were appreciated using social categories of identity as analytic tools for analyzing contextual power relations.

2.1 Philosophical Paradigms

Intersectional and Critical Theories are important to this CGT study because they inform the methodology and methods that I used to investigate cultural dominance and hegemonic social ideologies that reinforce structural inequalities in primary care settings in Nova Scotia by way of identity, including sexual orientation, gender, race, (dis)ability, and citizenship (Chan & Howard, 2020; DePoy & Gitlin, 2016; Lane, 2021). Intersectional and Critical Theories are broad in scope and thus inclusive of the diverse perspectives held within the 2SLGBTQ communities (Chan & Howard, 2020; Lane, 2021). Chan & Howard (2020) argue that Critical Theory promotes analyses of relationships that are grounded in imbalances of power to "realize consciousness that transforms systems of power and empowers marginalized communities" (p. 1255), which can be expanded upon by way of how Intersectionality Theory confronts relationships between identity and power (Cho et al., 2013). As such, Critical and Intersectionality Theories are employed to inform CGT methodology and methods to highlight, critique, and resolve specific social injustices that diverse 2SLGBTQ populations experience in primary care in Nova Scotia.

2.1.1 Critical Theory

The philosophical tradition of the Frankfurt School invites a radical reconsideration of society and supports the rejection of stigma's inherently negative association. Critical Theory is important to this study because the generation of theory that works to further understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia could bring about reform in the health system, anticipate historical injustices, intervene upon social inequalities, and transform power relations therein. Theodor Adorno & Max Horkeimer were prominent members of the intellectual lineage of philosophical thought that emerged from the Frankfurt School (Groff, 2014). Adorno and Horkeimer sought to create a theoretical framework that could be used to interrogate scientific objectivity, gain insight into the cultural dominance that they saw as characterizing modern society, and emancipate humans from their conditions of enslavement (Groff, 2014). Critical Theorists therefore see traditional (i.e., positivistic) scientific theories as a means by which dynamic social processes are reductively conceptualized, presented as "facts", and then positioned in opposition to subjective knowledge (Horkeimer, 2002).

Critical Theorists see all knowledge as subjective (Horkeimer, 2002). Subjectivity is thus conceived as thinking in and of itself (Adorno, 1973). Dominant cultures are those whose members are positioned to not only construct the "truth" from their own subjective realities, but to reproduce existing power relations through cultural differences and social categories of identity that obscure social inequalities (Groff, 2014). Critical Theorists question knowledge production, potentiate multiple truths by challenging the notion that there is but one "truth", and interrogate "taken-for-granted" assumptions that shape social discourse, structures, institutions, and other means by which oppressive conditions are sustained (DePoy & Gitlin, 2016). Critical

Theory advanced a theoretical understanding of social structures that reproduce relations of power within society (Ryan, 2018). Employing Critical Theory to inform CGT methodology and methods invites the exploration of power relations within health care, not to determine what they are, but more so what they "do", how they are exercised, and what is being done to make "the dissimilar comparable" (Adorno & Horkeimer, 1997, p. 7). Adorno (1973) rejected identity theory because it is a "primal form of ideology that imposes universalizing social categories upon individuals in such a way that subjects could become opposed to – and thus – negate one another through contradictory belief systems. Adorno saw identity theory as a necessary precursor for domination because it can provide false context for the limitations that are place upon human agency. " (Lane, 2021, p. 3). Power relations that rely on oppositional relationships to exist are those that serve dominating interests and can be reproduced under negative conditions; Adorno's (1973) rejection of identity theory is thus grounded in the problem of universalized social categories of identity that create oppositional relationships between those who are constructed as dissimilar (Lane, 2021). The problem with universalized social categories is what makes them useful for exploring underlying power relations, but only if understanding is sought through the differences within and between social categories (Agger, 2006; Lane, 2021).

This Critical Theory informed CGT researcher considered the stigmatization of 2SLGBTQ populations within health care (by way of normatively constructed Heterosexual culture) as inseparable from the broader social context. In so far as Critical Theory considers the reproduction of dominant cultures in relation to the structured totality of society, the dominance of heteronormative cultures allowed me to gain appreciation for how the health system is connected to, influenced by, and evolving in relation to broader social structures. Historical realism is used by Critical Theorists to understand subjective meaning and the influence that power relations have on the conditions of human existence; they believe that the complexities of social domination characterize the dynamic nature of relationships and subjective meaning relies on their historical contexts (Horkeimer, 2002; Ryan, 2018). The stigmatization that 2SLGBTQ populations have experienced can be seen as a historical process that offers evidence that culture, politics, and mass media manipulate views on sexuality and gender that coincide with dominant cultures and can be used to understand how human interactions within the healthcare system have been shaped over time (Best et al., 2018; Charmaz, 2019; Eliason & Chinn, 2018; Groff, 2014; Hadley, 2019; Ryan, 2018).

Critical Theorists assert that they are a part of the society they study and use this understanding to think about the situated contexts they intend to transform (Groff, 2014). In so far as Critical Theory is inherently temporal, it is a useful theoretical framework to apply to efforts that seek to "specify the dynamics of an on-going process" (Groff, 2014, p. 186). Critical Theory can then be used to "think through" the health system and examine multiple subjectivities (by way of subject positions/social categories of identity) as part of a larger whole; history can thus serve as an objective domain that can be used to understand the significance of the processes and factors that shape the conditions under which health services are currently delivered to 2SLGBTQ populations. Critical Theory is not without its limitations and Adorno's (1973) rejection of identity theory is why Intersectionality Theory is so important to this study.

Anti-Semitism and the atrocities of Nazi Germany in World War II was the specific socio-historical context within which Adorno's work was grounded, but his understanding of identity renders his work relevant to contemporary contexts and how the opportunities of individuals are shaped by power relations. As such, feminist scholars have extended Adorno's work and his understanding of identity as a means by which gender can be understood in relation to broader social contexts (O'Neill, 1999). For example, heteropatriarchal societies are those that rely upon gender norms to tie the sexuality of Women to that of Men (Lane, 2019). Power relations within heteropatriarchal societies thus rely on the historical reproduction of gender norms and normative constructions of Heterosexuality, which shape the subjective realities of individuals. In relation to the proposed research, Adorno's work can then be used to understand how gender norms shape subjective realities, which is beyond the conditions in which he conceived cultural dominance, because it captures, "via metaphor, the subjective conditions developed by a system of binary sex/gender within a heteropatriarchal society" (Duford, 2017, p. 789). Adorno is therefore an important philosophical influence that is key to creating a link between Critical and feminist theories, including Intersectionality Theory.

The embeddedness of heteronormativity within health care suggests that the stigmatization and historical treatment of 2SLGBTQ populations is a dynamic and ongoing process that has yet to be explained in relation to gaps in health knowledge that coincide with a lack of training on 2SLGBTQ health issues. I was curious about what transpires when individuals find themselves negotiating others' gaps in knowledge when they are disadvantaged by contextual power relations. The DSM serves as a historical record of the labelling, stereotyping, and characterization of 2SLGBTQ populations that requires no interpretation; it is a historical record that can be used to understand "the political, economic or 'taken for granted' power structures that exist in society" (Ryan, 2018, p. 11). In so far as Critical Theory uses historical realism to understand how subjectivity is modified by social structures, it can be used to understand stigma in relation to social structures and by way of the history of 2SLGBTQ stigmatization in health care. Epistemologically (Ryan, 2018), I am therefore using Critical Theory to inform CGT methodology and methods to explore how individuals have come to understand the social worlds that are shaped for them by broader social issues and how power relations are negotiated at intrapersonal, interpersonal, and contextual levels.

2.1.2 Intersectionality Theory

In response to essentialist understandings of Women's experiences purported by a feminist movement that was grounded in the experiences of White Women, Intersectionality Theory was developed by Black feminists to highlight the variation of lived experience within and between different groups of Women (Collins & Bilge, 2020; Crenshaw, 1989). As a critical social theory, Intersectionality Theory offers a way of thinking about power relations that can be traced back as far as the 1830s when African American Women were asking "Am I not a woman and a sister?" with respect to their status as slaves (Crawford, 2012). This phrase was later adapted by Sojourner Truth in 1851, whose statement, "Ain't I a woman?" is an early and widely cited example of Intersectionality Theory. As an analytic tool for exploring social injustice in relation to their historical contexts, Intersectionality Theory is useful for understanding how "power relations […] are not discrete and mutually exclusive entities, but rather build on each other and work together; and that while often invisible, these intersecting power relations affect all aspects of the social world" (Collins & Bilge, 2020, p. 2).

In the late 1980s, Kimberlé Crenshaw introduced the notion that Black Women were differently disadvantaged by discrimination laws than their White counterparts and problematized the separation of race and gender, although there are multiple pre-existing narratives on intersectionality (Al-Faham et al., 2019; Collins & Bilge, 2020; Crenshaw, 1989; Jordan-Zachery, 2006). Crenshaw (1989) highlighted how Black Women were multiply disadvantaged by race *and* gender in relation to Black Men (disadvantaged by race but advantaged in terms of their gender) and White Women (advantaged in terms of race but disadvantaged by gender) and coined the term intersectionality. In her New York Times opinion-editorial that explains why she left the Queer rights movement, Smith (2019), who in the 1970s co-founded the Combahee River Collective, a group of Black feminists who organized under social justice and political issues that impacted the lives of Black Heterosexual Women, Lesbians, and Gay Men, explains her reason for defection. The shift in the movement toward mainstream issues, such as HIV/AIDS, that largely affected White Cisgender Gay Men with relatively more privilege than all the other sexual and gender minorities, meant that organizing under multiple issues became more difficult and the concerns of groups with relatively less privilege were deprioritized (Smith, 2019). This shift toward prioritizing the concerns of White Gay Men in the West highlights power relations within the 2SLGBTQ communities and the diverse subjectivities therein, whereby essentialist understandings of 2SLGBTQ populations obscured shared responsibilities, allowing for priorities to be set in ways that failed to broadly address social inequalities that had diverse impacts. This made it possible to prioritize culturally dominant groups over those who became marginalized within their own movement (Women, Black, Indigenous, Trans, (Dis)Abled, lower class, and the elderly, among others).

Intersectionality Theory is employed to expose the interlocking nature of power relations and how subjective realities are shaped (Cho et al., 2013). Al-Faham et al. (2019) explain that ‘[t]he great promise of intersectionality lies in its disruptive capacity” (p. 257). Intersectionality Theory interrogates social inequalities in relation to the historical conditions that contribute to the erasure of power relations that shape contemporary social arrangements (Cho et al., 2013; Choo & Ferree, 2010). Intersectionality Theory contests what is accepted as necessary, positioned as natural, or universalized by exposing processes of differentiation and their (often unintended) consequences (Al-Faham et al., 2019). It is then not simply the inclusion of oppressed groups and individuals or underrepresented perspectives that drives an intersectional analysis because such an oversimplified perspective fails to account for the differences within and between groups, thus objectifying that which is subjectively experienced and universally conceived (Cho et al., 2013; Collins & Bilge, 2020; McCall, 2005). Necessary to understanding the persistence of social inequalities are social categories of identity that uphold cultural dominance and hegemonic social ideologies, such as Whiteness, masculinity, or Heterosexuality, because subject positions are multiply determined, and power relations are mutually constituted and reinforced (Choo & Ferree, 2010). In other words, social categories of identity that are constructed as necessary, natural, and/or representational of a universal experience uphold and reproduce power relations by way of creating an unachievable standard for individuals with characteristics that are oppositionally constructed. The complexity of identity can be appreciated when these social categories are conceived as contextual, located politically, and contingent on unique personal histories (Narayan, 1993; Robertson, 2002; Rosaldo, 1980). Intersectionality Theory is thus not a single-axis approach to exploring power relations because it simultaneously confronts power and intersecting social categories of identity (Cho et al., 2013; Crenshaw, 1989).

Oppression and privilege are treated by Intersectional theorists as inseparable because identities represent intersecting categories of power that are intertwined, mutually constitutive, and can thus be comparatively understood through the power conscious lens of Intersectionality Theory (Collins & Bilge, 2020). Intersectional theorists thus apply the concept of inseparability in a context that is more specific than what is done by Critical theorists. The former is focused on identity (including the inequalities within groups) to understand power relations, while the latter purports an abstract conceptualization of identity, rejects social categories of identity as reductive and essentialist, and does not resolve the fallacy of logic that subjects are conceived in opposition to that which they are not so that the superiority of one is held up by the inferiority of the other (Adorno, 1973). Intersectionality Theory reveals the complexity of power relations because social categories of identity can be used as an entry point for exploring contextual power relations by reconceiving infinitely complex social categories of identity into one of two oppositional categories: dominant and non-dominant, to appreciate the impact of power relations on individuals' ability to interact within and experience various social structures. In other words, Intersectionality Theory would have us broadly define social categories of identity and consider their intersections to promote an analysis of power relations that appreciates the potential for difference (between and within social groups), but then reduces each into a binary that strategically reconceives what is impossible to reduce into one of two categories (Agger, 2006). As such, hegemonic power relations can be explored to further understanding of the structures, systems, processes, and decision-making that uphold dominant cultural supremacies. There is no philosophical claim being made that such a binary could ever adequately capture the complexity of identity and power relations. The argument is that a dominant versus non-dominant binary that is created by considering the many strands of identity that exist can be repurposed as an analytic tool for broadly exploring power relations that are grounded in oppositional social categories of identity (Adorno, 1973; Agger, 2006; Collins & Bilge, 2020; McCall, 2005; Narayan, 1993). Intersectionality Theory allows me to do what Adorno (1973) could not by first conceiving social categories of identity as infinitely complex and acknowledging that there are as many differences that exist between and within social groups, but then creating a social binary that can then be repurposed as an analytic tool for exploring power relations in a studied context. This brings the common issues into focus by exploring power relations through different perspectives.

Intersectionality Theory as a Corrective Lens. Intersectionality Theory can be used to negate Adorno's (1973) rejection of identity and resolve the problem of social categories of identity being irreducibly complex but conceiving them as infinitely complex. Intersectionality Theory relies on historical analyses to magnify the social injustices that converge upon structurally marginalized communities who are multiply disadvantaged (Chan & Howard, 2020). The concept of intersectionality is grounded in theoretical analyses of complex social realities (Else-Quest & Hyde, 2016; McCall, 2005). Recognizing that "people are characterized simultaneously by multiple social categories and that these categories are interconnected or intertwined" (p. 155) is central to Intersectionality Theory (Else-Quest & Hyde, 2016). Intersectional theorists thus assume social inequalities are embedded within socially constructed categories of identity and depending on social context, take on different characteristics (Else-Quest & Hyde, 2016). As such, Intersectionality Theory historically situates social interactions and develops complex understandings of inequalities in relation to the configuration of contemporary society. Intersectionality Theory's framework is thus used to negate Adorno's rejection of identity theory because the former complicates identity in ways that were inconceivable to the latter, which allows for an exploration of power relations and socially constructed differences that would otherwise be objectified by way of oppositional categories (Lane, 2021). While Adorno (1973) rejects identity theory as objectifying because it reduces particularities within groups into oppositional categories that inadequately capture that which they claim to represent, Intersectionality Theory provides an antithesis to his position by simultaneously confronting power and identity through socially constructed differences that are reified into social categories of identity (Lane, 2021). Extending Critical Theorists' understanding of knowledge as an instrument of power (Duford, 2017), Intersectionality Theory provides an explanation for the role that power relations play in perpetuating social injustices that have disproportionately burdened historically marginalized communities (Choo & Ferree, 2010). In health care, taking an intersectional approach to appreciating the complexity of power relations at intrapersonal, interpersonal, and contextual levels is as possible as it is important (Gahagan & Subirana-Malaret, 2018): social inequalities are diffuse across social systems by way of hegemonic power relations, allowing for subtle discriminations and prejudices to persist because dominant cultures are upheld by way of education, practice, and policies that omit diverse experiences (Eliason & Chinn, 2018).

One of the challenges to intersectionality is that there is, at times, an overemphasis on social categories of identity, which pulls focus from the power relations that cause social inequalities (Cho et al., 2013). If social categories of identity are resolved into oppositional categories of dominant versus non-dominant, the differences are subsumed into one of two categories, which promotes a focus on contextual power relations (Agger, 2006). The obvious limitation in reducing all social categories of identity to a dominant versus non-dominant binary needs to be addressed before an explanation of why this might be done for the purpose of reducing power relations down to their most primitive form so they can be explored. Creating a dominant versus non-dominant binary and reducing power relations into their most primitive forms is doomed to reproduce standards set by dominant groups that disadvantage members of non-dominant groups if done without strategy or purpose. Outlined in the methods chapter are the steps that were taken to conceive a sample population that overrepresented historically underrepresented perspectives by using McCall's (2005) strategies for managing intersectional complexities to create more points of comparison on the non-dominant "side" of the binary. Creating a binary for the strategic purpose of analyzing hegemonic power relations in a studied context involves a series of intellectual steps: 1) conceiving identity as infinitely complex using Intersectionality Theory, 2) creating a binary by reconceiving points of comparison across five social categories of identity (sexual orientation/gender, sex, race, (dis)ability, and citizenship) using Critical Theory, and 3) comparing differences within and between groups on either side of the binary to explore contextual power relations. Sexual orientation and gender are grouped together above because they equally comprise the social category of 2SLGBTQ and are thus inseparable.

The risks and prevalence of HIV/AIDS is an example of how identities operate in intersection and can be used to illustrate how power relations can be explored by comparising differences within and between groups. I offer the following to illustrate the complexity of Intersectionality Theory and how identities can serve as a starting point for understanding how social injustices converge upon members of historically marginalized communities so that power can be conceived in relation to the totality of society. The following is not an attempt at providing a comprehensive account of the risks and prevalence of HIV/AIDS, rather it intends to demonstrate the complexity of identity when it is conceived through the lens of intersectionality.

During the 1980s, HIV and AIDS were positioned by American society as something that affected Gay Men (AIDS.gov, n.d.). Within an American context, Black populations comprise 51% of HIV/AIDS cases and yet make up only 12% of the overall population; Black Men and Women are 10 and 25 times more likely to contract HIV/AIDS respectively than their White counterparts (Anderson & Simmons III, 2010). For Black populations then, HIV/AIDS is not necessarily a “Gay disease”. Attributed to higher rates of incarceration (Shabazz, 2015), relations of power shape social structures and overlapping risks that Black populations experience differently than their non-Black counterparts, which are concealed when HIV/AIDS is positioned as a disease that affects Gay Men (Follins & Dacus, 2017). This concealment happens when race is not considered. Trans communities, who engage in higher rates of sex work, are influenced differently by power relations yet again with regards to HIV/AIDS (Becasen et al., 2018). The prevalence of HIV/AIDS within American Trans communities is 14%; however, Black Trans communities have some of the highest rates of infection at 44% (Becasen et al., 2018). When gender is not considered, the differences in HIV risk between Cisgender versus Trans Black populations are concealed. This example shows how power relations intersect by way of social categories of identity to influence health outcomes differently.

Social identities expose the ways in which power relations interlock, operate in intersection, and shape the lives of individuals *in different ways*. These differences matter and can be problematicized using Intersectionality Theory; social categories of identity serve as analytic tools that highlight social justice issues through different social inequalities, and the limitations of Critical Theory are thus addressed. Problematizing social justice issues by understanding how power works to exclude or marginalize based on differences (Crenshaw, 1991) is possible because of Intersectionality Theory attends to the irreducible nature of categories of identity thus informing this study's methodology and methods to further explore power relations in a way that Critical Theory does not. Intersectionality Theory can capture that which Critical Theory cannot, but the latter critiques oppositional relationships, such as (scientific) objectivity versus subjectivity, in a way that the former does not. As such, this study Intersectionality Theory and Critical Theory together to inform a CGT of the experiences of study participants in such a way that oppositional relationships can be explored in relation to social identities to appreciate the disproportionate disease burden carried by populations who are historically underserved in health care and conceived as inferior to dominant groups who can therefore reproduce themselves as superior. Their complement is an important philosophical lens for this study because the institutionalization of heteronormativity within health care calls scientific objectivity into question and promotes an exploration of how power relations work through stigma at intrapersonal, interpersonal, and contextual levels with consequences that perpetuate social inequalities therein and in broader social contexts.

Defining Diverse 2SLGBTQ Populations. The 2SLGBTQ communities are ever-evolving, continuously expanding, and their infinite diversity can be captured by Critical Theory when viewed through an intersectional lens (Chan & Howard, 2020; Lane, 2021). Even so, it is challenging to "define" these populations because such a definition would be subject to society's changing views on sexuality and gender, which are fluid and always under construction. Definitions are hereby qualified as reductive to avoid creating a standard by which members of 2SLGBTQ populations can be objectified by members of non-2SLGBTQ populations. The false binary created for the purpose of exploring power relations at intrapersonal, interpersonal, and contextual levels is problematicized using Intersectionality Theory so that, in addition to using categories of identity as analytic tools, the oppositional categories of 2SLGBTQ and non-2SLGBTQ will serve the same purpose. Artificial oppositions, such as "2SLGBTQ versus non-2SLGBTQ", represent what Haraway (2016) calls "oppositional categories" (p. 165) that can be explored using a "relational mode of thinking" (Bourdieu, 1989, p. 15) to further understandings of power relations within a studied context. As such, the binary of 2SLGBTQ versus non-2SLGBTQ promotes the exploration of how power works through stigma at intrapersonal, interpersonal, and contextual levels according to contextual subject positions.

Being specific in what "2SLGBTQ" represents risks objectifying the range of subjective experience being analyzed by way of its reduction but is done here to be broadly inclusive of social inequalities that exist between and within social categories of identity that served as analytic tools for exploring power relations. While the 2SLGBTQ acronym signifies there are intersections of identity beyond sexual orientation and gender within 2SLGBTQ populations by way of the Two Spirit identity, other social identities including race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation are implicitly included and thus, not explicitly represented. The 2SLGBTQ acronym therefore fails to represent the full range of diversity within and between 2SLGBTQ populations because it reductively conceives sexual and gender minorities and implicitly includes other intersecting social categories of identity, which oversimplifies subjective meanings, perceived challenges, and multiplicity of overlapping advantages and disadvantages (Lane, 2020a; Schmitz et al., 2019). This illustrates how reductive conceptualizations of diverse groups risk characterizing partial connections when socially constructed differences between and within groups are not also explored in ways that avoid focusing on differences to such a degree that they overshadow the analysis and promote oversimplified conceptualizations of power relations (Cho et al., 2013; Collins & Bilge, 2020; Marcus, 1994; Narayan, 1993).

Within the context of this study, “2SLGBTQ” is inclusive of all social categories of identity because sexual and gender minorities exist within all populations. Even Heterosexuals are included because orientation is different from gender; for example, Trans people can identify as Heterosexual. “2SLGBTQ” should thus be understood as representing more than just sexual orientation and gender due to the ways in which they intersect across all other social categories of identity. For the purpose of this study, “2SLGBTQ” is understood to include groups of individuals who experience “multiple interlocking systems of privilege and oppression” (Bowleg, 2012, p. 1267) as a result of deviating from cultural norms in a heteropatriarchal society. This “definition” is intentionally broad so that socially constructed differences within and between 2SLGBTQ populations experience can be seen as starting with sexual orientation and/or gender identity, but then necessarily expanding to include all other intersections of identity. Placing Two Spirit at the beginning of the acronym signifies intersections of identity beyond sexual orientation and gender identity, which explicitly attends to the historical challenges faced within the 2SLGBTQ communities in addressing the concerns of groups therein who experience power relations differently (Lane, 2020a). This is because “2SLGBTQ” has been oppositionally and negatively constructed according to a heteronormative standard that upholds a false binary with that which it is not (i.e., non-2SLGBTQ) and thus sustains power relationst hat benefit Heterosexuals over those who are constructed as non-Heterosexual. As such, in addition to social categories of identity, the 2SLGBTQ versus non-2SLGBTQ binary served as an analytic tool for exploring power relations.

2.1.3 Constructivism

Qualitative researchers have a wide-range of practices available to them; the version of reality that they uncover through investigation depends upon the methods they use (Denzin & Lincoln, Y.S., 2011). Qualitative researchers operating within the philosophical paradigm of constructivism understand that reality is socially constructed, situational constraints shape their inquiries, and social worlds can be conceived as representations of reality (Denzin & Lincoln, 2011; Ryan, 2018). Constructivism argues “that social organization and social experiences form our perspectives of reality and truth” (Ryan, 2018, p. 8) and “views human actions as constructing self-situation, and society” (Charmaz, 2014, p. 262). Within the Constructivist paradigm is the sociological theory of symbolic interactionism; its core principles assume that meaning is constructed through social interaction (between individuals and within institutions), shapes human behaviour, and can change when situations and experiences are perceived differently (Ryan, 2018). This complements Bourdieu's (1977) position that our experiences, worldviews, standpoints, and identities are shaped by our ongoing interactions that result in a "twofold social genesis [that], on the one hand [constitute] schemes of perception, thought, and action […] and on the other hand of social structures" (Bourdieu, 1989, p. 14) that are shaped by cultural practices and reproduce relations of power. What follows is by no means an attempt to offer a comprehensive history on symbolic interactionism, rather it is merely to establish the link between the philosophical and methodological approaches used in this study.

Symbolic interactionism is not an explanatory theory, rather it seeks to emphasize how the meaning given to action can be recognized in relation to individual, collective, and contextual perspectives, thus underscoring the dynamic nature of social interaction (Charmaz, 2014). It assumes language plays a crucial role in forming meaning within observed realities, that it reflects views and values, can be shared and interpreted, and pre-exists the individual (Charmaz, 2014). Grounded Theorists have used symbolic interactionism as their major theoretical perspective and in doing so, the theory has become part of their method (Charmaz, 2014). As Charmaz (2014) explains, "symbolic interactionism gives you a glimpse of the power of unifying theory and method" (p. 261). Symbolic interactionism has been used to gain insight into the ways in which gender norms can cause individuals to unknowingly contribute to sexual and gender inequalities (Sumerau et al., 2020). Moreover, symbolic interactionism has emphasized the ways in which stigma is built into everyday practices by way of normative belief systems that underpin modern healthcare settings (Nicholls et al., 2016). Symbolic interactionism informed this inquiry that sought to gain insight into subjective realities involved in the reproduction of social inequalities by way of power relations within healthcare settings when delivering health services to 2SLGBTQ populations. This study thus used social interactionism to emphasize the dynamic nature of social interactions that are shaped by stigma in heteronormative health care settings, and the contextual meaning that individuals give to their actions.

Explaining how Critical and Intersectionality Theories relate to the philosophical paradigm of constructivism is necessary before I delve into the methodology of CGT and how I plan to use it. The philosophical paradigm of Critical Theory is congruent with Constructivism, but in order to stay true to constructivist theories I need to think through subjective realities (Gibson, 2007), and this requires a consideration of the interpretive and dynamic nature of human interaction (Polit & Beck, 2017). The Frankfurt School's Critical Theory dovetails with Intersectionality Theory and complements constructivist research methods by thinking through "objective" knowledge by way of a critique that situates it within a broader social context, and using it to gain insight into how dominant cultures manifest in everyday situations (Agger, 2006; Gibson, 2007; Groff, 2014; Hadley, 2019; Horkeimer, 2002). Gibson (2007) argues that the Frankfurt School can enhance vigilance toward, awareness of, and sensitivity with respect to subjective experiences. Approaches that investigate dominant cultures in relation to taken-for-granted meaning would then examine subjective meanings within everyday actions that reproduce dominant cultures by way of social interactions (Wuest, 2007), such as health service delivery.

2.2 Constructivist Grounded Theory

I am using CGT for this study to generate theory that works to further understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Other qualitative methodologies offer theoretical analyses, but do not generate new theory, making CGT methods desirable and appropriate for the purpose of this study. Grounded Theory represents a “family of methods” (Bryant & Charmaz in Hadley, 2019, p. 564) that can be used to conceptualize social phenomena within studied contexts (Charmaz, 2014) and is necessary to appreciate the constructivist stance I took to address the stigmatization of 2SLGBTQ populations within healthcare settings.

Barney G. Glaser and Anselm L. Strauss began working together in the 1960s to address the hegemony of quantitative research methods at the time (Glaser & Strauss, 2017). Conceiving what is now referred to as Classical Grounded Theory, Glaser and Strauss created a rigorous qualitative research methodology that offered a systematic approach to generating theoretical knowledge (Glaser & Strauss, 2017; Rieger, 2019). Over time, Grounded Theory methods took on relativistic characteristics and viewed research as more of an interpretation of reality rather than an objective discovery. This marked Grounded Theory’s turn toward constructivism. In her handbook chapter, ‘Objectivist and Constructivist Methods’, Kathy Charmaz (2000) rejected the separation of researcher from research; “notions of a neutral observer and value-free expert” (Charmaz, 2014, p. 13) were incongruent with how she understood constructivist research. She dispelled positivist accusations with the contention that viewing subjects give meaning to viewed subjects’ experience by way of interactions that take place between researcher and those who are researched (Charmaz, 2000). As such, Constructivist Grounded Theorists acknowledge their own privileges, preconceptions, and values, recognizing that not only do they influence the analysis, but what constitutes the analysis itself, thus rejecting a separation between researcher and those being researched (Charmaz, 2014). CGT therefore enables a thinking through of socially constructed realities, sees action as a demonstration of making sense of pre-existing circumstances, and seeks to gain insight into how individuals have come to understand their social world (Charmaz, 2014).

2.2.1 Extending Constructivist Grounded Theory Methods

Constructivist Grounded Theorists can use their methods to remain open to where the data take them and be guided along a path that thinks against domination, oppression, and the objectification of human experience (Charmaz, 2014; Wuest, 1995). CGT "assumes that people create and maintain meaningful worlds through dialectical processes of conferring meaning on their realities and acting within them" (Charmaz, 2000, p. 521). Situated within the Constructivist philosophical research paradigm, CGT endorses multiple realities and recognizes that perception is shaped by experience (Rieger, 2019; Ryan, 2018). CGT provides the tools to access the lived realities of research participants and explore their situated realities. The researcher using CGT methodology and methods creates a rendering of reality through data collection and analysis and can integrate Critical Theory, Intersectionality Theory, and Symbolic Interactionism. Such an approach supports the exploration of specific interactions in relation to social phenomena and assumes individual realities are made up of unique and conflicting instances of power and subordination that connect to broader social issues. Like CGT, Critical Theory is grounded in a desire to analyze the subjectivity of human experience in such a way that extends beyond Marx's critique of capitalism (Charmaz, 2014; Schofield Clark, n.d.). Critical Theorists purport a modified version of subjectivity, which recognizes the limitations that social circumstances place on human agency (Ryan, 2018) and can be used to structurally situate human interaction as it is understood by constructivists (Charmaz, 2014; Hadley, 2019). This methodological and theoretical complementarity is significant to this study's aim to conceive health service delivery in such a way that power relations are explored by way of stigmatizing constructions of 2SLGBTQ populations. The way that I used CGT methodology and methods is significant with respect to how I employed methodological and theoretical perspectives in data collection and analysis to raise the level of abstraction of the findings into a structural context. CGT is designed so that the researcher examines participants' socially constructed realities to not only gain insight into how they have come to understand their world, but how their social worlds are shaped for and by them.

Hadley (2019) describes a 'Critical Grounded Theory' that honors the qualitative research tradition of Grounded Theory and credits the Frankfurt School as the progenitor of the Critical Social Theory, but defines the methodology in relation to a broad range of philosophical perspectives concerned with issues of social justice (i.e., Feminism, Critical Race Theory, and Queer Theory). Hadley's (2019) position is compelling, but the minimization of the Frankfurt School is problematic because it may limit the critical exploration of social inequalities, and conceive processes of social reproduction in separation and focus on the differences, rather than in intersection to explore underlying power relations. Partial understandings might offer solutions that address the social inequalities faced by one group, but at the expense of others, and may risk reproducing hegemonic power relations because they were only partially explored (Allen, 2016; Vogelmann, n.d.). Charmaz (2019) endorses Hadley's position and suggests addressing issues of social justice using critical inquiry; however, clear direction on how to invoke a critical lens is not provided. In so far as the distinguishing characteristic of the Frankfurt School is its approach to social criticism, to first conceptualize social problems in relation to their historical preconditions, then to think through this construction of reality, with human emancipation as the ultimate goal (Best et al., 2018), Critical Theory can be applied with an intent to transform power relations and conceive a just society (Horkeimer, 2002). Critical inquiry is similarly used with CGT methods, but to understand social interactions under specified conditions (Charmaz, 2019), not in relation to the totality of society. Considering the meaning behind the actions people take in relation to constraining social conditions is useful to interrogate actions and processes for taken-for-granted meanings and how they are supported by the structures and relationships that shape a studied context (Wuest, 2007). The historical domination of 2SLGBTQ populations highlights the possibility for oppression in health service delivery and suggests social injustices perpetuate 2SLGBTQ health disparities. In this study I interrogated taken-for-granted assumptions, called into question the meaning in action, and rendered visible social structures (Green, 2017) that influence health service delivery thus seeking to understand how the health system might contribute to the persistence of 2SLGBTQ health disparities.

2.2.2 Methodological Reflexivity

Methodological reflexivity was used to appreciate knowledge as situated, that any one perspective is limited, part of a larger truth, and shaped by broader social processes that influence how individuals perceive themselves in relation to others (Marcus, 1994; Nader, 1972; Narayan, 1993; Salzman, 2002). In so far as methodological reflexivity recognizes knowledge as situated, comprising multiple, even infinite, subjective realities, subjectivity, as thinking in and of itself (Adorno, 1973), is further understood as thought processes that construct meaning according to subject position and social interactions through which that meaning is co-constructed (Haraway, 1988; Razack, 1998; Salzman, 2002). Methodological reflexivity also promotes an understanding of subjectivity as being shaped by the social circumstances under which meaning is constructed and the positioning of subjects therein (how subjects position themselves and are positioned by others), which has very “real” consequences on how knowledge is produced and what partial perspectives are given priority according to prevailing power relations (Haraway, 1988; Nader, 1972; Razack, 1998; Ryan, 2018).

Methodological reflexivity assisted me in situating knowledge within the studied context, attending to the subject positions of participants, and then relating them to my own so that I could explore subjective realities as part of a broader social context without having the requisite knowledge of experiencing them myself (Haraway, 1988; Marcus, 1994; Nader, 1972). CGT methodology and methods are designed for the researcher to remain open to participants' experiences to problematize issues of identity and highlight social justice issues. This allowed me to explore power relations within primary care settings by way of practices that construct, shape, and perpetuate the stigmatization of 2SLGBTQ populations. As a nurse with stigmatized and non-stigmatized parts of my identity, I experience the impacts of power relations that justify 2SLGBTQ invisibility and unexamined heteronormative assumptions, personally and professionally. The good intentions of others do not matter when their impact is harmful. Self-awareness is a key step to understanding our own perceptions; without such an ability, individuals in a given context are less likely to develop the skills necessary to recognize the ways in which they are influenced by, let alone the roles they can take in reproducing, questioning, and/or transforming power structures (Bourdieu, 1977; Horkeimer, 2002; Nader, 1972; Verovšek, 2019).

I see methodological reflexivity as an entry point for Intersectionality Theory because they complement one another; both look at how we all hold positions of privilege and disadvantage in different contexts. Intersectionality Theory thus promotes an appreciation of how context influences the salience of identity. Such reflexivity supports the rendering of realities that complicate issues of identity and conceive power relations accordingly. Otherwise, I run the risk of reducing realities, oversimplifying issues of identity, and creating distinctions that jettison the organization of diverse groups under multiple issues because the focus is on difference instead of relationships (Collins & Bilge, 2020; Rosaldo, 1980). For example, as a Lesbian in a heteropatriarchy, I am predisposed to stigma in my everyday reality, but as a White person in a White supremacy, my sexual orientation is often less conspicuous, particularly given my traditionally feminine presentation (and if I am without my masculine-presenting wife). The multiple identities that I hold are inseparable and provide insight into how privilege and disadvantage intersect in relation to parts of my identity that are historically overrepresented versus those that are historically underrepresented to constitute my lived reality. Data collection and analysis, interpretation, and knowledge production was enhanced by methodological reflexivity because it offered valuable insight that supported decisions made during the research process. I did so by challenging my own preconceptions, comparing them to the perspectives of research participants, and identifying the biases I hold in terms of what I perceive as unjust. This approach enabled a critical exploration of 2SLGBTQ stigmatization as a pre-existing circumstance that is reinforced by social structures, replicated in the educational opportunities of learners within the medical and health professions, and reproduced by way of power relations that influence the delivery of health services.

2.2.3 Sensitizing Concepts

Charmaz (2014, 2019) explains that sensitizing concepts are starting points for investigation; to critically inquire about social justice issues, sensitizing concepts are often related to power. I could then use a sensitizing concept to create a starting point for my research that sought to explore the social interactions that take place between individuals when health services are being delivered in relation to socio-structural factors. Stigma is such a concept; 2SLGBTQ populations are broadly stigmatized in relation to sexual orientation and gender, but depending on context, stigma can cause a person’s race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation to take on particular qualities. Moreover, stigma grounds the opposition between 2SLGBTQ and non-2SLGBTQ and thus reproduces the power relations that construct the latter as superior at the former's expense.

Stigmatization is a social process that elicits histories of exclusion that conceptualize certain groups and individuals as "other" (Goffman, 1963). Conceptualization might be a process of categorization that necessitates arbitrarily ignoring distinguishing characteristics (Nietzsche, 2010), but Adorno (1973) argues that rendering distinguishing characteristics invisible can obscure the means by which oppression is carried out, and Intersectional theorists (Collins & Bilge, 2020) would have us strike a balance of acknowledging differences in ways so that power relations can be explored, but without such specificity that a standard by which non-dominant groups can be judged by dominant groups. Stigma has been identified as a social issue that negatively impacts 2SLGBTQ populations and highlights power relations that are reproduced within healthcare settings but originate from society more broadly. Using stigma as a sensitizing concept helped me to open my inquiry with a social construct that operates at multiple levels and is experienced broadly and differently, depending on one's own unique understanding of the social world.

Stigma can be seen as a shared starting point for disrupting essentialist understandings of 2SLGBTQ populations to render intersections of identity beyond sexual orientation and gender visible, including race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation. Stigma impacts 2SLGBTQ populations, and knowledge of and experience with 2SLGBTQ stigmatization provided me with situated knowledge of how social structures are internalized in relation to social identity and then externalized through practice accordingly. For example, non-2SLGBTQ individuals would internalize stigma differently than those who identify as members of the 2SLGBTQ communities because they do not experience stigmatization in relation to their sexual orientation and/or gender. Arguably then, if practice is a symbolic externalization of social structures (Bourdieu, 1977), then unrealized opportunities to bring about social change (Adorno, 1973) might be brought about by way of intervening upon structural processes, such as stigma (Metzl & Hansen, 2014). Opportunities for social transformation may include diminishing stigma-related stress, enhancing health outcomes among affected groups, and influencing factors and processes that operate at intrapersonal, interpersonal, and contextual levels. If stigma was not a meaningful construct to participants, like all sensitizing concepts, it would have been dispelled and replaced by that which was meaningful to participants.

2.2.4 Focusing on Process

The interpretive, inferential, and abductive nature of CGT is grounded in a basic methodological principle: the methods of data collection "flow *from* the research question and where we go with it" (Charmaz, 2014, p. 27, italics in original). Charmaz (2014, 2019) encourages the exploration of implicit meanings by way of examining unstated assumptions, which can facilitate making critical connections between data and the (structural) conditions from which they emerge. Processes "may have identifiable markers with clear beginnings and endings and benchmarks in between or may be much more diffuse and less visible but nonetheless evidence when comparisons are made over time" (Charmaz, 2014, p. 344). By employing CGT methods informed by Critical and Intersectionality Theories, I viewed health service delivery as a historical learning process (Allen, 2016) and confronted the institutionalization of society's changing views on sexuality and gender within healthcare settings (Flick, 2020). Extending CGT methods with Critical and Intersectionality Theories enabled my analysis to focus on stigma, as a social process that was meaningful to participants, and raised the level of abstraction of the findings to examine relations of power between and among different groups based on sexual orientation, gender, race, Indigeneity, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation (among other intersections of identity).

Discrimination, socialization, inclusion, and exclusion shape experiences, dictate intersecting inequalities, and frame situated relationships between power and identity (Carby, 1992; Cho et al., 2013; Crenshaw, 1989; Harnois, 2015). Using stigma as a sensitizing concept influenced how my path of inquiry unfolded, allowing for an exploration of power relations that carry advantages for members of dominant cultures within healthcare settings. Thus, the task was to "delve more deeply into the causes, the background, the wider social currents, and question those places where oppression, discrimination, and inequity become the status quo" (Hadley in Charmaz, 2019, p. 7). As a sensitizing concept, I used Goffman's (1963) understanding of stigma to explore health-related educational and institutional structures, systems, processes, and decision-making in relation to practices within the primary health care system in Nova Scotia. Insight that allowed for connections between events to be established (Charmaz, 2014) raised the level of abstraction because Bourdieu's (1977) framework informed my understanding of practice as an externalization of social structures. I viewed and focused on health service delivery under structurally stigmatizing conditions as a social process influenced by relations of power and used CGT methods to access participants' realities and how they made sense out of (and thus interpreted) social interactions within healthcare settings (Charmaz, 2019). In doing so, I describe participants' subjective understandings of the conditions under which primary health services are delivered to 2SLGBTQ populations in Nova Scotia.

2.3 Summary

This chapter presented the philosophical and methodological underpinnings of the research, which began with a description of Critical Theory and how its limitations were addressed by way of employing the power-conscious lens of Intersectionality Theory. The complement between Critical and Intersectionality Theories highlights the analytic utility of social binaries that are comprised by social categories of identity for the purpose of exploring oppositional relations of power. CGT was justified as the most appropriate methodology to answer the research questions due to its utility in generating new theory. This is because it complements Intersectional and Critical Theories in ways that allowed me to use stigma as a sensitizing concept to explore the delivery of primary care services under structurally stigmatizing conditions as a social process influenced by power relations that operate upon individuals by way of social categories of identity that are constructed in opposition to one another. It was argued that the structures, systems, processes, and decisions-making that keep dominant cultural norms in place through hegemonic power relations can be explored by way of strategically creating social binaries that reconceptualize irreducibly complex social categories of identity into two oppositional categories, which is possible when power and identity are simultaneously confronted using Intersectionality Theory.

CHAPTER THREE – METHODS

This chapter describes the study methods. The setting in which the research was conducted, sample population, recruitment methods, ethical considerations; how the data was collected, analyzed, interpreted, and how the theory generated will illustrate the alignment between CGT methods and the philosophical and methodological underpinnings described in the previous chapter.

3.1 Setting

According to the 2016 Census, the population of Nova Scotia grew from 921,727 in 2011 (S. C. Government of Canada, 2012) to 923,598, which was a 0.2% increase since 2011 and lower than the national average of 5% (S. C. Government of Canada, 2017a). Aside from the Northwest Territories, Nova Scotia was identified as having the smallest population increase among the Canadian provinces and territories in the 2016 Census. The 2021 Census paints a different picture as the population increased by 5% to 969,383 (S. C. Government of Canada, 2022a). In 2021, the provincial capital, Halifax, had the fastest growing downtown among Canada's large urban centres with a 9.1% increase in population (S. C. Government of Canada, 2012, 2022c, 2022a). More than half of the population live in urban areas; however, 41.1% of the population lives in rural areas (S. C. Government of Canada, 2012, 2017a, 2022b). In so far as age, income, language and other 2021 Census data dissemination dates are pending (S.C. Government of Canada, 2021), the following are statistics from the 2016 Census. Nova Scotia has a larger aging population with 19.9% of the population at 65 years of age or older as compared to 16.9% nationally (S. C. Government of Canada, 2017a). In terms of language, 91.8% of Nova Scotians speak English exclusively, while 3.4% are French speaking only, 4.1% speak neither French nor English, and 0.7% speak multiple languages (as compared to national percentages: 56.9%, 21.3%, 19.8%, and 0.8% respectively) (S. C. Government of Canada, 2012). In 2015, the median total income among 744,260 Nova Scotians (total number of income recipients over the age of 15 in private households) was almost $32,000 as compared to a national median of $34,204 (S. C. Government of Canada, 2017a). Respectively, the median income of males and females in Nova Scotia in 2015 were $38,379 and $26,750, both below national medians of $40,782 and $28,860 (S. C. Government of Canada, 2017a). Despite an estimation of about 4 to 13% of the population being 2SLGBTQ, there is no disaggregated Census data on sexual or gender minorities, let alone for intersecting social categories of identity therein. The first national survey results on sexual and gender minorities were released in September of 2020, and while gender-based violence, health-risk behaviour, and mental health issues were found to be significantly higher among 2SLGBTQ populations in Canada than their non-2SLGBTQ counterparts, the survey did not account for differences across social groups or provincially (S. C. Government of Canada, 2020). The need for disaggregated data has been noted by others (Etowa et al., 2021; Owusu-Bempah & Thomas Bernard, 2021), and the Government of Canada is currently working towards collecting data in ways that highlight social inequities across "diverse groups" (S. C. Government of Canada, 2021).

Nova Scotia has a centralized and publicly funded health system that serves as a useful setting for scholarly work (Fierlbeck, 2018). The health system is managed across four zones (see figure 1 on page 74). The Nova Scotia health system renewal project that started in 2015 with the merger of nine district health authorities was identified as an opportunity to address issues of social exclusion, workplace diversity, and equity, which brought a need for "consistent curricula and cultural competence education […] to mobilize and bring together the province's diversity efforts" (Nova Scotia Health, 2017, p. 4). Nova Scotia's population has higher rates of patients without a primary care provider than other Canadian provinces, a growing population of married same-sex couples, and 2SLGBTQ HSUs were found to be less certain about the level of competence in the delivery of health services that address their identity-based health needs (Fierlbeck, 2018; Gahagan & Subirana-Malaret, 2018; S. C. Government of Canada, 2017b). Nova Scotia Health (NSH) has a primary care portfolio that has been identified as a key site to bring about transformational change within the Nova Scotia health system (Primary Health Care NSH, 2019). Primary care settings in Nova Scotia are thus appropriate to study the processes and factors that shape conditions under which health services are delivered to 2SLGBTQ populations and to further understandings surrounding stigma as a socio-structural determinant of health.

Figure 1. NSH management zones (Nova Scotia Health, n.d.)

Research suggests that the health needs of 2SLGBTQ populations in Nova Scotia are not currently met within primary care settings and pathways for its delivery require improvement (Gahagan & Subirana-Malaret, 2018). In comparison to other Canadian regions, Nova Scotians have poorer health outcomes, which place 2SLGBTQ populations in Nova Scotia at an even higher risk for health disparities than if they lived elsewhere in Canada (Colpitts & Gahagan, 2016). There is no “Gay neighborhood” in Nova Scotia like there are in other provinces that have larger urban centres (i.e., Toronto in Ontario, Montreal in Quebec, and Vancouver in BC, which have neighborhoods with large 2SLGBTQ populations). A lack of place matters when health and health care are being considered, particularly for 2SLGBTQ populations (Baker & Beagan, 2016). This is because heteronormativity is not fixed or stable with respect to how it manifests in social structures, which means there are regional differences in how the needs of 2SLGBTQ populations are perceived (Baker & Began, 2016; Colpitts & Gahagan, 2016). In Nova Scotia, there are no clinics dedicated to serve 2SLGBTQ populations, and aside from prideHealth, which is part of the primary care portfolio at NSH and has one full-time staff member, health-related resources that specifically address the needs of 2SLGBTQ populations are limited. Services offered by prideHealth are limited and based on my experience in working there as patient navigator, largely dedicated to assisting Trans and gender diverse patients navigate the health system to obtain gender-affirming care, such as hormones and surgeries. Furthermore, prideHealth’s mandate is to service Central Zone, making the other three zones less accessible for 2SLGBTQ populations to access the care they need. Making primary care settings more accessible to 2SLGBTQ populations across the province may work to address some of the contextual factors that impact ways of working through stigma.

3.2 Sample Population

The “specificity of experiences, knowledge, or properties among the participants included in the sample” (Malterud et al., 2016, p. 1755) is a key resource of data that enhances analytic scrutiny and potentiates the generation of a robust grounded theory (Charmaz, 2014). 2SLGBTQ populations are often minimized in terms of their size (Waite & Dernier, 2019), but when the percentage is calculated, a rather large population is revealed. A study (Basque, n.d.) estimated that 13% of the Canadian population identifies as 2SLGBTQ, which means that out of a total Canadian population of 36,543,321 (S. C. Government of Canada, 2017c), there were approximately 4,750,632 Canadians impacted by the social inequalities that are uniquely experienced by sexual and gender minorities. Nevertheless, Statistics Canada recently released results from a national survey that estimated 4% of the population self-idenitified as sexual and gender minorities (S. C. Government of Canada, 2020). This discrepancy underlines the challenging nature of obtaining an accurate estimate of a population that is largely invisible. The unmet health needs of a population that is as large as 4.75 million people in size must have a significant impact on the publicly funded Canadian health system and if properly addressed, could promote a better allocation of resources. This sort of response is particularly needed at a time where diminishing resources and increasing demands are recognized as key challenges with regards to strengthening the health system (World Health Organization, 2013).

The sample population recruited for this study consisted of a total of 30 participants from across Nova Scotia. This sample size was sufficient for small and theoretically informed projects that use CGT methods, such as this one (Charmaz, 2014; Malterud et al., 2016). The sample was constituted by three subgroups: 2SLGBTQ HSUs (n=10), 2SLGBTQ HSP participants (n=10), and non-2SLGBTQ HSPs (n=10). The purpose of having three subgroups was to explore power relations through stigma as a sensitizing concept and by creating points of comparison using Intersectionality Theory (as described in chapter three). The reason for doing so was that 2SLGBTQ HSUs experience stigma in relation to their sexual orientation and/or gender; in addition, because they do not provide health services (i.e., bring recipient experiences only and lack the formal education and training of HSPs), they are inherently disadvantaged within a health system that prioritizes clinical knowledge over that which is subjective. The HSP subgroups do not experience that inherent disadvantage within the health system when within their professional roles, but the 2SLGBTQ HSP subgroup would experience stigma differently than the non-2SLGBTQ HSP group, particularly with regards to their sexual orientation and/or gender. These separations are recognized as reductive, as are the oppositional categories of 2SLGBTQ and non-2SLGBTQ that participants were strategically organized into; this promoted an analysis of hegemonic power relations within the context of primary care settings in Nova Scotia. Intersectionality and Critical Theories permit such reductions because the former conceives identity as infinitely complex and simultaneously confronts power relations while the latter seeks to understand sustained cultural supremacies by strategically grouping differences together into oppositional categories that reflect the same social binaries that the reproduction of hegemonic power relations must rely upon. Subgroups were conceived across five social categories of identity: sexual orientation/gender, race, people living with (dis)abilities, and citizenship. A visual representation (figure 2) of the subgroups in the sample population can be found below.

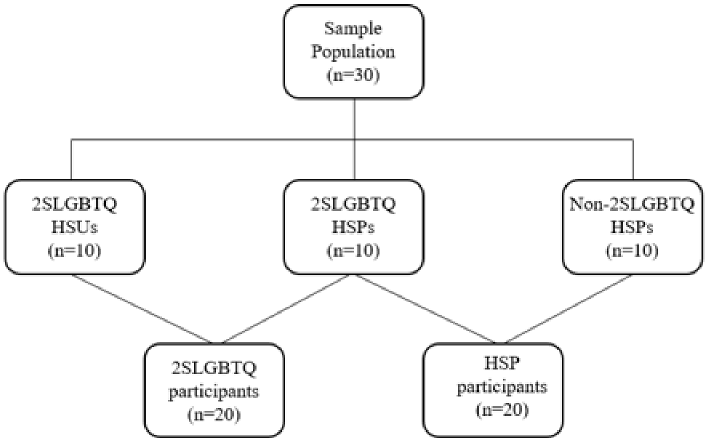

Figure 2. Visual representation of the sample population and participant subgroups

Despite being done for strategic purposes (Agger, 2006), there are analytic consequences to reducing infinitely complex identities into opposed and universalized social categories that must be addressed (Collins & Bilge, 2020; Rosaldo, 1980). This is necessary because this study reduces participants' identities into an identity-related binary (2SLGBTQ versus non-2SLGBTQ) to promote an exploration of power relations that influence the conditions under which health services are delivered to 2SLGBTQ populations in Nova Scotia. This is possible because the strategic purpose of broadly grouping differences is to explore underlying power relations through socially constructed differences, and common experiences are thus illuminated (Agger, 2006). Narayan's (1993) argument that identities cannot be simply split into two, casting aside various other aspects of an individual's identity, highlights the opportunity to repurpose reductive binaries as tools for analyzing power relations across described characteristics grounded in socially constructed differences that create and maintain oppositional categories. It may be true that social categories of identity cannot be so neatly split, and yet there is evidence of social binaries everywhere. The proclivity to construct minoritized populations by way of a binary that defines them in relation to dominant populations is why socially constructed binaries have analytic utility for the purpose of exploring contextual power relations. Social categories of identity are far too often split down a middle and the boundaries of power relations between dominant and non-dominant groups thus "materialize in social interaction" (Haraway, 1988, p. 595). This is not to suggest that such a binary is "real", rather opposing categories merely highlight the utility of identity as analytic tools for exploring relations of power (Collins & Bilge, 2020; Rosaldo, 1980). Essentializing distinctions into a binary thus has a strategic purpose; creating false binaries that use Intersectionality Theory to appreciate the infinite diversity within social categories of identity is strategic because it allows for contextual power relations can be analyzed in relation to broader social contexts (Collins & Bilge, 2020; Rosaldo, 1980). Rosaldo (1980) illustrates my point when she discusses the political and scientific "facts" that arise from oppositional categories of Man and Woman by exploring the dualities of the past that reinforce socially constructed differences, rather than exploring the relations of power that rely on those differences (Rosaldo, 1980). While Rosaldo (1980) highlights the analytic consequences of universalist accounts, her arguments are grounded in a dualism of the past that reproduces power relations that render the experiences of Trans and gender diverse individuals who exist beyond the gender binary invisible. This further illustrates her point and underscores the importance of focusing on power relations as opposed to socially constructed differences (Rosaldo, 1980), particularly when social binaries are being used as analytic tools.

Eligibility criteria for each subgroup is provided in table 1 below. Participants had to be 18 years old, which is a reasonable minimal age to obtain informed consent. Extra attention was given to purposively sampling from historically underpresented groups for maximum variation in points of comparison for data analysis. This is described in detail under recruitment methods (3.3.1 Recruiting a Diverse Sample Populations). Primary care does not operate in a vacuum, rather can be seen as a point of entry for any health-related service. As a result, "HSP" was broadly defined to include anyone involved in the delivery of primary care to gain a broad perspective on the care delivery process. For example, if an individual was interested in participating in this study and worked as a nurse on a hospital unit where services are being delivered that are initiated by a referral from a family physician, that person would be eligible to participate in this study if no exclusion criteria apply and they also saw themselves as part of the primary care system. An administrative clerk working in a collaborative care centre would be eligible to participate in this study as an HSP because they are involved in the delivery of primary care and interact with HSUs accessing those services. Such inclusions meant that I was able to explore aspects of the care delivery process that are sometimes overlooked. What is it like for the hypothetical nurse above to discharge a patient after their surgery, knowing they should see their family physician for follow-up, but that they will not be able to get an appointment in a timely manner? What kind of training do administrative clerks receive on social inequalties so that they can be more understanding when a patient who experiences discrimination in their everyday lives is late for their appointment? Primary care may thus involve more than what happens in primary care settings because it can initiate a series of events across the health system that participants in this study saw as part of primary care.

Table 1

Inclusion and exclusion criteria by subgroup

	Subgroup	**Specific criteria**	**Rationale**
Inclusion criteria	HSUs	2SLGBTQ identified, accessing health services in primary care settings in Nova Scotia for 2 or more years	Inclusion criteria are broad so they promoted purposive sampling of a diverse subgroup of 2SLGBTQ-identified persons from anywhere in Nova Scotia who had accessed health services in primary care settings for a reasonable period and would have sufficient experience to draw upon when answering interview questions.
	2SLGBTQ HSPs	2SLGBTQ identified, delivering health services in primary care (or with primary care providers) in Nova Scotia for 2 or more years	Inclusion criteria are broad so they promoted purposive sampling of a diverse subgroup of 2SLGBTQ-identified persons from anywhere in Nova Scotia who were involved in the delivery of primary care services for a reasonable period and would have sufficient experience to draw upon when answering interview questions.
	Non-2SLGBTQ HSPs	Non-2SLGBTQ identified, delivering health services in primary care (or with primary care providers) in Nova Scotia for 2 or more years	Inclusion criteria are narrow in terms of sexual orientation and gender so that participants in this subgroup would not have experienced stigma in relation to their sexual orientation or gender, but would have formal training as an HSP, and professional experience involving the delivery of primary care services.
Exclusion criteria	HSUs	Non-2SLGBTQ identified, health professional designation, employment in health care that is involved in delivering primary care services, less than 2 years accessing health services	Exclusion criteria ensure that participants in this subgroup identify as 2SLGBTQ (at risk for experiencing stigma in relation to their sexual orientation and/or gender), do not have a professional experience in or with the delivery of primary care services as a medical or health professional or healthcare worker (no or limited insight into the training or practice of medical and health professionals involved in primary care), and have

		in primary care settings in Nova Scotia	sufficient experience to draw upon when answering interview questions.
	2SLGBTQ HSPs	Non-2SLGBTQ identification, delivering health services in primary care (or with primary care providers) in Nova Scotia for less than 2 years	Exclusion criteria ensure that participants in this subgroup identify as 2SLGBTQ (at risk for experiencing stigma in relation to their sexual orientation and/or gender), have professional experience in or with the delivery of primary care services as a medical or health professional or healthcare worker (insight into the training or practice of health professionals involved in primary care), and have sufficient experience to draw upon when answering interview questions.
	Non-2SLGBTQ HSPs	2SLGBTQ identified, delivering health services in primary care (or with primary care providers) in Nova Scotia for less than 2 years	Criteria exclude those who are not at risk for experiencing stigma in relation to their sexual orientation and/or gender but have professional experience in or with the delivery of primary care services as a health professional or healthcare worker (insight into the training or practice of medical and health professionals involved in primary care), and have sufficient experience to draw upon when answering interview questions.

3.2.1 Health Service Users

In so far as patient engagement is important to health research (Manafo et al., 2018), in this study, it was necessary to gain understanding of the unmet health needs of 2SLGBTQ populations from the perspectives of those accessing care. Diversity within the sample broadly explored how primary health services are delivered to 2SLGBTQ populations in Nova Scotia from multiple points of comparison. The 2SLGBTQ HSU group (n=10) also intended to highlight the differences in experience between members of the 2SLGBTQ communities who have (versus those who do not have) the formal education that medical and health professionals receive. In addition to being 18 years of age or older, inclusion criteria were having at least two years' experience accessing health services in Nova Scotia, and self-identifying as a member of the 2SLGBTQ communities.

3.2.2 Health Service Providers

Participants who work within primary care settings permitted an exploration of the current conditions under which primary care services are delivered to 2SLGBTQ populations. HSP participants made up two subgroups, one of which included individuals who identify as members of 2SLGBTQ populations and the other consisted of non-2SLGBTQ individuals. These subgroups aimed to be representative of collaborative family practice teams at NSH because these are the professions involved in delivering primary care within Nova Scotia (Primary Health Care NSH, 2017). Collaborative care teams in primary care consist of many professionals and other healthcare workers, including family physicians, nurse practitioners, family practice nurses; dieticians, social workers, and occupational therapists that work in primary health care; community pharmacists, clerical support, leadership/management support, and other primary and secondary care resources, including paramedics, care coordinators, and community-based nurses (Primary Health Care NSH, 2017). Support staff may play an important role in cultivating inclusive conditions under which health services are delivered, so those who work with provincially regulated medical and health professionals have valuable information pertaining to 2SLGBTQ health service provision. Including these participants in the study promoted the exploration of multiple perspectives on the primary healthcare system in Nova Scotia in relation to multiple scopes of practice and various social categories of identity.

2SLGBTQ Health Service Providers. These participants (n=10) provide health services in primary care settings in Nova Scotia *and* experience stigma in relation to their sexuality or gender. They were included in the sample to gain perspective on how formal education on health that lacks content pertaining to 2SLGBTQ health needs, as a form of identity-based stigmatization (Austin, 2016), impacts the learning experiences of HSPs in delivering health services. To be eligible to participate in the study, in addition to being 18 years of age or older, 2SLGBTQ HSP participants had to identify as members of the 2SLGBTQ communities in addition to having two years of experience in providing and accessing health services within Nova Scotia. Participants in this subgroup had to hold a professional designation in a provincially regulated profession (or work within the role of support staff with those who do). Including 2SLGBTQ-identified participants who experience health service delivery as *both patient and provider* fostered an investigation of primary care delivery in relation to a lack of education on 2SLGBTQ health issues *and* lived experience with the stigma that 2SLGBTQ populations face within health care and society more broadly.

Non-2SLGBTQ Health Service Providers. This subgroup (i.e., non-2SLGBTQ HSPs, n=10) were included in the study because they do not experience stigma in relation to their sexuality or gender and so their perspectives on stigmatization would be different than the 2SLGBTQ HSP participants. Non-2SLGBTQ HSPs could have held different perspectives on the ways in which power works through stigma to exclude and marginalize 2SLGBTQ populations in primary care settings. I hoped to gain insight into how formal education on health that lacks content on populations to which HSPs do not belong impacts their learning experiences of delivering to those populations by exploring the ways in which these participants bridged both a lack of formal education on 2SLGBTQ health issues *and* lived experience with stigma in relation to sexual orientation and/or gender when delivering health services to 2SLGBTQ populations. In addition to being 18 years of age or older, inclusion criteria for non-2SLGBTQ HSPs was having at least two years' experience in providing primary health services as a provincially regulated medical and health professional (or working within the role of support staff with those who do) in Nova Scotia.

3.3 Recruitment Methods

Following REB approval, a sample that consisted of HSPs and 2SLGBTQ HSUs was recruited using electronic recruitment posters (Appendix A) that were shared through my social network via Facebook (a group was created for the purpose of recruiting participants for the study). Posters were also embedded in an email message that was sent via NSH listservs; community-based organizations, including organizations such as AIDS Coalition of Nova Scotia, the Youth Project in Cape Breton, Halifax Sexual Health Centre, and others that are part of the prideHealth network (where I was a part-time employee at the time); and other organizations/institutions; such as Dalhousie University, Building Research for Integrated Primary Healthcare in Nova Scotia (BRIC NS), the Association of Black Social Workers, the College of Paramedics of Nova Scotia, and Emergency Health Services (EHS). Using social media enhanced the sharing of the recruitment poster, which alleviated some of the challenges in reaching 2SLGBTQ populations, for which there are no fixed geographical areas of residence in Nova Scotia. Furthermore, given the COVID-19 related restrictions at the time of recruitment, social media was a feasible method for recruiting participants.

The electronic recruitment poster linked through to a website where details on the study were provided, including the consent form and my contact information. After reviewing consent form information on the website, at the bottom of the page was a short questionnaire that participants were invited to complete (Appendix B). The questionnaire was created using Microsoft Forms and embedded in the study website. The questionnaire was rudimentary in the sense that its purpose was to confirm eligibility, collect information about potential participants' identities, and to obtain consent to contact them to further discuss their participation in the study. Aside from the sections that confirm eligibility and collect contact information, the questionnaire followed a "select all that apply" format to facilitate the recruitment of a diverse sample population, which enhanced purposive sampling as previously described and later, the theoretical sampling process (Charmaz, 2014) as explained in the data analysis section. Demographics on the questionnaire included age, self-identification (sexual orientation, gender, race, (dis)ability, citizenship, and a text box was provided so that those who wished to disclose additional aspects of their identity that were not included in the questionnaire could do so; education, employment, duration of time interacting with the NS health system; and when appropriate (i.e. with HSPs), professional designation, scope of practice, and practice setting. Collecting demographics on potential participants was necessary because it helped me to determine whether potential participants represented the desired diverse sample population (Salkind, 2010). There were 80 responses in total, each confirming eligibility to participate in the study. Participants were contacted and a short discussion took place to determine where they lived (if they were HSUs) or practiced (if they were HSPs), confirm their interest/eligibility, and a total of 30 individuals were purposively selected to participate in the study.

3.3.1 Recruiting a Diverse Sample Population

To maximize sample variation so that a broad range of experience and meaning was available among participants (DePoy & Gitlin, 2016; Flick, 2018), purposive sampling was used to recruit a diverse sample population. Purposive sampling is a technique whereby participants are selected by a researcher according to specific traits that are important for the study (DePoy & Gitlin, 2016). My goal was to recruit a sample that was equitable in terms of representation of populations historically underserved in the health system as well as representative of the geographic regions in Nova Scotia and medical and health professionals/workers within the primary healthcare system. This meant maximizing variation across NSH's services areas, HSP roles, and categories of identity. Sexual orientation and gender cut across all intersections of identity, which potentiated a diverse representation of Nova Scotia's population. Purposive recruitment thus took place by maximizing variation within the sample population across five social categories, starting with sexual orientation/gender, then with regards to race, (dis)ability, and citizenship. The aim was to have an overrepresentation of historically underrepresented perspectives (as shown in figure 4) by purposively recruiting for difference, for example, in *and* within racial categories.

I must acknowledge that recruiting participants in such a way that there is diverse representation does not achieve the full range of experience that a social category of identity can represent, nor was this the aim. To do so would be to engage in a form of tokenism that would undermine the intersectional approach this study sought to employ. Furthermore, some identities are broadly described as "other ethnic minority" or "other health-related (dis)ability" not because I do not know what the specific identity of the participant is, but to protect their anonymity. The aim was *not* to represent a full range of experience for various social identities, but to access different subjective realities and analyze them in a way that promotes a complex understanding of power relations in the studied context. It was *not* about exhausting all possible meaning that a given identity category might represent. It *was* about exploring hegemonic power relations through examining the various ways that participants internalize stigma and externalize it through practices, thus reproducing social structures that influence social interactions at intrapersonal, interpersonal, and contextual levels. As such, purposive sampling allowed for maximum variation in perspectives (personal, professional, and geographical) to create as many points of comparison as possible so that the theory generated was as inclusive as possible. It should also be noted that some participants asserted more than one identity in each category. For example, one participant self-identified as Black and Indigenous. In so far as multiple racial identities were asserted by participants in the 2SLGBTQ HSU subgroup, a total of 16 racial identities were self-identified even though there were only 10 participants in that subgroup, which highlights the differences within groups that can be appreciated using Intersectionality Theory.

The sample population was described as being recruited purposively across five categories of identity: sexual orientation, gender, race, (dis)ability, and citizenship. It should be noted that gender is a category of identity that is inherently intersectional because it includes the spectrum of masculinity and femininity (Man, Non-Binary, Woman, etc.) as well as whether there is congruence between gender identity and that which was assigned at birth (Trans, Cisgender). Across sexual orientation and gender identity (SOGI), Two Spirit, Lesbian, Gay, Bisexual, Trans, Queer, Non-Binary, Asexual, Grey Asexual, Pansexual, Demisexual, Boi, Man, Woman, Cisgender, and Heterosexual identities were represented in the sample population. Beyond SOGI, and in terms of race, Indigenous (Mi'kmaq and unspecified), Black (African, Black/African Nova Scotian, Caribbean, and unspecified), Asian (Japanese, Chinese, and unspecified), other visible minority, other ethnic minorities, and White were represented in the sample population. For people living with (dis)abilities, those living with mental illness (depression, post-traumatic stress disorder (PTSD), and anxiety), neurodevelopmental disorders (ADHD and other unspecified neurodivergence) and other health-related (dis)abilities were represented. Citizenship included First Nations (Mi'kmaq), Acadian, and Canadian (first, second, and third generation Immigrants, as well as non-Immigrants). Participant ages ranged from 24-69 years old. Geographically, all NSH management zones were represented with 17 of 30 participants living and/or practicing in Central Zone, seven in Western, two in Eastern and Northern Zones each, and two HSPs whose practice was province wide. In terms of healthcare workers, the HSP subgroups included family physicians, nurse practitioners, nurses, social workers, paramedics, management, clerical/administrative staff, and a community pharmacist. The differences within the sample population are graphically represented below in figure 3 and detailed in a table in appendix C.

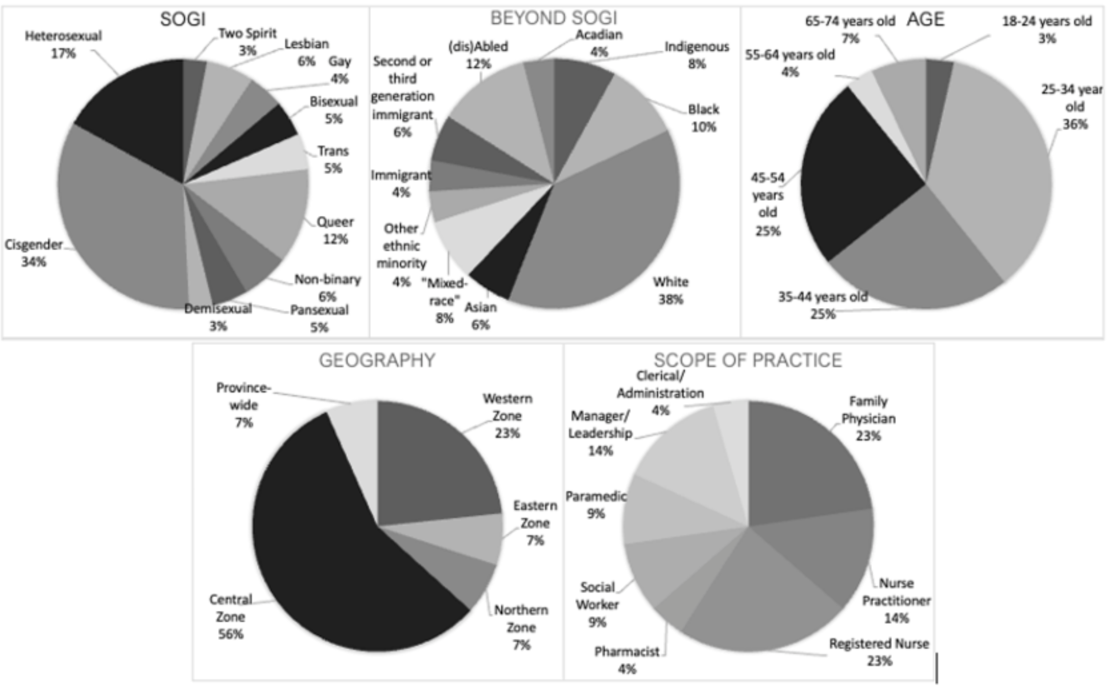

Figure 3. Overall percentages of characteristics of the sample population. Scope of practice is only for the 2SLGBTQ HSP and non-2SLGBTQ HSP subgroups.

2SLGBTQ HSUs. The HSU subgroup (n=10) was comprised of individuals who were all 2SLGBTQ-identified. Their role as HSUs distinguished them from the HSP subgroups. These care recipients' experiences helped me to explore the power relations that shape health-related educational and institutional structures, systems, processes, and decision-making from the perspective of HSUs. They also helped me identify how positive change within the primary care system might influence the conditions under which health services are delivered. Power relations were thought to be experienced differently by this subgroup as compared to the HSP subgroups because 2SLGBTQ HSUs experience stigma in relation to their sexual orientation and/or gender and receive health services, but are not equipped with the necessary clinical knowledge to deliver them.

Characteristics of this subgroup in terms of SOGI were Two Spirit, Lesbian, Gay, Bisexual, Queer, Non-Binary, Asexual, Grey Asexual, Pansexual, Demisexual, Boi, Woman, Man, Trans, and Cisgender. Beyond SOGI, more identities were selected than there were participants in this subgroup with respect to race, and included three who self-identified as Indigenous, four as Black, six as White, and three as “Mixed-race” (in quotations as this is the language used by participants to describe their racial identity); five participants self-identified themselves as persons living with (dis)abilities; and aside from one participant who asserted being from a First Nation as part of their identity, all participants were Canadian, one of which immigrated to Canada when they were a child. Ages ranged from 24 to 69 years of age. Seven participants in this subgroup lived in Central, two in Western, one was from the Northern Zone and there were none from Eastern Zone. This information is graphically represented below in figure 4 and detailed in a table in appendix C.

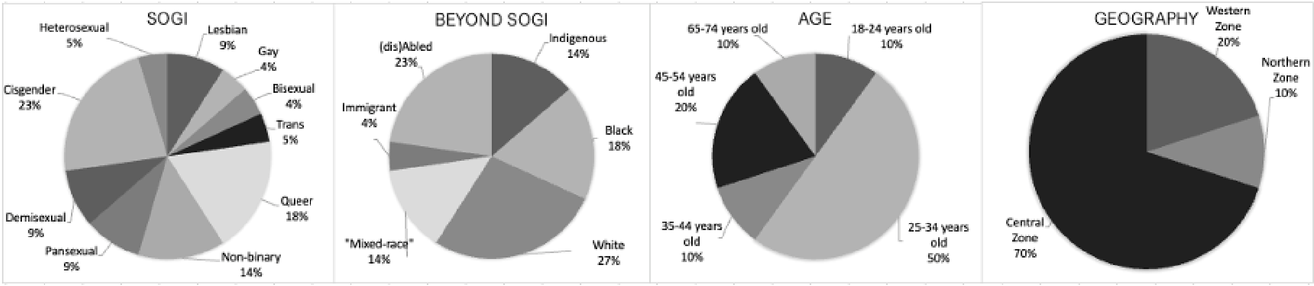

Figure 4. Percentages of characteristics of the HSU subgroup.

HSPs. The HSP subgroup (n=20) was divided into two groups, HSPs who were 2SLGBTQ-identified (n=10), and HSPs who were non-2SLGBTQ identified (n=10). HSP participants were thus organized into 2SLGBTQ HSP and non-2SLGBTQ HSP subgroups to explore the learning experiences of HSPs in delivering primary care services to diverse 2SLGBTQ populations in Nova Scotia from different perspectives. The aim of doing so was to explore the power relations involved in working through stigma through the subjective experiences of participants who experience stigma in relation to their sexual orientation and/or gender as compared to their counterparts who experience stigma differently because they conform with social norms surrounding gender. In doing so, power relations that shape health-related educational and institutional structures, systems, processes, and decision-making were explored to identify how positive change within the primary care system might influence the conditions under which health services are delivered.

2SLGBTQ HSPs. These participants (n=10) provide health services in primary care settings in Nova Scotia *and* experience stigma in relation to their sexuality or gender. As such, this subgroup is distinguished from the HSU subgroup because they deliver primary care services and from the other HSP subgroup due to their 2SLGBTQ identities. Power relations were thought to be experienced differently by this subgroup as compared to the other subgroups because they experience stigma in relation to their sexual orientation and/or gender that the non-2SLGBTQ HSP subgroup does not, and they have the formal health-related education that participants from the HSU subgroup do not have.

Characteristics of this subgroup in terms of SOGI were Two Spirit, Lesbian, Gay, Bisexual, Queer, Non-Binary, Pansexual, Woman, Man, Trans, and Cisgender. Beyond SOGI – five were White, two were Asian, one was Black, and one identified as “Mixed-race”; one participant disclosed a (dis)ability; and in terms of citizenship, there was one First Nations individual, first and third generation Immigrants and, non-Immigrants present in the sample.

Ages ranged from 28 to 67 years. In terms of geographic location, five practiced in Central Zone, two in Western, two in Eastern, none in Northern, and one practiced province wide. Scopes of practice included: three family physicians, two nurse practitioners, three registered nurses, one social worker, one paramedic, and no pharmacists or clerical/administrative staff. One participant also held a leadership position in this subgroup. This information is graphically represented below in figure 5 and detailed in a table in appendix C.

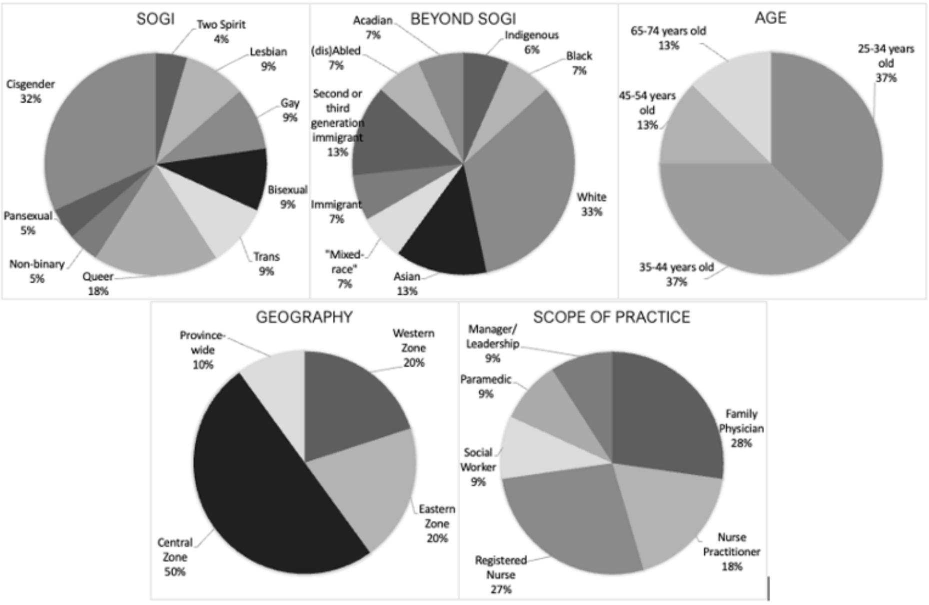

Figure 5. Percentages of characteristics of the 2SLGBTQ HSP subgroup.

Non-2SLGBTQ HSPs. These participants (n=10) provide health services in primary care settings in Nova Scotia but do not experience stigma in relation to their sexuality or gender. Power relations were thought to be experienced differently by this subgroup as compared to the others because they do not experience stigma in relation to their sexual orientation and/or gender that the 2SLGBTQ HSP group does, *and* they have the formal health-related education that participants from the HSU subgroup did not have.

Characteristics specific to this subgroup were as follows: SOGI – all self-identified Heterosexual and Cisgender; nine identified as Women and there was one Man; beyond SOGI – eight were White, one was Asian, and two were ethnic minorities; none disclosed a (dis)ability; and in terms of citizenship, there was one Acadian, and ten Canadians (one second or third generation Immigrant and nine non-Immigrants) were present in the sample population. Ages ranged from 30 to 55 years. In terms of geographic location, five practiced in Central Zone, three in Western, one in Northern, none in Eastern, and one practiced province wide. Scopes of practice included: two family physicians, one nurse practitioner, two registered nurses, one social worker, one paramedic, one pharmacist, one clerical/administrative staff member, and two participants also held leadership positions in this subgroup. This information is graphically represented below in figure 6 and detailed in a table in appendix C.

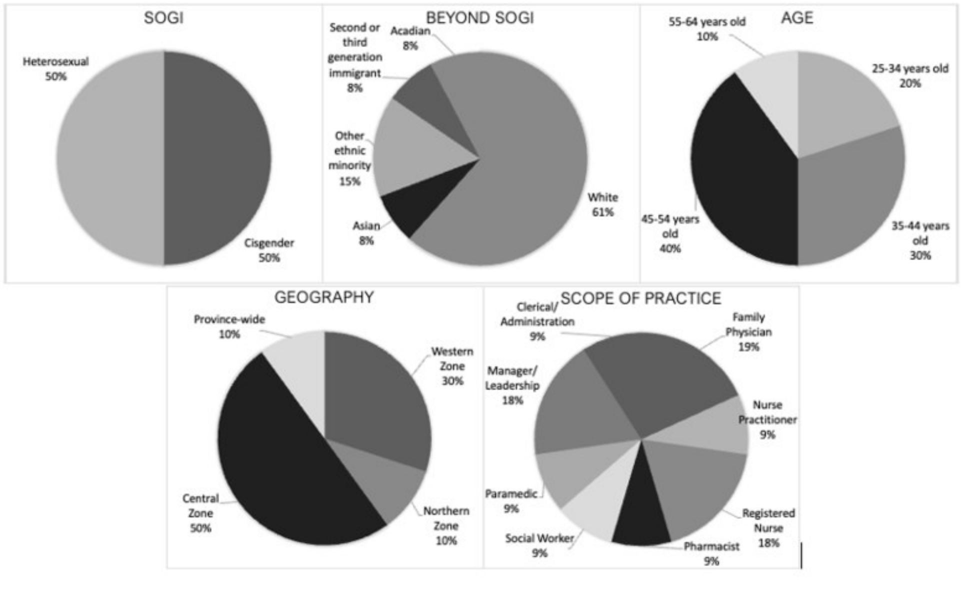

Figure 6. Percentages of characteristics of the non-2SLGBTQ HSP subgroup.

3.4 Ethical Considerations

Ethics approval was obtained through NSH REB. I requested approval from my manager (as an employee at prideHealth) to sign the letter of support form to have NSH join the study as a collaborating partner. To obtain support from EMS to send recruitment materials to paramedics through the College of Paramedics of Nova Scotia, the ethics application submitted to NSH REB was provided to their review committee. The role of collaborating partners was to assist with recruitment only. Due to the interest to participate in the study, I obtained permission from my supervisor to increase the number of participants in the 2SLGBTQ HSP subgroup from five to ten, and submitted an amendment to NSH REB, which was subsequently approved. Once participants were accepted into the study, the REDCap system was used to obtain informed consent. Individual links were created for each participant and sent by email for signature. Once each participant signed the consent, I signed as the person conducting the consent discussion and again as the principal investigator. Participants understood that they could withdraw at any time and without reason; consent was obtained without coercion and in an ongoing manner. The consent form (Appendix D) explained the intent and purpose of the research, that results will be publicly available and shared with regional and community stakeholders, and how they will be used (i.e. paraphrasing or directly quoting narrative data in publications and/or other knowledge dissemination methods) (Creswell & Poth, 2018). The consent form also outlined the measures that were taken to maintain privacy, and confidentiality in addition to identified risks and benefits. All identifying information was replaced – with pseudonyms and institutions, communities, etc. were redacted from transcripts. I was the only person with access to the password protected file that held participants' identifying information (Creswell & Poth, 2018; Polit & Beck, 2017).

REB approval included the use of Zoom, a video-conferencing platform that allowed me to download the interviews directly onto my personal and password protected computer, and a web application for transcription, called Otter.ai. I confirmed with the company that all data would be confidential, private, and held on their secure server in North America (personal communication, September 27, 2020). They do not sell or share data with third parties, nor do they access their clients' data for any purpose unless they are given permission to do so (personal communication, September 27, 2020). I had full control to delete my conversations and files, and once this was done, they were permanently deleted from their servers (personal communication, September 27, 2020). Once the interviews were transcribed, they were saved on my Dalhousie share drive. All data was stored electronically. In so far as I am affiliated with Dalhousie University, per their policy, de-identified research data was stored in a different electronic file folder than any information that could be used to identify participants on One Drive in Microsoft Outlook (Dalhousie University, 2017). Identifiable participant information was kept in a password protected file and stored in a separate folder on One Drive in Microsoft Outlook as described above, which is consistent with the university's general guidelines for researchers (Dalhousie University, 2017). Data collected from the website will be stored in Microsoft Forms until the study is complete, then it will be deleted twice to ensure it cannot be restored. Microsoft Forms is a password protected online resource that is available via Dalhousie institutional Microsoft Office accounts and their servers are in Canada.

This study is consistent with what is defined as minimal risk research in the risk assessment guide resource provided by NSH's REB (Nova Scotia Health Authority, 2015). Risks for HSP participants included experiencing discomfort when discussing the conditions under which health services are delivered to 2SLGBTQ populations due to a lack of training on

2SLGBTQ health issues. Risks for 2SLGBTQ participants included being reminded of negative experiences from their past. The greatest risk to all participants was related to confidentiality. Every measure was and will continue to be taken to protect the identity of all participants as the study goes into end of project knowledge translation. There were no direct benefits to participants; however, the aim of this study was to bring about broader benefits by producing knowledge that can be used to change the ways people think about the provision of health services so that the conditions under which they occur might also change.

Honoraria were offered in the form of $25 gift cards before each interview, an amount that was not enough to be coercive in terms of persuading individuals to participate in the study. It was made clear to participants that they did not have to complete their interviews to receive the honorarium, or if they chose to retract consent and not participate in the study.

3.5 Data Collection

This study used interviews for data collection because they "invite the participants to explore the topic from the vantage point of their experiences" (Charmaz, 204, p. 71). Grounded Theorists use a qualitative research method, called the constant comparative method, to generate categories from the data by way of collecting and analyzing data simultaneously (Glaser & Strauss, 2017). In CGT, until data are sufficiently saturated, Constructivist Grounded Theorists often stop to analyze data before they start collecting more (Charmaz, 2014). If the constant comparison method revealed a need to do so, data collection could change to follow a lead or test hunches (Charmaz, 2014). Data collection methods are outlined here as if they were used linearly, however CGT is a flexible methodology that allows for the exploration of ideas through writing a memo, diagramming, or theoretical sampling (Charmaz, 2014), which are described in more detail below. Constant comparative methods are unique to Grounded Theory and were used in this study to “establish analytic distinctions- and thus make comparisons at each level of analytic work” (Charmaz, 2014, p. 132). This method worked to analyze data during its collection so commonalities and differences could be identified, ideas successively developed, and contextual meaning generated from the data understood (Charmaz, 2014; Rieger, 2019). With respect to exploring power relations, I was able to gain appreciation for practice, as structured actions, which represented the externalization of subjective understandings of the social world and reflected individuals’ perceived ability to act, react, think, and feel (Bourdieu, 1977) within the context of primary care settings in Nova Scotia. During data collection, codes were generated, grouped by category, and then used for constant comparison between issues (Rieger, 2019) that arose in relation to the roles participants took in the delivery of health care services to 2SLGBTQ populations.

Qualitative trustworthiness was achieved using two methods (Morse, 2015). A form of member-checking was used by sharing (de-identified) interview data between participants, but during interviews; such as, asking if one participant’s experience resonated with another’s (Morse, 2015). Member-checking as such facilitated the identification of common or conflicting experiences among participants (Hunting, n.d.; Morse, 2015) across and within subgroups, categories of identity, geographic regions, and/or scopes of practice. For example, interview data obtained from a non-2SLGBTQ HSP could be shared with a 2SLGBTQ HSP, between participants who were both Trans (one identifying as a Woman and the other a Man), a 2SLGBTQ HSU and a 2SLGBTQ HSP, an HSP in Western zone versus one in Central, or between nurse practitioners who practice in different settings or identify differently. The second method used in this study to achieve trustworthiness was negative case analysis. Negative case analysis involved the identification of cases that were less common, yet key to challenging assumptions that I might have been unaware that I was making, and thus crucial to understanding the overall process (Morse, 2015). In so far as negative case data require saturation (Morse, 2015), this strategy informed theoretical sampling (see section for detailed description) because I used it in collecting data pertaining to cases that are conceptually and theoretically underrepresented (Charmaz, 2014).

3.5.1 Interviewing

I developed an interview guide keeping in mind that data and thus meaning are co-constructed in the process between the participants and me (and understanding the context for the data being collected) (Charmaz, 2014) (Appendix E). The interview guide evolved as data were collected to facilitate theoretical sampling. Interviews took place using Zoom, a video conferencing platform, due to COVID-19 related public health restrictions. Prior to initiating the interview, permission for digital recording was confirmed (having already been obtained). One-to-one, semi-structured interviews took place with HSP and 2SLGBTQ HSU participants, lasted up to 90 minutes, were video-recorded, and I transcribed audio files verbatim, as described, using the Otter.ai web application. Interviews began with the confirmation of demographic information (already collected during recruitment) and then shifted to exploring how primary care services are delivered to 2SLGBTQ populations in Nova Scotia. Situating myself (as a Lesbian and Registered Nurse) prior to asking interview questions and appropriate use of self-disclosure fostered reciprocal and trusting relationships between the participants and me (Mills et al., 2006).

Interviews sought to gain insight into the processes and factors that shape the conditions under which primary care services are delivered to 2SLGBTQ populations in Nova Scotia. Interviews focused on health service delivery within primary care settings in Nova Scotia in relation to a lack of population specific training on 2SLGBTQ health issues *and* lived experience (or lack thereof) of being stigmatized because of sexual orientation and/or gender. I cultivated reciprocal relationships between the participants and me (Mills et al., 2006; Morse, 2015) that broadened my understanding of the barriers involved in delivering primary care services to 2SLGBTQ populations in Nova Scotia. As noted above, member-checking was used in the interview process and involved asking participants to comment on data that had been collected from others and using other participants' interview data to ask prompting follow-up questions. For example, if a participant had a very similar or different experience than another participant, I would mention what was said in a previous interview to prompt the interviewee to expand upon what they had already said. This provided the interviewee opportunity to clarify their perspective, enabled me to test my hunches as I collected data, and contributed to study trustworthiness.

There were four follow-up interviews conducted (three 2SLGBTQ HSUs and one 2SLGBTQ HSP) relatively early in the data analysis phase (after all initial interviews had been completed) to share emerging concepts and confirm their relevance, which supported further data analysis. Two additional follow-up interviews were conducted (one 2SLGBTQ HSU and one 2SLGBTQ HSP) when categories were being generated and diagrammed that illustrated the relationships between the categories. In the final stages of data analysis, four more follow-up interviews were conducted (one 2SLGBTQ HSU, one 2SLGBTQ HSP, and two non-2SLGBTQ HSPs) to share an outline of the generated theory and the late-stage diagram.

3.6 Data Analysis

Charmaz (2014) asserts that context determines content, actions have meaning, and actors are influenced by social structures. To understand how it is that power relations influence the context of health service delivery, I used CGT methods to explore the content and meaning of the social interactions that take place within healthcare settings within the boundaries of an analysis that depended upon the sample population and historical conditions that shaped the social and historical context of the study. The theory generated depicts the analysis of action as process, which allowed for connections to be made in a way that exposes the role of stigma in reproducing power relations at intrapersonal, interpersonal, and contextual levels (that operate through culture, politics, race, gender, class, and mass media) (Charmaz, 2000, 2014, 2019). Data analysis employed the constant comparison method but continued through memo-writing and diagramming. By way of an ongoing process of making decisions about categorizing large amounts of data according to similarity in meaning, collapsing of categories in favor of theoretical concepts as they became sufficiently saturated (Saunders et al., 2018). Appendix F provides an overview of the progression of concepts and sub concepts that were co-created through data analysis.

3.6.1 Exploring Subjectivity in a Diverse Sample Population

As stated, Intersectionality Theory was used to account for what Critical Theory does not. Intersectionality Theory addresses the abstraction of identity carried out by the Frankfurt School and challenges their rejection of identity theory by accounting for the irreducible complexity that Adorno could not conceptualize (Lane, 2021). It is necessary to outline how Intersectionality Theory was used to further engage in data analysis that first acknowledged the irreducible complexity of social categories of identity, conceived differences within and between those categories, which then informed the recruitment of a diverse sample population that was comprised of individuals whose socially constructed differences could be used to gain insight into social locations (i.e. subject positions) in ways that promoted an exploration of the power relations constructing unique personal histories (i.e. subjectivities). By purposively recruiting a sample that maximized variation across social categories of identity, socially constructed differences among participants could be strategically reconceptualized into subgroups (2SLGBTQ HSUs versus 2SLGBTQ HSPs versus non-2SLGBTQ HSPs) and then oppositional categories created (2SLGBTQ, stigmatized in relation to sexual orientation and/or gender; versus non-2SLGBTQ, not stigmatized in relation to sexual orientation and/or gender). Analytic tools for exploring common experiences and/or factors being shaped by contextual relations of power were thus produced (Agger, 2006). Strategically reconceptualizing the socially constructed differences among participants into broader categories allowed for the recognition of common experiences and underlying relations of power (Agger, 2006). The following explanation of managing intersectional complexity informed the application of negative case analysis that was used to achieve qualitative trustworthiness and is described in the section on theoretical sampling.

Managing Intersectional Complexity. Now that the social binary was created, points of comparison had to be created so that there was an overrepresentation of historically underrepresented perspectives in the sample population. Intersectionality Theory furthers understanding of how power excludes or marginalizes based on differences (Crenshaw, 1991); such as the stigmatizing processes of differentiation that 2SLGBTQ populations undergo in relation to gender norms (Goffman, 1963). Importantly, there are differences in how processes of differentiation happen, including when 2SLGBTQ populations are reductively conceptualized as what they are not (i.e., Heterosexual). Equating 2SLGBTQ with non-Heterosexual is a reduction of the diversity found within the 2SLGBTQ communities. This highlights one way that power works through stigma; diversity in non-dominant groups can be reduced into a social category of identity, then positioned in opposition to dominant groups that can then define that which they are not as inferior, thus constructing themselves as superior. Recruiting a diverse sample population promoted an intersectional analysis of power relations whereby I could explore power relations through different social categories of identity, including race, (dis)ability, and citizenship. McCall (2005) discusses the importance of managing the complexity of intersectional analyses and offers guidance on how to do so by outlining three approaches to managing the complexity of intersectional analyses. I used these approaches to engage in an analysis that captures the diversity within 2LSGBTQ populations prior to reducing them into broader categories for strategic and analytical purposes. I aimed to explore how socially constructed differences are sites through which power works through stigma, impacting individuals at intrapersonal, interpersonal, and contextual levels. Figure 7 (Lane, 2021) provides a visual representation of how McCall's approaches were used to be systematic in conceptualizing and managing the intersectional complexity of this study's diverse sample population.

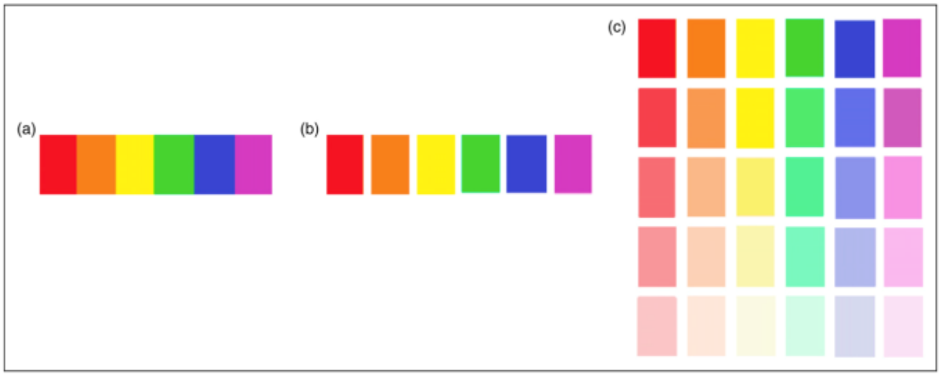

Figure 7. McCall's approaches support the conceptualization of 2SLGBTQ intersectional complexity, a) the anti-categorical approach took an anti-essentialist stance and allowed for an appreciation of "2SLGBTQ" as a social category that is irreducibly complex, b) the inter-categorical approach was used to explore differences *between* each population that constitutes the 2SLGBTQ communities, c) the intra-categorical approach was used to explore differences *within* each population; differences such as race, ability, citizenship, and other intersections of identity can thus be considered.

I used the anti-categorical approach first. It requires one to take an anti-essentialist stance toward social categories because accounting for the full range of potential for difference in any population is impossible (McCall, 2005). The anti-categorical approach sees social categories as inherently reductive if the processes by which they are produced, experienced, reproduced, and resisted are not the centre of focus (McCall, 2005). Sherene Razack (1999) states that "[t]here is little chance of disturbing relations of domination unless we consider how they structure our subject positions" (p. 170). Differences among and between groups and individuals comes as a result of historical processes; they are socially produced and reproduced (Bourdieu, 1989; Razack, 1998; Törrönen, 2001). Social relations are hierarchical, contextual, and shifting; power is arranged, can be interrogated, and reveals how individuals are implicated in the subordination of others (Razack, 1998). Under structurally stigmatizing conditions, power relations are arranged in such a way that groups and individuals can be excluded or marginalized based on differences that distinguish them from dominant groups (Link & Phelan, 2014). As such, the anti-categorical approach challenges the reduction of 2SLGBTQ populations as consisting of "only" sexual and gender minorities and supports a critical exploration of how subject positions are structured by, between, and within each population while acknowledging the "impossibility of exploring differences in a way that effusively captures the complexities existing within and between these groups" (Lane, 2021, p. 4). This critical exploration included reflection upon the fact that "2SLGBTQ" is defined by what it is not ("Heterosexual"), not by what it "is", which is an infinitely diverse group with its own social hierarchies and structures of subject positions.

Using what McCall (2005) refers to as the inter-categorical approach, understandings of the differences *between* 2SLGBTQ populations were appreciated by examining the processes by which constructions of sexual and gender minorities are produced, experienced, reproduced, and resisted. Categories of identity coincide with subject positions and influence how social phenomena are experienced, such as stigma, because with each process of differentiation comes a relational shift that places less value on some and more on others. Processes of differentiation thus have varying effects and multiple intersections of identity overlap upon individuals, creating relational shifts that have historical significance (McCall, 2005). These shifts represent power relations that rely on socially constructed differences to structure subject positions (Cho et al., 2013; Razack, 1998). To provide a reductive example for the purpose of illustrating my point, Lesbians who are marked (i.e. stigmatized) by their 2SLGBTQ identity and race are doubly disadvantaged; for each category of difference, processes of differentiation vary in terms of how they relate to social structures, which has varying outcomes (Bowleg, 2008). The process of differentiation would be different for a non-racialized Lesbian, as would their subject position and the impact of power relations. I used the inter-categorical approach to manage unpacking these relational shifts and support their conceptualization as infinitely complex.

To extend my understanding of social hierarchies that exist within 2SLGBTQ populations, next I used what McCall (2005) refers to as the intra-categorical approach to compare differences *within* 2SLGBTQ populations. Jordan-Zachery (2006) explains that the intra-categorical approach can be used to gain insight into how social categories of identity influence relations of power. This exposed points of intersection within each 2SLGBTQ population and disrupted understandings that would reduce their diversity to sexual orientation and gender identity. In doing so, I could appreciate intersection of identity that influence power relations within healthcare settings and during health service delivery.

3.6.2 Coding

The level of abstraction in the data was raised through the simultaneous collection and analysis of “data with data, data with code, code with code, code with sub concept/category, sub concept with sub concept, and sub concept with concept” (Charmaz, 2014, p. 342). A pivotal step in the construction of this grounded theory was coding; it helped to explain the data and shaped further data collection in such a way that generalizing theoretical statements could be made (Charmaz, 2014). Transcripts underwent initial coding, which entailed using words that end in “–ing” to define and label data line-by-line so that the implicit meaning behind processual action could be identified (Charmaz, 2014). This was done in accordance with Charmaz’s CGT approach; she does not use letter coding, rather data underwent two phases of coding (initial and focused) whereby terms that described what was happening were used to further the co-creation of meaning being constructed by myself and the participants through shared understandings and interactive analysis (Charmaz, 2014). What was happening in the data became my focus (Charmaz, 2014). Co-constructed themes were categorized under three concepts; depending on context, an intricate rendering of the contextual salience of identity; resolving histories, the impacts of collective and personal experiences; and surviving the situation, individuals’ negotiation of contextual power relations.

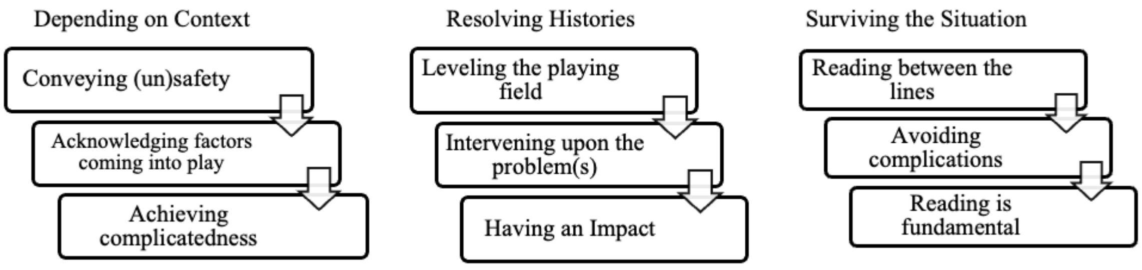

Figure 8. Examples of theory development according to concept.

Initial codes of significance became focused codes and were subsumed into tentative sub concepts/categories that account for larger segments of data (Charmaz, 2014; Rieger, 2019). Focused coding entailed the analysis of large amounts of data by way of concentrating on initial codes that are alike, recurring, and significant, and directed and supported theoretical decision-making in relation to data collection and analysis (Charmaz, 2014). In coding participant narratives, I compared perspectives and looked at the particular conditions that shaped the interplay of sexual orientation and/or gender identity with other intersections of identity. Participants' identities, geographic location, and scopes of practice when appropriate, were used to sensitize me to bias in coding (Gibson, 2007), which assisted in avoiding making incorrect assumptions that were influenced by dominant discourses. Table 2 below illustrates initial versus focused coding using an excerpt from an interview transcript.

Table 2

An excerpt illustrating initial coding, focused coding, and raising the level of abstraction to sub concept status

Excerpt	Initial Codes	Focused Codes	Sub Concepts
I find that you have to take more time with some clientele. Just because, first of all, it takes a while for them to trust you. When I first came to the clinic, I was not part of the community. No one knew me. And so, I had to earn their trust. And it took a while to do that.	Finding that more time is needed with some clientele Taking a while to build trust Recalling when first starting at the clinic Being from outside the community Being known by no one Having to earn trust Taking a while to earn trust	Making time to build trust Having to earn trust	Having an impact (re)Setting the stage

3.6.3 Memo-writing

I began memo-writing after the first interview. Many memos summarized the interview, particularly in the beginning of data collection. As data collection continued, memos included less summarization and more interpretation. By interview 25, the overall process emerged as “working through stigma”, after having been tentatively set as “learning through stigma” through memo-writing after interview 20. After a concept’s properties were saturated, I used memo-writing to raise the level of abstraction so that the theory generating was an interpretive rendering of, and grounded in, what I saw and learned from the data. Memo-writing allowed me to explore concepts that sometimes led nowhere, others found their way into the grounded theory. The process by which the theory of “working through stigma” was generated from the data is described in more detail in the results chapter. Memo-writing was an essential CGT method for analysis because it supported me in shifting from inductive to abductive reasoning; I was able to scrutinize and interpret the data so that theory was developed by way of abstract and contextual understandings of the social interactions under observation (Charmaz, 2014; Lempert, 2010). Memo-writing was thus integral to understanding participants’ ways of working through stigma and supported the non-linear nature of CGT and how its methods were used for data collection and analysis in this study.

3.6.4 Diagramming

Diagramming was another essential analytic method in CGT because it is an engaging and intellectually energizing step in the dialectical process of data collection and analysis, supports the process of raising the level of abstraction, promotes the emergence of conceptual sub concepts, and kept me involved with the data so that patterns could be discovered and the path of theory construction recorded (Charmaz, 2014; Lempert, 2010). Diagramming also served as a method that I used to demonstrate the complexity of emerging concepts through visual representation (Nelson, 2017). With whatever format appealed to me, I used diagramming to integrate my memos and determine connections and relationships between concepts and sub concepts/categories (Charmaz, 2014). This helped me to bring initial codes into concretion and supported the development of a set of focused codes (Charmaz, 2014). The non-linear nature of CGT and how its methods were used to analyze data in this study is best described with the results, including diagramming, but through diagramming I discovered that there is no beginning or end to the overall process of working through stigma. Various sequences were used and illustrated by the diagrams, but not until the diagram depicted an ongoing cycle was it a rendering of what the data were telling me.

3.6.5 Theoretical Sampling

Abduction is a method that is used in CGT to promote the consideration of possible causes for the observations that researchers make so theoretical sense can be made out of the data being collected and analyzed (Conlon et al., 2020). Abductive reasoning is used by Constructivist Grounded Theorists to make connections between empirical data and theoretical understandings of the studied phenomenon and gain insight into common experiences and/or those which are dissimilar, which informs further data collection and analysis. Abduction is particularly useful to the researcher when they are confronted by puzzling data. By making inferences from the data that can be tested through further data collection, but with the intent of exploring a certain concept or idea, they may seek imaginative understandings of the phenomenon under study (Charmaz, 2014). This process is called theoretical sampling. Testing inferences using negative case analysis assisted me in considering possible solutions to problems that arose for participants when they were involved in the delivery of primary care services. Theoretical sampling is part of the constant comparison method, but often takes place later in the research when theoretical sub concepts lack robustness. The non-linear nature of CGT and how its methods were used to analyze data in this study is best described with the results, particularly with regards to theoretical sampling, but in terms of how negative case analysis was used for the purpose of theoretical sampling is described below.

Theoretically Sampling Through Negative Case Analysis. In social justice research, theoretical sampling can be used to establish connections between social structures and the subjective experiences they shape (Charmaz, 2019). Once all theoretical possibilities were explored by way of theoretical sampling, which allowed me to do more than achieve theoretical saturation because it assisted me in recognizing power relations and generate theory that could imagine solutions to social injustices (Charmaz, 2019). I used this method of theoretical sampling with an aim to identify how power relations shape the delivery of health services in primary care settings and to check for possible solutions that sought to anticipate social injustice in future practice and change the conditions under which health services are delivered to 2SLGBTQ populations.

Negative case analysis was used for the purpose of theoretical sampling to not only produce robust concepts (Morse, 2015), but to extend them by exploring ways that 2SLGBTQ health disparities might be addressed by "uncover[ing] perspectives not yet represented in the data and create additional points of comparison that enhance the credibility, richness, and depth of qualitative analysis" (Lane, 2021, p. 2). I used what I have called Adornian negative case analysis (ANCA) to purposively sample participants from historically underrepresented groups so that they were overrepresented in my sample population (Lane, 2021). This means I was considering qualitative trustworthiness from the onset of the study by way of maximizing the points of comparison that would be available later when I was analyzing the data, engaging in theoretical sampling, and pursuing theoretical saturation. The method of negative case analysis was thus employed with an aim to be inclusive of perspectives that are historically underrepresented in research, create points of comparison that would otherwise be missing, and challenge assumptions that render the experiences of non-dominant groups invisible (or positioning them in opposition to dominant perspectives) (Lane, 2021). This allowed me to recognize connections between social structures, subject positions held by participants, and their experiences of health service delivery in primary care settings in Nova Scotia, which promoted the development of robust concepts. ANCA thus contributed to achieving qualitative trustworthiness by way of reconceptualizing social categories of identity into broader categories so common experiences and underlying power relations operating through stigma could be understood through different points of comparison (Agger, 2006; Lane, 2021). A broadly inclusive analysis that recognized the irreducible complexity of social categories of identity was thus possible by way of the differences in participants' experiences and the diversity in perspective held by the sample population (Lane, 2021).

Heteronormative health systems affirm Heterosexuality and negate the identities of 2SLGBTQ patients. This affirms the lived realities of Heterosexual persons and negates the subjective experiences of 2SLGBTQ persons, whose subject positions are then situated as contradictory to heteronormative cultures. I used the construct of stigma to recognize negation and explore power relations that shaped participants' experiences, which contributed to achieving qualitative trustworthiness. I thus used ANCA to identify stigmatizing processes of negative affirmation that in turn uncovered power relations that were shaping dissenting points of view. Negative cases that contradicted traditions and norms set forth by HSP formal training thus became the grist for analyses that could then be used to explicate broader social processes in ways that emergent hypotheses captured aspects of phenomena that exist beyond the limitations of medical ways of knowing. This promoted theoretical saturation of concepts.

3.6.6 Writing the Dissertation

When data collection ended, analysis continued by way of the writing process (Charmaz, 2014; Rieger, 2019). Memo-writing turned into writing my dissertation, which entailed situating the grounded theory within theoretical frameworks to gain context on and resolve conflicts that arose while conducting a second literature review, which was used in the discussion chapter to situate the results from this study within existing research (Charmaz, 2014). Revisions provided opportunities to scrutinize theoretical concepts, grapple with arguments that lacked qualification, establish connections with existing literature, support arguments that unfolded during the analysis, and present and refine the processes by which the findings were generated from the data (Charmaz, 2014). Each draft succeeded the previous in its comprehension of a theory (Charmaz, 2014) that furthers understanding of stigma and how it can be worked through within and beyond primary care settings within Nova Scotia.

3.7 Summary

This chapter described the setting within which the study took place, the sample population, ethical considerations, and how qualitative trustworthiness was achieved. Research methods used for recruitment, and data collection and analysis were also presented. Semi-structured interviewing with 2SLGBTQ HSUs and HSPs (2SLGBTQ and non-2SLGBTQ) served as the primary source of data. In accordance with CGT methods and methodology, coding, memo-writing, diagramming, theoretical sampling, and writing this dissertation are described in terms of how they were used for data collection and analysis.

CHAPTER FOUR - FINDINGS

Working Through Stigma

Working through stigma depicts the negotiation of power relations impacting the delivery of health services to diverse 2SLGBTQ populations in Nova Scotia. Findings illustrate that power works through stigma at intrapersonal, interpersonal, and contextual levels within primary care settings in Nova Scotia and shapes the conditions under which health services are delivered to 2SLGBTQ populations in ways that influence health outcomes. Stigma impacted HSPs in addition to HSUs, which suggests that more work needs to be done to diminish barriers to delivering and accessing health services. These barriers require active and intentional intervention to disrupt power relations that overlap and converge upon individuals by way of social categories of identity. If an HSP is not actively working through stigma, this means their share of the work falls upon the HSU and highlights the inequities that exist in health care and why underservicing of historically underrepresented groups persists. The ways that barriers are overcome to resolve the discrepancies between what is needed versus what is attainable depends on context; "how" stigma is (and can be) worked through is a complex process that is informed by ongoing and interacting personal and collective histories. The learning experiences of HSP and care recipient experiences of HSU participants reveal various ways that power relations work through stigma and highlight an opportunity to transform how health services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Positive change could thus be supported within the primary care system if health-related education and institutional structures, systems, processes, and decision-making influenced the conditions under which health services were delivered by working through stigma in ways that disrupt, challenge, and transform power relations, rather than reproducing them.

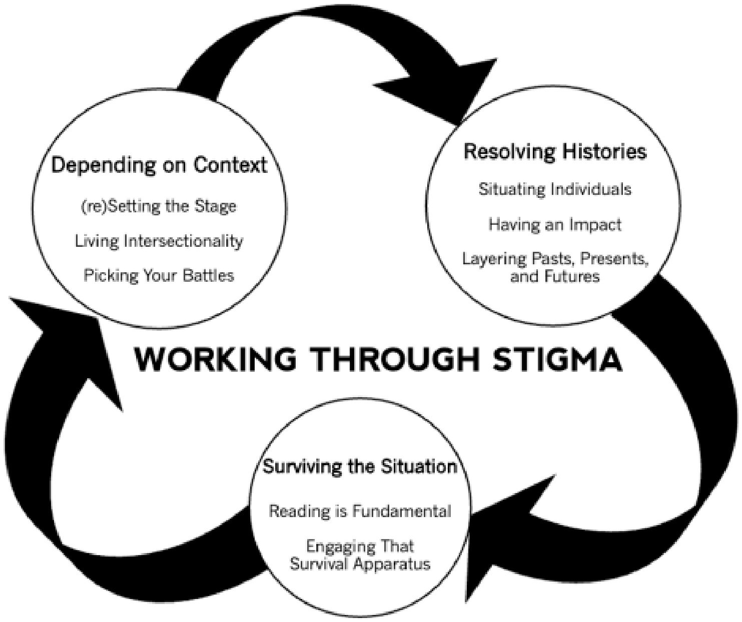

Figure 9. A depiction of a theory of working through stigma.

The significance of the construct of stigma was confirmed by participants from the onset of data collection. In the first interview, stigma was described as a scale, a range of disgrace and shame that influenced access to health services. The second interview included a description of stigmatizing coming out processes that endorse colonial perspectives on sexuality and gender. This participant describes his rejection of the “pressure” and “invisible barrier” that people must work through when they come out as a sexual or gender minority. By endorsing Indigenous perspectives on sexuality and gender that were available to him by way of his culture, this participant was able to work through stigma in ways that challenged the colonially constructed liberating “coming out” process. Each interview permitted theoretical sampling around stigma’s role in delivering health services to 2SLGBTQ populations in Nova Scotia. Participants across all subgroups shared experiences that illustrate stigma’s broadly inclusive, yet negatively affirming, nature; it was not just 2SLGBTQ participants who endorsed stigmatizing experiences, and it was not just non-2SLGBTQ participants who acknowledged that they negatively constructed others by stigmatizing them. Findings show that meaning was created within primary care settings by all participants as they worked through stigma and the various strategies they used to negotiate power relations when health services were being delivered. Participants described attempts that they made to resolve negative constructions in relation to personal and collective histories a theory of working through stigma thus emerged from the data.

4.1 Depending on Context

Depending on context means that outcomes are conditional and circumstantial. When working through stigma, individuals' ability to act depends on the impact of contextual power relations according to subject position (surviving the situation) and interactions with(in) society (resolving histories). Possibilities and opportunities depend on context because they are shaped by contextual factors that impact individuals in different ways. Participants described the ways that stigma complicated access to health services and while the studied context was primary care, in so far as the health system is a part of society, the work done by participants through stigma also depended on power relations within broader social contexts. Nailah (2SLGBTQ HSU), the participant who provided the in vivo code for the depending on context concept, explains how her perceived ability to act or speak up depends on context. She refers to the acquisition of platforms that enabled her to speak up, but it depended on context as to whether she felt safe to do so.

> [N]ow that we have a voice and platforms, we speak up, yell, we scream, and we do whatever it takes to point those instances out. But individually is really hard because

> depending on the context, where you are, sometimes it's dangerous. I've been in places where I can't say certain things, because if I do, then I'm a target and my life could be potentially in danger.

Whether it is safe to speak up and “point those instances out” depends on the context of the situation in which Nailah finds herself. When she “can’t say certain things”, her ability to act is circumstantial and conditional. Nailah is working through stigma whether she speaks up or not. It may be safer to avoid harm by silencing herself, but in so doing, she is working through stigma and negotiating power relations by choosing not to speak up.

Nailah illustrates the three sub concepts that comprise “depending on context”. The stage is set for situations (individual situatedness, a set of circumstances, or an event at a given time and place), based upon what has happened in the past (individually and collectively). Contextual factors that complicate situations inform perceptions around what course of action is best to take. Having a voice or platform to speak up are contextual factors that help Nailah to make waves under these circumstances, doing so feels less risky, but at an intrapersonal level where others have different views, the risk is different and is not worth getting into. She learned from her experiences while in university that challenging the thoughts of her peers, many of whom unknowingly harbored racist ideas, prevailing power relations made it harder for her to speak up, making her feel excluded because she is Black, and the majority of her peers were White. Past experiences, in addition to broader social issues that work to marginalize her, thus set the stage, and inform her practice of working through stigma to diminish its negative impacts. Nailah’s situatedness causes her to experience overlapping stigmas, which means identity, as a representation of an individual's relationship to society, served to reproduce social divisions between her and others thus mutually constructing contextual power relations.

4.1.1 (re)Setting the Stage

What precedes individuals and interactions is what sets the stage for experiences to come. Participants recognized that ways of working through stigma depended on how the stage had been set. Rebekah (2SLGBTQ HSU) provided the in vivo code for this sub concept when she spoke about how the stage has been set differently for her children's generation by way of more 2SLGBTQ representation than she had growing up. As a sub concept, (re)setting the stage includes the ways in which the past influences the future.

Participants saw upbringing as an important part of setting the stage. Within the context of this study, upbringing was more than what an individual experiences during their childhood. (Re)setting the stage encompasses what pre-exists individuals and the knowledge they acquire throughout their lives. The stage is thus set by way of how individuals are "brought up" in worlds that are shaped for them and by them. The media indirectly influenced how the stage was set for participants but was not something that could be separated from other influences, such as family and education. Through stigma, power relations work to shape the opportunities available to individuals to learn about socially constructed differences. Artie (2SLGBTQ HSP) illustrates this by describing how their parents' views on sexual and gender diversity came to light in response to television media.

> When I started coming to terms with my sexuality, I didn't know what the hell was going on. So, it was like really frightening growing up that way. And of course, I couldn't turn to my parents […] just because I knew that… Well, they never talked about it, but I knew

> just from growing up, that it's not something that they would really be accepting of. So, I sought a lot out online with my friends. I grew up a lot on the internet. My parents would… things would show up on the news… and this was the mid-2000s. So, it became more prominent. People became more accepting. And if my parents saw news about Gay folks or Trans folks, they would openly say, ‘Well, I don't know why anybody would do that’, or ‘that's disgusting’. So, it was like super awkward, super shitty. So, the internalized homophobia, obviously, I had internalized transphobia. I'm still working through that conflict.

Artie illustrates how power relations work through stigma at intrapersonal (internalized homophobia), interpersonal (family’s views on sexuality and gender), and contextual (media coverage) levels. As a result, the internal conflict they experienced within the home of their family of origin set the stage for the stigma that Artie continues to work through to this day.

Some participants identified the media as a source of stigmatization, while others saw it as an opportunity to challenge negative constructions of 2SLGBTQ populations and reset the stage; however, this too depended on context. Positive outcomes were offered by participants who were White Gay Men. Social media was identified as a means by which events for 2SLGBTQ populations could be promoted, such as pop-up STI clinics and talks about mental health, addictions, and pre-exposure prophylaxis (PrEP). *Will & Grace* was also identified as an example of how the media can influence public opinion. The public was introduced to the notion of sexual minorities because *Will & Grace* “aired between 5 and 7pm and Straight Men who came home from work, ate supper, and watched it because it was on TV, and it was funny”. The public was thus engaged by a show where two of the main characters were Gay Men and caused them to work through stigma in ways that would have otherwise not happened. This illustrates how contextual level power relations worked through stigma, impacted intrapersonal levels by influencing individuals' views on Gay Men, and social interactions and the interpersonal level would be impacted, thus resetting the stage. *Schitt's Creek* was identified as evidence of "enjoying the *Will & Grace* generation" where one of the main characters is pansexual, but his sexuality is normatively portrayed and accepted by his family and the community. This progress comes because the stage was reset by way of power relations working through stigma; Gay male stereotypes were reproduced on *Will & Grace*, but the characters were White, Cisgender, non-disabled, non-Immigrants. This participant qualified these statements by acknowledging the unlikeliness of this progress carrying benefits for a Trans person living in rural Nova Scotia, which suggests the same power relations are working through stigma on shows like *Schitt's Creek.* The experiences of White, Cisgender, non-disabled, non-Immigrant individuals continue to be inadvertently prioritized over others by rendering the experiences of racialized, Trans, (Dis)Abled, Immigrant individuals invisible because there is a lack of attention given to intersectional identities with two or more stigmatized strands.

Participants discussed how omissions set the stage for misrepresentation, illustrating another way that power relations work through stigma. One participant recalled her formal education on Indigenous populations in school, illustrated how power relations work through stigma at contextual levels by reproducing historical subjectivities as if they were facts. The impact of education as such depends on context. This participant was taught that there were no more Indigenous people in Canada. It was not until the setting changed and she was in high school that she found this to be untrue.

> [W]hen you're a Refugee and you come to this country, you kind of buy into the lie that Canada's perfect. Canada's this and that, so you don't assume that they're lying. And then

> you find out that they're lying. And that completely changes the whole way you perceive the country, because it's like, if you're willing to lie about something like this, because you're afraid to confront your history, […] what else are you lying about? It's very insidious in the way that it works.

Power relations thus work through stigma by way of formal education. As this participant acquired more knowledge, she learned that the Canadian education system lies to young people, which set the stage for her questioning what other subjective information was passed off as factual. The impact on this participant may be different than it would be on someone who did not come to Canada as a Refugee because each individual's stage was set according to different upbringings.

There was a distinction between the HSU and HSP subgroups because the stage was set differently for each by way of the latter acquiring formal health-related education and training. Medical and health professional education and training was identified as contributing to the stigmatization of 2SLGBTQ populations due to limited content on 2SLGBTQ populations and positioning education on historically underserved populations, including but not limited to 2SLGBTQ populations, as elective. One 2SLGBTQ HSP recalls being faced with the options for elective courses in her social work program. They could not take all the courses, so they had to choose between electives on Indigenous populations, Black populations, or the mental health course, the latter of which would increase your chances in getting a job in a hospital. This is an example of power relations working through stigma and illustrates how the education and training of HSPs sets the stage for how health services are delivered to populations.

HSUs were "brought up" to expect certain treatment within the health system through the interactions they had when accessing health services. Participants demonstrated an appreciation for how experience sets the stage for health service delivery as they described a myriad of factors that influenced how HSUs were brought up in the health system as compared to HSPs. Different upbringings, particularly those between participants with professional health training versus those without, created differences in how stigma could be worked through. When hegemonic power relations were being reproduced under structurally stigmatizing conditions, the stage was set for how health services could be accessed, delivered, and subsequently received. Many HSU participants considered health service delivery of any kind primary to their care, meaning that primary care was not restricted to primary healthcare settings. All health services were part of how the stage was set for accessing, delivering, and receiving primary care services.

Stigma could set the stage for good intentions to become harmful on impact if hegemonic power relations were inadvertently being reproduced. Phoenix (2SLGBTQ HSP) shared an experience she had as an oncology patient and illustrated how the stage can be unknowingly set for harm. She did not realize until after the immediate shock had worn off how much harm had been inflicted during her treatment.

> [T]hat's when I started realizing. I was like, 'Well, that was shitty. Oh, that was so shitty to me. Like, they shouldn't have done that.' But going through it, I was just like, 'Okay, sure, okay, okay...' Because you're sort of overwhelmed […] you don't really know what to expect. So, you're just following along with the professionals who have seen this hundreds of times, and you're assuming they know what's best.

Phoenix trusted those providing her care. The power relations between HSP and HSU worked through stigma by way of the high stress situation of undergoing cancer treatment, which set the stage for her feel unable to speak up in the moment. Phoenix reveals how assumptions set the stage for encounters that take place within stigmatizing contexts and that power relations can make it harder for those who are constructed with relatively less power to access the care they need.

> He was like, ‘No, we really have to make sure because this could have serious consequences for your health. And, you know, if there was a baby.’ Eventually, I just had to come out and be like, ‘I'm not having sex with Men, there's no chance of pregnancy.’ And he was like, ‘Oh, sorry. Alright, then.’ But spent a good 5-10 minutes trying to convince me that I needed some sort of birth control when it was not necessary and didn't even register to listen to me when I said it's not necessary, or ask, ‘Okay, why not?’ That would have been much simpler rather than just telling me over and over what I need.

Phoenix was faced with a discrepancy between her understanding of risk of pregnancy and that of her oncologist because each perspective was informed by different upbringings that set their respective stages differently. This made it more difficult for her to work through the stigma because the assumptions being made about her were reproducing power relations that prioritized the oncologist’s perspective over her own. Phoenix illustrated how knowledge and experience set the stage for how stigma can be worked through: “If you've grown up, and you identify as Heterosexual, and that's what you're being taught, there's no reason for you, in your mind, to go outside that box, because it's just not relevant to your life.”

Participants from the HSP subgroups were aware of the negative impact that harmful interactions within the health system had on health-seeking behaviour. They recognized the importance of being open and non-judgemental in making it easier to work through stigma. Neutral language was a commonly cited communication strategy that participants used to set the stage for individual encounters. Stanley (2SLGBTQ HSP) explains the importance of signifying safety to patients and how neutral language can be used to reset the stage in ways that can convey intent to create safer spaces, where HSUs can share their stories.

> When we make assumptions, which we're taught to do from such a young age, we're telling other people's stories for them, and we're silencing them. And then they have to remove themselves from this context that we just put them in. And that's really hard to do. And it's scary. Because if you have to do that, you're questioning if you should, or if it's safe, or if this person is someone that would even consider… would they even consider that you could have a different narrative? So, I think by using neutral language […] you're showing that you hear them, you see them, you've made space for them, and that you have some kind of knowledge and that you've done some unpacking of your own and some work so that they can be themselves and they don't have to be threatened by my unconscious bias, which is always a threat. Always can be. We all have our biases, but it gives them a signal that maybe I'm [creating] a safer place than what I would be if I didn't give those signals.

Signaling as such is thus a way to work through stigma and reset the stage for interactions between HSPs and HSUs in ways that promote the disruption of power relations. Stanley also calls attention to unpacking one’s bias as a form of working through stigma that HSPs have internalized (intrapersonal level), which can make it easier for HSUs from stigmatized populations to work through the stigma that is between them and equitable health care. It can make negotiating power relations between individuals a little easier (interpersonal level), particularly in primary care settings where stigma influences how health services are delivered (contextual level). Unpacking biases and demonstrating to patients that work has been done to make the context under which health services are being delivered safer is thus an opportunity to reset the stage in ways that disrupt the reproduction of power relations and promote trust building over time between HSUs and HSPs within the health system.

4.1.2 Living Intersectionality

Living intersectionality means realizing socially constructed differences. This sub concept highlights that the concept of *depending on context* is just as much about who is involved in realizing socially constructed differences as it is about the circumstances under which those differences are realized. Examples of living intersectionality included conceptualizing groups as infinitely diverse, addressing biases by acknowledging advantages and how they structure disadvantages, and acknowledging the impossibility of fully understanding another's experience. Living intersectionality means realizing socially constructed differences through the intersections of one's identity so another's experience can be appreciated without having the lived knowledge necessary to fully understand it. Living intersectionality can be about appreciating others' experiences in relation to that of your own and disrupting the reproduction of power relations by bridging differences without putting people into boxes or telling their stories for them. If an HSP is not actively working through stigma, this can reproduce power relations in ways that make accessing health services more complicated for an HSU. This example is one where power relations are being reproduced in such a way that an HSU is living intersectionality without having had the HSP gain any sort of appreciation for the circumstances under which care is being delivered. If HSPs actively work through stigma with HSUs, then power relations can be disrupted, and intersectionality can be lived together to enhance the quality of care delivered.

Living intersectionality begins with conceiving populations as infinitely diverse. Jade demonstrates how she lives intersectionality by pointing out the diversity among Black populations within a Nova Scotia context and criticizing how health services are often delivered according to oversimplified conceptualizations identity.

> [W]ithin Nova Scotia, you have the quote, unquote, Black community, but it isn't. You can't say that and then assume that it is entirely just African Nova Scotian. We have a large number of people who migrate to this province from Caribbean communities. Then we have clients who access our health care for half the year because they're here as foreign workers from the Islands, and then they go back home. So, it's a very nuanced group and what the group needs can be different. Then we also have a lot of immigration from African countries. You know, a lot of families have come here from Ghana, from Nigeria, along the west coast of Africa in particular, and their experiences within our healthcare system can look different because they don't have the same experience of growing up within a Black minority province or country.

Jade illustrates how identity is both complicat*ed* and complicat*ing* and how living intersectionality can disrupt reproducing power relations by questioning the universalization of diverse groups. A Black participant without the same historical ties to Nova Scotia as Jade talked about what it means to "come from away" and further illustrates how living intersectionality involves realizing socially constructed differences through the intersections of one's identity. This participant remembers having to learn what Blackness was within a Canadian context because where she comes from, everyone is Black. The stage is set differently within the context of Canada, where Whiteness dominates. Social divisions are constructed differently because the social contexts are different, suggesting different power relations were at play.

> It’s a delicate topic and it’s still to this day because when I came here […] there was a big distinction. Though for the kids, we didn’t really care because we just grew up together, but the adults made the distinction. And then as more [Black people] came in, the distinction kept getting bigger and much more important. […] It is two different Black communities, which makes it harder for people like me, who grew up in those communities, but also had a different community. It can be a bit of a tense conversation. Some people are trying to bridge the gap today, but it’s all very touch and go, but that’s why I don’t call myself Black Nova Scotian even though Black Nova Scotians might call me that because I grew up here, some won’t.

Nailah further illustrates living intersectionality by making the distinction of being Black in Nova Scotia, but not Black Nova Scotian.

Those with multiple stigmatized identities are situated in ways that may make negotiating power relations more complex as compared to someone who experiences relatively less stigma in the same context. Living intersectionality happens by way of an appreciation for the need to negotiate power relations and how contextual factors informed participants’ ways of working through stigma. Everyone lives intersectionality differently, so it is not about determining who experiences the most stigmatization because this promotes the creation of new social hierarchies. Living intersectionality is a sub concept that can be used to garner an appreciation for how contextual factors work together to reproduce power relations that impact individuals’ ability to act. It is about determining what can be done to disrupt prevailing power relations by intervening upon stigma. A family physician from the 2SLGBTQ HSP subgroup speculates on how his situation informs interactions he has with patients. His identity affords him experience that he can draw upon to live intersectionality with HSUs in ways that allow him to go beyond a superficial level of working through stigma and disrupt power relations in ways that enhance the quality of care being delivered.

> Sometimes by being Gay, you're not going to skirt around questions. So, I'll sometimes let the history go to a detailed sexual history where I know some of my not Gay colleagues would be like, I wouldn't touch that with a 10-foot pole. You know, you are booked here for an ingrown toenail. I'm going to keep it to an ingrown toenail. […] [M]aybe I'm not afraid because my comfort level from coming from that world?

Being a Gay Man has complicated this participant's identity in ways that offer him insight into how to disrupt power relations and diminish barriers to health services. He uses detailed sexual health history taking as a means by which he can live intersectionality with HSUs, which can convey to those who have had past negative experiences that he is intentional in how he works through stigma to disrupt and challenge hegemonic power relations.

Participants recognized labeling others' situations as problematic and that it was important to be sensitive to negative constructs when attempting inclusion. Living intersectionality is thus about considering *how* inclusion comes about because it can be the difference between intending to disrupt hegemonic power relations by intervening upon stigma and inadvertently reproducing them. Jade (2SLGBTQ HSP) situates herself as a Black Woman. Her perspective on how power works through stigma is complicated by way of her intersecting identities.

> I've been working on a lot of different stigmas for a very long time. I wear it every damn day. […] None of these are siloed things. So, working with somebody, and understanding

> their gender identity and their sexuality is also going to have these intersections with their religion, with their ethnic identities, community, sense of belonging, with all those pieces determining health.

Jade describes one way that HSPs can work through stigma to live intersectionality with HSUs and disrupt prevailing power relations. There are however limitations on appreciating others' experiences in relation to that of your own. A 2SLGBTQ HSP participant complicates Queerness with his Indigenous identity. In doing so, he illustrates how Indigeneity complicates where he is located in relation to me, a White Queer person:

> [A]s Queer people, we both understand what it's like to be treated differently or to be looked at differently [...] I understand what it's like to be oppressed as a Queer person, but you don't know what it's like to be oppressed as someone who is Indigenous […] That's an experience you'll never understand. You'll never know the feelings associated... You may see there's hurt involved, but you're not going to know that feeling. You may feel the empathy of it, but you're not going to know that experience, this individual's feeling, and how long they're going to experience that.

We live intersectionality differently by way of our Queer identities because we are affected by power relations differently. I can understand how Queerness is complicating, but the the way that power relations work through stigma in my lived reality as a White Queer person does not afford me understanding of how power relations work through stigma to complicate an Indigenous person's situation. What it does afford me is an appreciation of the additional complications that arise by way of the stigmatization that Indigenous populations experience, relative to me. It allows me to recognize that the privileged intersections of my identity can contribute to that complicatedness because I benefit from prevailing power relations that work through stigma to construct Whiteness as superior. Such an appreciation can be used to mitigate contextual factors in ways that I can intentionally cultivate safer spaces and thus actively work to reduce the impact of stigma at an interpersonal level.

Living intersectionality was identified in the data from participant perceptions that past negative experiences revealed how power relations work through stigma to complicate the delivery of primary care to 2SLGBTQ populations. Data illustrate that negatively experienced situations were perceived to inform future behaviour; participants' sensitivity to this illustrates concern for how stigma could be worked through in ways that attend to the complexity of identity and how relevant factors are contextually dependent. Participants recognized the harm of reproducing hegemonic power relations through personal biases and assumptions and the risk for long term ramifications. Many described inclusive approaches for working through stigma that disrupted hegemonic power relations, assisted in avoiding making assumptions, promoted an exploration of an individual's subject position, to gain insight into the impacts of stigma at intrapersonal, interpersonal, and contextual levels. Inclusive approaches thus aimed to disrupt the reproduction of power relations that uphold the beliefs and practices of dominant cultures to simplify the health service delivery process for those whose identity is complicated by stigma.

4.1.3 Picking Your Battles

Recognizing the limitations of choice and trying to bring about sustainable change is what picking your battles means within the context of this study. Picking your battles refers to the processes by which the best available option was chosen according to contextual power relations. Many participants described having their own approach to picking their battles, and that depending on contextual power relations, decisions could become harder to make for some individuals as compared to others. Whether power relations were reproduced, challenged, or disrupted depended on the battles HSPs picked. If HSPs imposed their own opinions upon HSUs when delivering health services, power relations were reproduced at the interpersonal level, which could be the difference between HSUs feeling supported in making decisions that are contextually relevant to their lived reality or coerced into what the HSP thought was best based on a limited understanding of someone else's lived reality. As such, how intersectionality is being lived sets the stage for picking battles that are perceived to be worth fighting.

Picking your battles means deciding upon the course of action that is best for the situation because one cannot take on every issue that needs to be addressed. This sub concept illustrates how the three sub concepts that constitute the depending upon context concept relate to one another. Nailah explains how the stage is set by power relations and that her identity complicates the decision-making process around which battles she chooses to fight.

> I have to pick and choose my battles because my community could... I mean, they've already turned on... but they could turn on me or other people can turn on me. It's such a delicate… because what a lot of White and even White passing Queer people don't understand is that to them, it's okay. It's okay for them and their families and their communities to be like this. It's not that it's normalized but there's [relatively more] support there. So, in certain Black communities, there's not really support there. If word ever got back to, you know, my community back home, I could go back and there would be potential for them to try to hurt me or lock me in jail. Like, there's more ripples that affect… So having to kind of navigate the space in a very like… keeping everything on the low and like only saying to people here and there, and […] that's how a lot of,

> especially Immigrant, people have to behave. […] [S]afety means something different. Right now, it's not physical danger, but it could be.

Power relations influencing participants’ decisions of whether it was worth the risk to take action emerged from data analysis. Initially the focused code of “rocking the boat” emerged, but through theoretical sampling, the concept became “picking your battles” because it captured the decision-making aspect of what the participants were describing better than “rocking the boat”, which suggested the decision to disrupt or challenge prevailing power relations was already made. Data illustrated the influence that power relations had on decision-making processes leading up to taking action and that prevailing power relations were not always disrupted or challenged. As such, picking your battles represents the processes by which a ‘best’ course of action is decided upon according to contextual power relations, not the action taken. Following through on a decision made has consequences and falls under a different concept (resolving histories, having an impact) because the impact of actions taken is part of a related, but separate concept.

Participants described how picking your battles depended on context and that the impact of power relations sometimes meant the ‘best’ option was to do nothing. Phoenix (2SLGBTQ HSP) recognizes that “[i]t’s not [about] making good choices, it’s that you had good choices to make. Sometimes you don’t have those options. […] Sometimes it’s about survival.” Sam (2SLGBTQ HSU) feels HSPs can “really put their opinion on something and get upset that the patient is not choosing to do what they want them to choose. […] [I]f they could just explain gently what could happen, the risks, and if they could offer alternatives,” then there would be more options to choose from and HSUs could choose which best suits their needs instead of feeling imposed upon. Sam illustrates that HSPs need to pick their battles, not according to what they think the most important issue to address is, but as it relates to HSUs' lived context so that power relations that negatively impact the quality of health service delivery are not reproduced.

A family physician (2SLGBTQ HSP) recognizes that power relations "probably prohibit people from saying something in the moment, especially if you're seen as a gatekeeper to health care. I can see where someone might not want to rock that boat." Noelle (non-2SLGBTQ HSP) picks her battles in ways that disrupt prevailing power relations because she tries to find common ground when talking with HSUs about the challenges they face when making decisions about their health. This allows her to support HSUs in picking the best available option, not just according to the knowledge she has as an HSP, but in collaboration with the person who has to carry out and live with the consequences of the decision. "[S]mall sustainable changes are important. I'll say, 'We all struggle with our health, and we all struggle with our choices.'"

HSP participants were clearly decided: they wanted to take steps to level the playing field, stand up for wrongdoing, and recognized that they could work to bring about change through professional practice, but being able to do so depended on the context within which the course of action would be taken. A non-2SLGBTQ family physician in the study saw herself as being someone who "always stirs the pot a little bit" but found making small changes could be a better course of action than working to bring about change on a larger scale because it can feel like "you're banging your head against the wall". This participant illustrates how power relations work through stigma to constrain HSPs within their roles and hinder their ability to bring about large-scale change, which can feel insurmountable, even to those who are positioned to see the potential benefits. Alison (non-2SLGBTQ HSP) also subscribes to the small sustainable change model. When developing exam questions, she makes use of existing knowledge in a way that is inclusive to historically underserved populations, which can change the way that learners think and subsequently practice. Alison disrupts hegemonic power relations by modifying existing content to be inclusive of Trans and gender diverse persons who use a name that is different from what is on their legal documentation. “If Miss Stella White says, ‘Please call me Dot’, that's what you call her. It doesn't matter who it is. So yes, you can reference that in the textbook. Their gender doesn’t matter.”

Participants who work in primary care within clerical/administrative/managerial positions were able to use their roles as leverage, revealing that healthcare workers (in addition to those with professional designations) in the health system potentiate a range of opportunities to disrupt power relations and make changes that are unavailable to, but carry benefits for HSUs. A non-2SLGBTQ manager in the study identified making changes to the electronic medical record (EMR) system her clinic uses as the best course of action to be more inclusive towards HSUs who go by a name that is different from their legal name. In this clinic, patients can now book appointments in the name that affirms their gender or what is on their legal documentation, which is a change that can be made by any clinic that uses the Med Access EMR.

Joy has been working in health care for almost 20 years and she draws upon this experience to make a point about what kind of questions are appropriate to delegate to someone in an administrative/clerical position. She is critical of the expectations that are placed on healthcare workers and disrupts hegemonic power relations by refusing to ask questions just because she is told to do so. The *Start with Heart* program (a training module all employees must complete) at NSH would have all employees approach HSUs who appear to need help. Also relevant to Joy’s role is the expectation that clerks are to fill every field in a patient’s profile when they are doing an intake. She feels there is a better course of action in sensitive situations and picks her battles accordingly.

> I'm not going to walk up to a Woman in the corner in tears and say, 'Hi, hi, this is my name. What can I do to make your day?' I'm not going to do that, right? So, that depends on every single piece of that moment. [...] I've been doing this long enough. I'm not asking anybody if they're male or female just because there is a drop-down choice for it. […] [T]hey can answer it, in back, with their provider who they're supposed to trust with that information. I'm not asking that. […] I'm not going to ask an 80-year-old lady if she's a Woman, right? But I'm not going to ask a 14-year-old confused kid if they're a female or a male either.

Joy's stance on choosing not to ask sensitive questions highlights an understanding of how to work through stigma to disrupt hegemonic power relations that uphold the beliefs and practices of dominant cultures and benefit their members at the expense of non-members. She simply refuses because she believes that asking questions of a personal nature without having the relationship is rude and undermines the trust between an HSU and their HSP. For Joy, the battle worth fighting is promoting trust between HSPs and HSUs, not inadvertently reproducing power relations that would undermine that trust by blindly carrying out direction from her superiors.

Another 2SLGBTQ HSP participant also uses her scope of practice as a social worker to disrupt power relations in such a way that her clients are supported in making their own choices. This participant shared an example where a client felt safe to fight her own battle because "she knew she had the support of a known organization and could [take on the] challenge". Such support disrupted power relations that might have otherwise made it feel like a losing battle. Steve uses his scope of practice in conjunction with model of care to disrupt power relations that work through stigma and create barriers to accessing health services for Trans and gender diverse patients. He uses the informed consent model with those who wish to access gender-affirming hormones. “I don’t require the readiness letter. I have a goal to get rid of that and stop that discussion.” By using the informed consent model, Steve (2SLGBTQ HSP) makes primary health care the point of entry for gender-affirming care, which is a route that is less pathologizing and disrupts and challenges the power relations that have been reproduced by the psychiatric discipline’s historical mistreatment of 2SLGBTQ populations. These illustrations demonstrate that HSPs can pick battles that disrupt power relations in ways that diminish barriers to accessing services for HSUs by way of offering organizational support or delivering health services through alternative models of care.

Jade (2SLGBTQ HSP) believes primary health care is done best when nurses receive proper support and education so that they feel encouraged “to speak up with their colleagues when it’s not occurring”. She provides the example of correcting a physician who constantly uses the wrong pronouns for someone “rather than letting it slide” and feels this is no different than when nurses remind physicians and surgeons of such things as using gloves when examining a patient. Jade qualifies her position by acknowledging that negotiating power relations as such requires experience and understanding of “the weird power dynamics that our structure has in place”. Situational context is thus important to know *how* to pick your battles. “If it’s not happening in the room, and having that immediate need to fix, then it’s a much more private, compassionate conversation [that needs to be had].” Jade illustrates that determining the best course of action depends on the context within which a battle may take place, and that education can be provided to teach people how to disrupt power relations in ways that promote better patient outcomes. When working to bring about change in how individuals think, another 2SLGBTQ HSP echoes Jade’s desire to engage those with knowledge deficits through compassion and does not recommend a heavy-handed approach if the intent is to have them "enthusiastically on side". "We're not going to do anything about the fact that most healthcare practitioners are going to be Straight." This participant believes that picking battles with others in ways that pushes them away does not have HSUs' best interests in mind.

Stanley (2SLGBTQ HSP subgroup) shares an experience where he recognized how important it was to bring about awareness in HSPs that they were not on side with what the HSU needed. Stanley explains that HSPs can step in to pick battles for patients who need support and illustrates how to negotiate power relations in ways that carry benefits for HSUs.

> I saw the name of the chart, it was female, but they kept calling her 'him'. And so, then I went in to talk to this person, […] I asked about family and friends, and they said they don't have any real friends here at all and they don't get along with their family. […] So, eventually I shared with them that I identify as Trans. […] They just broke down. And it was just like… this person felt so alone, but also scared because other health care providers kept calling her 'he'. […] And I was like, here's somebody who just started to live their life for themselves. And they're being called 'he' over and over. Oh, it just... it killed me. […] I went up to the healthcare providers who were looking after her. I said, 'Who's looking after her?' And I took them aside and I was like, this is really important. This person goes by this name. I know it's easy to slip into our assumptions, especially when we're talking about prostate cancer, […] but this is this person's life. You know, this is so important. Anyway, I had a really good conversation with them, and they had questions for me.

These may seem like small things to change, but they are sustainable, within scope of practice/role, and represent a course of action that intends toward inclusive and equitable change in health care where power relations can be difficul to negotiate as they are working through various types of stigmas and shaping the conditions under which health services are being delivered.

4.2 Resolving Histories

The concept of resolving histories provides perspective on the scale of work that needs to be done to overcome the barriers created when power relations work through stigma to position subjects (situating individuals) within social settings (having an impact) and temporal environments (layering pasts, presents, and futures). Resolving histories are the processes by which individuals situate themselves and others, the impact of power relations that arise from social interactions, and influence of pasts and presents on future outcomes and opportunities. Resolving histories are the relationships between individuals, within various social institutions, and set the stage for social interactions. Within the context of this study, resolving histories emerged from the data as a concept that is necessary for expanding and connecting individual contexts that influence how the stage is set, complicatedness is achieved, and battles picked. Resolving histories are thus the broader context within which the concept of depending on context can be understood. Resolving histories is about situating subject positions in broader social contexts to appreciate the impact of power relations on individuals across their lifetimes, as periods of time in human history.

Resolve is a word with several definitions, all having relevance to this concept. Resolve can involve finding a solution to a problem, firmly deciding upon a course of action, and distinguishing between or separating a whole into its parts (Merriam-Webster, 2022). Musically, resolve means moving from dissonance (a lack of harmony) to consonance (harmonic unison), and medically, resolve is what happens when symptoms subside (Merriam-Webster, 2022). Resolving histories can carry as many meanings as there are layers of stigma to work through, but broadly speaking, it is a rendering of the relational process by which actions have direct and indirect impacts across time, for and between individuals, groups, and cultures. It accounts for the unintended negative impacts of decisions carried out on behalf of a group without having consulted with them, but it is what resolving histories *could be* that suggests a future where power relations that have unjust impacts are resolved by way of exploring and reconciling the differences between and within subjective realities. Participants described various ways they sought to find solutions to problems they faced in health care and in situations outside of healthcare settings. Power relations can create discrepancies which were described by 2SLGBTQ HSU participants as differences between what they felt was important versus what was deemed as such by their HSPs. Participants from the HSP subgroups recognized that these discrepancies could reproduce power relations that negatively impacted HSUs. Through resolving histories, discrepancies could be resolved, but historical injustices have caused power relations to expand and create disparities that are insurmountable for some individuals to overcome. There is a role for HSPs to assume in resolving histories, but they too need support from the institutions within which they receive training and practice. This is not to say that the burden can simply be shifted onto institutions; resolving histories would have us explore ways of supporting large-scale change that would make it easier for individuals to work through stigma and disrupt and challenge power relations in ways that have far-reaching benefits. This level of support is required from governments, the public, and even globally so that power relations are not being reproduced in ways that have unforeseen consequences when decisions are made based on partial understandings of complex social issues. As such, resolving histories conceptualizes stigma as something that can be worked through at contextual levels and across individual and collective temporalities so that discrepancies can be addressed in complex and meaningful ways.

4.2.1 Situating Individuals

Within the context of this study, situatedness was conceptualized as the product of an individual's subject position, which brought about differences in how the delivery of health services in primary health care was experienced. How individuals situate themselves and others depends on every single piece of the moment in which an individual is situated. Frames of reference are used for situating individuals; whether discrepancies (between how individuals situate themselves versus how others situate them) were exposed, expanded, or mediated depends on the context of the social interaction. Situating individuals means putting people into social categories (also referred to as "boxes" by many participants). Participants described their situatedness and that of others by way of various indicators, including presentation and frames of reference. Situating individuals is a dialectical process whereby subject positions are being structured and restructured according to context. Depending on the context in which complicatedness is achieved, individuals may negotiate power relations and resituate themselves by minimizing parts of their identities, a process that emerged from the data as "backburnering".

Participants consistently acknowledged that humans categorize themselves and others, and the sub concept of situating individuals thus emerged from the data. When participants described their identities, they reduced subject positions into various categories of identity. Participants who were 2SLGBTQ-identified often described their subject positions using categories of identity in ways that were more complex, thus demonstrating a familiarity with living intersectionality at an intrapersonal level that was not achieved by many non-2SLGBTQ participants. Situating individuals is when sets of criteria are used at intrapersonal and interpersonal levels by individuals to situate themselves and others. These sets of criteria can be stigmatizing and can reproduce hegemonic power relations in ways that create discrepancies between individuals' frames of reference that need to be resolved. Participants situated themselves at the beginning of each interview in response to questions that asked for a description of their identity in terms of sexual orientation and gender and then with regards to other intersections of identity. The ways in which participants described their identities provided insight into the frames of reference they used to situate themselves and others. When participants described being situated by others, discrepancies created by conflicting frames of reference could feel stigmatizing, particularly when interacting with individuals in healthcare settings or other structurally stigmatizing contexts. Stanley described the task of taking yourself out of a box in which you were mistakenly placed by another individual, which is insight he likely gained from the various subject positions he has held throughout his lifetime. He now identifies as a Pansexual Trans Man but was assigned female at birth and has situated himself as a Heterosexual Woman, Lesbian, Trans Man, and Gay Trans Man over the course of his lifetime.

Identity was often reduced by participants into terms that were relevant across different frames of reference. Lucy (2SLGBTQ HSP) describes her identity using labels that correspond with different frames of reference. She thus illustrates how social categories of identity are reflective of frames of reference being used by individuals as they situate themselves and how they perceive the frames of reference being used by the person they are interacting with. Lucy, like many other participants, recognized that situating yourself was an opportunity to provide information that offers more context on situatedness than what is available through presentation alone.

> I would say that I'm a Queer Woman. Lesbian, I like that term. You know, I connect with that term. Sometimes Gay if I'm talking to somebody for whom that particular label is

> relevant. It's not just about age either. It could have to do with cultural origins and other frames of reference.

As a situating individual, Lucy can use language to describe her identity in multiple ways. When she says she connects with the term Lesbian, she is engaging in the process of situating individuals at the intrapersonal level. When she considers the relevance of a label to someone else's reality, she is engaging in the process of situating individuals at the interpersonal level. As such, situating individuals can be a way that power relations can be negotiated.

Taylor (2SLGBTQ HSU) was once ridiculed by another member of the 2SLGBTQ communities for not having the language to situate themselves as Demisexual. They felt "not Gayed enough" and that there was an expectation of them to be absorbent of the ridicule, alluding to a role that power relations may play in the processes by which individuals situate themselves and others. Sam (2SLGBTQ HSU) just wants to feel accepted and allowed to be who she wants to be. Others have situated her in ways that negatively impact her sense of belonging, which is something she has routinely experienced over her lifetime. She is Black presenting, was brought up religiously, and around mostly White people. On multiple occasions her surname has been incorrectly changed to one that many Black Nova Scotians have. Sam believes that changing the spelling of her surname without asking is evidence of being reductively situated by well-intended individuals who make incorrect assumptions about her that are based upon the colour of her skin. This illustrates how power relations that benefit White populations are often inadvertently reproduced at the expense of Black populations. She needs to correct them each time it happens. At the time of her interview, it had happened three times since moving to a new pharmacy and once again at the time of a follow-up interview. Siyanda described something similar when they situated themselves as a Boi, a gender identity that they describe as a Black-specific term used by people who were assigned female at birth but are masculine in terms of their gender. “I actually run into a lot of White people using Boi.” A White person situating themselves as a Boi is a misappropriation of a racialized identity and further highlights the ways in which power relations that benefit White populations are often reproduced without intending to negatively impact Black populations.

Artie illustrates how the gender binary represents normative views that have caused them to be situated by others in ways that do not align with how they situate themselves in terms of their gender. This is often referred to as being misgendered.

> I don't really subscribe to gender, whether it's presentation or norms […] I don't attempt to be ambiguous, but the way I describe myself is, if you look at me, is that a Man or is that a Woman? Who cares, please don't refer to them, you just don't know. But recently, I wish… I just went through a lot of processing and stuff, and I came out more Trans masc than Non-Binary, which means I just lean more on the masculine spectrum, and I prefer to present and be to be seen that way. So, I will be taking steps towards that hopefully in the next little bit.

This illustrates how power relations that benefit Cisgender populations are often inadvertently reproduced at the expense of Trans populations. Artie will undergo medical transition, which may influence how they are situated by others because their presentation may be interpreted through gender normative frames of reference as masculine. Gender norms have caused Artie to be situated as ambiguous by others, which used to align with how they saw themselves when they identified as Non-Binary. In so far as they now situate themselves as Trans masculine, being situated by others as ambiguous is now a means by which power relations that negatively impact them are reproduced at the interpersonal level.

A 2SLGBTQ HSP participant thinks that situating yourself is better than having someone do it for you.

> [Y]ou need to recognize your own privilege, right? I say this all the time. I wear my White privilege. […] I have to recognize this. […] Because if you don't, then it's going to be very quickly labeled for you. And you're going to be really uncomfortable, right? Because you’ll have egg on your face. So, you need to.

This illustrates how individuals can situate themselves for others for the purpose of conveying a recognition of the impact of prevailing power relations and what social categories of identity, in this case Whiteness, may represent to others in relation to their past experiences. By attending to this aspect of his identity, this participant can convey that he is aware that Whiteness is constructed as superior within the context of a White supremacy and in doing so, he disrupts the reproduction of hegemonic power relations at the interpersonal level.

Luka (non-2SLGBTQ HSP) situates himself as a White-presenting Cisgender male and explains how categorizing others can reproduce power relations through stigma at interpersonal levels and how this changes depending on the context of the social interaction.

> I always assume that there's never going to be a label put on me. But I am a White-presenting Cis male. I don't know if I'd be offended, but I would be raising my eyebrows if someone's like, ‘Oh, this is my White friend.’ I'd be like, ‘Okay, yep. That may appear to be true, but why did you have to introduce me like that?’ [...] I'm just a person with this different heritage. Labels can be helpful, but I think they can be hurtful in a way. [...] I think a lot of Trans folks, for instance, would be upset if they were introduced as Trans, perhaps. I would think if they were meeting somebody and being introduced by saying,

> ‘Oh, this is my Trans friend.’ I don't think they would want to be labeled like that, even though they identify as Trans. […] Now, if I was writing a letter for to a specialist, I would state that this individual is Trans, because I think it's important information. So, I think it's how we put the labels on.

Being White presenting may be a good thing socially for Luka even though it may also be a bad thing for him personally in so far as it erases part of his identity. Siyanda spoke to this distinction in their interview:

> There’s this idea that saying someone is Straight passing or Cis passing, or that you grew up with male privilege is such a terrible thing to say because part of your identity is being erased. And it’s like, yeah, but the point of privilege is how others treat you and what others give you. It doesn’t have to be a good thing for you personally to be a good thing for you socially.

Luka and Siyanda illustrate the contextuality of power relations and that putting labels on others can oversimplify others’ situatedness and may be stigmatizing if solely based on their presentation. Situating an HSU as Trans may be relevant to how health services are delivered to a patient for which Luka is making a referral, suggesting that applying that label may be in the best interests of the patient; however, in a situation where it is irrelevant, the same label may have a harmful impact. Luka and Siyanda thus illustrate how the impact of placing a label on someone is influenced by contextual power relations.

Participants described ways of situating themselves so that they intentionally left parts of their identities undisclosed. Participants engaged in a process called backburnering, which is a stigma management strategy that participants employed to negotiate hegemonic power relations.

According to Sorrel (2SLGBTQ HSP), sometimes it is easier to just play along. As someone who presents as a "Cis Straight White Woman", Sorrel can do what others whose differences are more visible cannot. Sorrel illustrates playing along as a form of backburnering that can be used by those who present as they do to 'pass' as members of dominant groups, much like Emmanuelle does when she backburners her sexual orientation when accessing health services that are unrelated to her sexuality. This can be contextually advantageous and may be a strategy for avoiding stigmatization, but in this case, power relations are being reproduced at an intrapersonal level. Emmanuelle (2SLGBTQ HSU) explains that her sexual orientation rarely comes up and her presentation, as a feminine Lesbian who "completely pass[es] as a Heterosexual Woman", further benefits her as someone who accesses health care with White privilege. Assumptions are made about Emmanuelle's sexual orientation because of her presentation that causes others using heteronormative frames of reference to situate her, reproducing power relations that carry benefits for those who can "pass". The point of privilege is in what others give her based on how they situate her. Emmanuelle avoids the negative impacts of power relations working through stigma because she is situated by others as Heterosexual and because her identity is rarely relevant to the care she requires, she does not have to disclose information that may challenge the frame of reference of an HSP who has relatively more power than her. She recognizes that "anybody who has a different identity from that [of White Men and Women] does not feel seen, heard, represented, or respected in health care."

As someone who cannot access health care with White privilege, Nailah shares what she must consider when attempting to access health services and illustrates the impact of hegemonic power relations that work through stigma by way of racism to uphold the cultural dominance of Whiteness.

> I'm reading between the lines. I was told there was only one way to access health care. And that's at a very base level. […] [W]hat they see, what they think, and what they assume that you are. That's how you have to operate. From their assumptions. Not from what you're saying. [...] So, a lot of practitioners and teachers try to force it in that box and then in forcing it, they kind of get rid of [...] everything that humanizes you and talks about your identity. It just strips it all away. So, all you can do is just show up [...] as a body in health care and that's who you are. Everything else is just fluff. It doesn't really matter. So, then you enter health care as if none of the identities matter. Or if it does matter, it's born out of stigma. I'm a Black Woman, therefore this is what I can expect. There will be an assumption that I am able-bodied, and I don't feel as much pain or I'm a drug addict, so if you give me too many drugs, I'll get addicted. All these are the only ways that your identities are seen. It's always in a negative way. So, you're fighting that and also the idea that you're just a body so everything else is kind of fluff, unless it's racist, or sexist, or homophobic. Then that matters.

Nailah illustrates how power relations work through stigma and that they can overlap upon individuals by way of categories of identity, particularly when she is situated by HSPs. She enters the health system and is reduced to a body that is objectified without consideration for how stigmatized aspects of her identity negatively impact her ability to access equitable health services, unless identity is considered and then it is done so in stigmatizing ways, which creates barriers to care. To resolve the problems, she encounters when accessing health services, Nailah works through stigma according to what individuals tell her when they make assumptions about her situatedness. She has learned to read the situation to mitigate the impact of disrupting power relations by challenging those with relatively more contextual power than her who are using stigmatizing frames of reference.

A racialized 2SLGBTQ HSU negotiates power relations by putting parts of her identity that could be stigmatized on the backburner. She can backburner her sexual orientation and (dis)ability, but as a Black Woman, her race and gender are on display. This makes backburnering an important strategy in how she negotiates power relations, particularly when working through stigma with those using frames of reference that conflict with her own. As such, she mitigates the process by which complicatedness is acheived, particularly with those with relatively more contextual power who do not have the experience to appreciate how her identity is complicating.

It is harder to play along for the purpose of passing or going undetected when you are a visible minority. A person who is racialized can be closeted as a sexual minority, but the colour of their skin is on display. Participants who were visible minorities perceived that bringing invisible parts of their identity forward, such as sexual orientation and gender, may cause them to achieve complicatedness in ways that others could not understand. As such, they influenced the impact of stigma by dropping parts of their identity in an attempt to make it easier for others to understand them. One participant (2SLGBTQ HSP) explains:

> I'm a Chinese first gen Immigrant who grew up mostly in Canada. […] Patients and coworkers have preconceived notions of me. So, when I navigate the world that way, a lot of what goes on in my personal identity in terms of like sexuality and presentation, it's very backburnered. At work, I'm pretty much not out at all. […] Most folks by now have figured out I'm some sort of Queer. I come off that way. […] But beyond that, they don't

> know about any of the Trans things I have felt going on. They don't know I identify as Non-Binary. I've never spoken up about it because as someone who's already a visible minority, in the same way as like an angry Black Woman trope, it's like if I speak up, am I that one person, that's known that when somebody goes around me, they're like, 'Oh, well, you can't say any phrase in front of her because she'll tell the manager or go to HR or speak back or something like that.' […] I would never bring to the forefront that I'm Gay or Queer.

In a follow-up interview, this participant shared that they have since come out at work, but now they find themselves backburnering the education that is often needed to help others understand them. They need to pick their battles and educating others needs to be put on the backburner as they manage the reality of being out as Trans at work. Siyanda engages in backburnering when they would rather not take the risk of correcting the person who uses the wrong name and pronouns to address them; "I just don't bother fight with them because I just wanted to get my prescription and leave." Siyanda puts the affirmative aspects of the care they need on the backburner. Backburnering was thus illustrated by racialized participants as social process that highlights intersectionality.

4.2.2 Having an Impact

Having an impact is characterized by data that describe the consequences of power relations. Interacting with the knowledge and experience of others can highlight the functional purpose of stigma in reproducing power relations. Stigma can create boundaries that constrain some and in so doing, others are afforded greater freedom. Working within the boundaries of one's own knowledge and experience was a key strategy used by participants who attempted to negotiate power relations and minimize the negative impacts of stigma. This process emerged from the data as “staying in your lane”. The notion of staying in your lane emerged from the data as significant to participants who appreciated the risks involved with working through stigma. Staying in your lane meant helping others to understand you by relating to them in ways that were expected. Leo’s dream experience in health care is evidence of the value of staying in your lane when working through stigma; he stayed in his lane by fitting the mold as a Gay Man living with HIV, which made his health needs easy to understand by those providing his care. A strategy that could be employed when working through stigma, staying in your lane could work to minimize the impact of power relations. Some stayed in their lane to influence the impact that relations had on them so they could fit in, others did so to avoid having to mediate the consequences of crossing professional boundaries. One participant (2SLGBTQ HSP) recalled feeling a pressure to fulfill stereotypes to fit in with the dominant group. He made use of how the stage had been set for him by way of stereotypes in the media, specifically the sitcom *Will & Grace*, which he felt played a role in promoting the social acceptance of Gay Men. As a television show that met huge popularity in the early 2000s, he was able to use its characters as a means by which members of dominant groups could relate to him.

> [Y]ou felt that pressure to like, in order to fit into a non-Gay group, you had to help them understand you by staying in your lane. So, you were a Jack, or you were a Will. […] or you were a Beverly Leslie, or, you know, the various ones.

The impact that power relations had could thus be influenced by staying in your lane or fulfilling what the non-Gay group expected a Gay Man to “be”. This participant was able to create a lane for himself and negotiate power relations by using the representation of Gay Men in *Will & Grace* to be understood and accepted by his non-Gay peers.

Jade wishes there were tips available to help some people to understand what it means to stay in your lane. Not everyone knows the impact they have when they step out of their lane. She knows what it means to stay in her lane and is intentional in doing so, but because she is working through stigma, her behaviour can be distorted by negative stereotypes, which can cause misunderstandings and reinforce the power relations that negatively impact her as a Black Woman in contexts where Whiteness is constructed as superior. Staying in her lane does not necessarily have an impact on the members of dominant groups with which Jade is interacting. Through power relations that promote the use of stigma in ways that disadvantage her, Jade has to do more work to avoid being perceived negatively when others do not stay in their lane. She illustrates how her White colleagues may be unintentionally reproducing power relations that benefit them by negatively interpreting her actions, despite the intentional steps she takes to stay in her lane.

> [W]e stay in our lane, but a lot of people don't really understand what that means. It means when you have a meeting about equity and diversity, that you let the marginalized people get a voice because that doesn't happen. When I speak up in a sensible volume and relatively calm tone in a meeting, I'm perceived as an angry Black Woman. [...] I have to be very cautious in meetings and tone police myself, which is bullshit. But I have to do these things, or I get spoken to because I'm perceived as intimidating even when it makes sense for me to speak up.

Some participants shared experiences where power relations blurred the line between HSU and HSP lanes. Eli’s family physician assumed that they would know what their testosterone levels should be, which is beyond what an HSP should expect from an HSU. The omissions in medical and health professional education and training on gender-affirming care is a form of stigmatization that reproduces power relations in ways that an HSP who could learn about testosterone levels chooses not to and then expect the HSU to bridge a gap in knowledge without the formal education and training necessary to do so. Leo shared an opinion with a specialist once and felt slapped on the wrist when the response was "I'm the doctor, you're the patient." Eli's and Leo's experiences highlight how HSPs can pick and choose when and if HSUs should stay in their lane, which highlights the contextuality of working through stigma. Laverne (non-2SLGBTQ HSP) helps us to understand HSPs having an impact on each other. She illustrates how scope of practice can define the boundaries of HSPs' lanes and how staying within those boundaries impacts professional relations, an advantage that HSPs have that HSUs do not. She respects professional lines as a pharmacist who works with physicians in a collaborative practice setting. "I've been there long enough now that I think they trust it. And I have decent judgement and I'm not trying to be a doctor. I don't overstep the lines." Steve (2SLGBTQ HSP) on the other hand was able to straddle a line with his own family physician who was not going to prescribe him PrEP.

> I have a lot of Gay friends. And you know, I'm always, you know, get on Truvada, get on PrEP, and none of their physicians will prescribe it. My physician wasn't even going to until I told her, I was like, 'This is what I do.' You know, this is how we do it. And so, it's been kind of very simple for me, in that sense, but I thought, my god, if I was a teacher, or... what would I do? I would just have to leave the office without being on PrEP.

Steve was able to straddle the line between his scope of practice and that of his family physician's because he too is a prescriber. As prescribers, Steve and his family physician can share a lane, whereas his friends are unable to do so because they do not have the knowledge necessary to explain how Truvada is prescribed. Steve illustrates how some HSPs can have an impact by occupying different lanes because they have training and experience that allows them to do so.

Stigmatized identities cause individuals to negotiate power relations and manage situations in ways that the impact of stigma can be mitigated, but for individuals who do not experience stigma in relation to their identity, the role they take in reproducing power relations may be beyond the limitations of what they consider. They may not appreciate the significance of stigmatization or the subtle ways in which it works to reproduce power relations. The lack of learning about 2SLGBTQ populations is a means by which power relations work through stigma because it means that non-2SLGBTQ identified persons could complete a professional health program without ever having to consider the impacts of or their role in perpetuating stigma. In this manner, interpersonal interactions can initiate stigmatization from multiple levels and the initiator can have a complete lack of awareness of their role in doing so because they were not made to challenge their problematic views during their training.

Lucy (2SLGBTQ HSP) acknowledged the dual role she plays as both stigmatizer and stigmatized, which provides her with insight into the impact of power relations working through stigma to create barriers, not just to health service delivery, but also to learn about the impact she can have on others. Lucy would have us consider the role that stigma plays in an interaction and its sociohistorical impact at intrapersonal, interpersonal, and contextual levels.

> I think stigma… when we attach meaning to it, that I'm less than. I'm stuck here. I won't change. I'll be found out. I'll be, you know, all of that. If the meaning I attach to it is that somehow, I am... I just think it's useful to notice all of our thoughts. […] I think stigma

> plays a very important part. It can either shut the learning down, or it can be an opportunity, if named directly.

As such, considering the roles we play, even those that we *could* play or *should* play, the meaning we might inadvertently attach to someone else's identity, and the impact we have on ourselves, others, and within various social contexts are central to this sub concept.

Joy (non-2SLGBTQ HSP) noticed that there were no family physicians at the clinic she works in, but that there were some in the area. Being located rurally, Joy was surprised that clinicians in the area did not know each other. Relationships had yet to be established between HSPs in the area. So, she started organizing lunch and learns, where a drug company would sponsor the lunch, and Joy would invite HSPs from her clinic and the surrounding area. Joy illustrates having an impact. She fostered relationships between HSPs in her area with the intent of benefiting the patients who come to her clinic.

> I invite the drug reps and the doctors to come to us. Now, once a week we have lunch and learns. […] I've invited VON, who was never included, and the pharmacy. […] And now, if my NP that's here wants to ask a GP a question. She'll just call him and ask because we probably just ate sandwiches with them two days ago. It just changed things. And it made it better. So yeah, we're having a great time here. […] I want the continuing care girls to be here and the VON and the LPNs and the CCAs because they're the ones in the houses of people who are not getting to the doctor, but maybe they're on a two to three-year waitlist for a hip replacement. So, I bring in a drug rep with a pain med, right? […] It's very old school way. But it's so open minded. […] That way, it's never an argument. […] I love it. We havin' a ball. And I get to ask the questions to the drug reps that the local

> person is going to ask. Because I answer the phone, and I know what they wanted to know. So that's awesome.

Building partnerships at a contextual level like Joy illustrates having an impact on those who deliver and receive health service in her clinic. Whether they are the HSPs who work in the clinic or the surrounding area, or the HSUs who access care, individuals can have an impact and influence power relations working through stigma.

4.2.3 Layering Pasts, Presents, and Futures

This sub concept means that pasts, presents, and futures are layered in and across contexts, and reminds us that the consequences of historical events are collectively and individually experienced over time. Layering pasts, presents, and futures can be appreciating the impact of power relations on social interactions and demonstrating an awareness for historical injustices by anticipating social inequalities in the present to enhance future outcomes. Power relations between groups and individuals create discrepancies in opportunities by way of socially constructed differences that accumulate across time. As such, discrepancies that individuals may attempt to resolve can accumulate over lifetimes; structural stigma promotes accumulation of advantages and disadvantages across time for individuals and the groups with which they belong. Stigmatizing constructs of the past may thus be anticipated in the present to inform future change. If power relations working through stigma are disrupted, challenged, and transformed, stigma-related barriers to care are diminished, and less work needs to be done to access resources, including health services. Individuals, whether they are HSUs or HSPs, need to be supported as they work under structurally stigmatizing conditions so that their anticipation of stigma's negative impacts is enough to disrupt the reproduction of power relations that create barriers to care. If a lack of resources makes stigma-related barriers to care at the interpersonal level insurmountable, then contextual level intervention may be required. Through the layering of pasts, presents, and futures, intervening upon stigma can be appreciated in terms of the historical contexts that inform the present and bring about equitable change in the future.

Stigma emerged from the data as something that connected individuals across time and was not always negative on impact. Individuals' identities could represent multiple stigmas, which overlapped, and created layers that can be worked through so that power relations could be challenged, disrupted, and transformed. As such, layering pasts, presents, and futures provides scale to the extent of work that is done to mediate the impacts of reproducing hegemonic power relations under structurally stigmatizing conditions. A 2SLGBTQ HSP participant recognizes barriers as someone who experiences them in relation to his identity to understand the way that stigma can negatively impact individuals and populations by way of layering pasts, presents, and futures. As an HSP, he has an appreciation for how professional health education is a means by which stigma can be enacted when it reproduces biases about historically underserved populations and fails to cause those who do not experience stigma in relation to their identity to question the problematic histories that they will inadvertently perpetuate in their future practice. Professional education is thus a means by which hegemonic power relations can be reproduced in the present and persist in the future by way of health disparities. This participant feels the health system presents an opportunity to disrupt historical power relations, provide equitable care in the present that avoids re-enacting those stigmas, promote healing among populations historically underserved in the health system, and set the stage for futures where outcomes are positively impacted.

> Indigenous people and health care. It's a bond that's been broken because of assimilation and colonization in Indian residential schools. […] I think when we start treating people

> like they are humans and not less, I think that healing can start. That relationship can start healing. One negative experience for someone who is Indigenous, someone who is Black, someone who is Queer, or someone who is living with a (dis)ability. One negative experience, you close that door for care. You close that door for any opportunity for primary prevention, secondary, or tertiary care. For good. And you don't realize how many invisible barriers that they had to go through to actually get to you. You don't think that they've exhausted all their options before they got here? Do you think this is their first thought, 'I'm going to go to ER'? […] [So, there's always a risk that] you close that door for good. […] And if they do come back, they're going to have this in mind that you know what, the last time I was here, this is what I experienced. So, I don't feel welcome here. I don't feel comforted here.

Considering what past steps an individual has previously taken, prior to accessing the health system in the present can change the course of individuals' lives and through resolving histories, change is thus possible.

> And if this is something that we change, and this is something that is a right for individuals to preserve those things I just talked about [love, dignity, respect, and compassion], […] that's not going to happen anymore. You're not going to have a million thoughts in your head […] I'm going to take Tylenol and take ibuprofen; I'm going to try these two-year-old antibiotics and try this and that [without the support of an HSP]. Rather than, no, I'm going to go where I know I will feel comforted and welcome. And that's how it should be. It shouldn't be like you go through these million things before you get to the door. Because by the time you get to that door, you could be septic. By the time you get to the door, your cancer could have metastasized.

This participant illustrates the layering of time, across individual and shared histories, and how stigma connects us all. Resolving histories is a concept that accounts for our collective histories whereby a doorway to connectivity exists. The trauma experienced by some and caused by others provides opportunities to build relationships in the present that mend broken bonds of historical significance, through such initiatives as Canada’s Truth and Reconciliation recommendations, whereby our shared humanity can be leveraged through resolving histories for the purpose of healing.

Rebekah (2SLGBTQ HSU) recognizes that there are implications to carrying around baggage that accumulates from the “histories you have with people”. Rebekah illustrates the layering of stigma in the present that impact individual across their lifetimes. Rebekah bore witness to negative interactions accumulating over time for her child as it became harder and harder for them to work through stigma.

> And it really started to come to light when this child would go into the female washrooms, which is where they'd always gone. We didn't question things; it wasn't a problem before. Suddenly they were starting to get very odd looks in public. So, going into a public washroom, a Woman would scamper out with their toddler. And this is a tiny kid who's five-one so this is not an assuming dangerous looking person at all. And then again, in the classroom, hallways, or in the washrooms at school, people starting to make comments or whispering or looking. And so, it was other people questioning and making assumptions that made my child very uncomfortable and starting to become very paranoid and spin [...] [T]he concept of femininity didn't mean anything to this child until high school. And puberty, of course, was a huge traumatizing thing, which was what the first alarm bells were.

Participants, particularly those from the 2SLGBTQ subgroups required time to sort out their own identities and accept themselves for who they are, not what society had them believing they were. Kourtney described multiple layers of stigma to work through every day, which makes the simple act of leaving the house, something that many take for granted, a barrier that she needs to overcome.

> [W]orking through stigma is like… being Trans, it's working through the daily struggles of everyday life, but you have to do it every single day, because you're working through things deeper inside yourself, and to push yourself to go out in public, and to do all of these things, like just to even get to the appointment, but to be yourself and go to the appointment. That's a whole other thing, you just have to work to get outside of your house. So those are just more added things that are hard for Trans and Queer people to do and access health care.

Kourtney illustrates how the stigma she internalizes is yet another layer that needs to be worked through in an ongoing manner and how this influences access to care in the present, thus impacting future health outcomes.

A participant from the 2SLGBTQ HSP subgroup describes how his views on identifying as a member of the 2SLGBTQ communities has shifted over his lifetime, but that the racialized aspect of his identity creates another layer that he is still working through.

> In terms of being Gay or Queer […] I've noticed a difference across my life span of me being more comfortable and accepting of that identity. I don't think it was something I was very comfortable with when I was younger, going through grade school, for instance, and even in university and things like that, but now, and maybe it's just me becoming

> more mature and more secure, I feel a lot more able to be out and uncomfortable. […] I find being mixed race, which is... I'm not really sure... I haven't really found a good way to describe that, that makes me feel comfortable. But I do find, it's definitely an othering sort of experience and not really feeling like you necessarily fit culturally in either group. And that's something that I think I still struggle with a little bit more than being Gay. Potentially. It's like an ongoing point of growth. […] I haven't really seen a ton of attention paid to mixed race stuff, lots of Asian stereotypes or what have you. But it is like a particular experience. Kind of in between.

This ongoing point of growth is happening across time and illustrates the layering of pasts, presents, and futures, which cause him to feel out of place with regards to his racial identity, but more comfortable with regards to his sexual identity.

A non-2SLGBTQ HSP participant notes a form of compulsory Heterosexuality that is intergenerational for Women, and particularly persistent for those from rural settings in Nova Scotia. She has seen how having a male partner is ingrained for these Women; "everyone in her small community does that and her mom did, and her grandmother did it". The layering of pasts, presents, and futures impacts individuals' abilities to question what is constructed as normal, which is illustrated by power relations being reproduced in ways that the only sexual orientation available to these Women was Heterosexuality. Kourtney (2SLGBTQ HSU) lives in rural Nova Scotia and describes the process by which she became aware of how society would perceive her, the judgements that would be made, and transphobia she would experience. As a Trans Woman, Kourtney caused individuals to question cisnormativity in rural Nova Scotia. To avoid this, she used to hide.

> I hid away for the longest time. And then when I started to actually make friends that were okay with it, I would start to go out in public. But you know, friends never last forever when you're young. So, then I would stop having friends or I'd move away and then it would just start… and I'd hide again.

As time moved on, Kourtney stopped hiding because people stopped caring so much.

4.3 Surviving the Situation

Surviving the situation means doing what is necessary to get through a given set of circumstances. When one has coped with a situation to get through, they have survived the situation. Survival may be harder for those whose survival instinct is triggered relatively more often than others'. Surviving the situation is comprised of two sub concepts: "reading is fundamental" and "engaging that survival apparatus". The former represents assessing situations to identify threats to survival and the latter includes the ways in which individuals mitigate perceived threats. In a basic sense, surviving the situation is referring to what individuals do to survive the situations they find themselves in, which can be encountering the health system for whatever reason care is being accessed as well as their subject position/situatedness. Surviving the situation thus means getting through moments in time as well as entire lifetimes.

Stanley provides a layered illustration of surviving the situation when he recalls helping a patient who was distressed over blood pressure monitoring. Stanley illustrates how being Trans (situatedness) can carry an increased risk of triggering an individual's survival apparatus in situations where health services are being delivered. Stanley asked what the HSU's name was and how they identified because he believed they were Trans.

> They became defensive. They were like, ‘Whoa, I'm transitioning.’ And I said, ‘Okay.’ When I was asking a couple more questions, they became really defensive because they were afraid. And so, I said, ‘Actually, I identify as Trans and I physically transitioned, and I remember it being a really challenging process. And it was scary at times, because I was afraid if I had any health concerns that they would take me off my meds. Is this something that you're feeling right now?’

Stanley read the situation and responded in a way that intended to diminish the negative impacts of power relations working through stigma that Trans people experience in health care. Stanley demonstrates his intent to make this situation easier for the HSP to get through by reading defensiveness as fear of what would happen if their medications, which are considered lifesaving for Trans populations, had to be adjusted or worse, discontinued. Stanley recognized the HSU’s perceived threat and provided reassurance by explaining that “it's not best practice to take Trans people off their medications altogether. It’s about mitigating risk. […] Because your medications are your lifeline. And the last thing you want to do is not transition.” This allowed Stanley to demonstrate his understanding of the situation and that fear creates barriers to being “100% honest with your healthcare provider”, which may have unforeseen negative consequences for HSUs that may inadvertently put their health at risk. He knows this because he experienced a similar situation.

> You feel threatened. And I've been there […] I've been dishonest about things with my medication because I was afraid […]. I remember once I got jaundice. […] And I was terrified. And my friend at the time was like, you need to go in and let your healthcare provider know that your liver is being affected right now. And I was like, ‘No, I don't

> want them changing my dose. I don't want them reducing my dose. I don't want them changing it. Because right now I feel okay.’

Stanley thus illustrates what working through stigma means for individuals who are negatively impacted by power relations within the context of surviving the situation. We can understand defensive behaviour as a survival strategy that is adaptive within the context of that individual’s lived context. Stanley can relate to this HSU in a way that they can work to influence power relations working through stigma *together*. They are connected by the work they are doing through stigma. Without stigma to connect them, collaborating as such would be more difficult. Surviving the situation can thus be made more difficult or less so, depending on the context of the interactions and the accumulating impacts of stigma through which connections can form.

4.3.1 Reading is Fundamental

This sub concept is both figurative and literal. Participants from the HSP subgroups recognized the importance of seeking out information on 2SLGBTQ populations. Some felt that it was a professional responsibility to read up on the gaps in their training, seek out resources, continuing medical education opportunities post-licensure, and consult with subject matter experts who were well-read on 2SLGBTQ health needs. Participants felt self-education and quite literally reading-up on the issues experienced by populations who have been historically underserved in health care was necessary. Read more to know more, increase awareness surrounding the social causes of illness, gain insight into how individuals can influence power relations working through stigma in practice settings, and make survival easier for those who have fewer “good” options to choose from.

Figuratively, reading is a skillset used to situate individuals and assess situations and surroundings. Reading goes beyond the reductive process of categorizing individuals and explores situatedness and surroundings to identify threats before they trigger one's survival instinct. Reading individuals' situatedness can be done in relation to their surroundings, to identify potential risks, and employ coping strategies that will improve chances of survival. The ability to read one's surroundings depends upon situatedness, particularly when your reality is constructed in such a way that knowledge that would help you to find your place in the world is difficult to access. One 2SLGBTQ HSU participant who identifies as a Gay Man could not make sense out of society's expectations of him as a teenager and he knew he did not see "things as the other guys do". Marrying a Woman did not make the world make more sense. Eventually he was no longer able to explain away his interest in Men and accepted being Gay.

Reading is a term that is being adopted from ballroom culture because it helps to describe the process by which participants identified flaws that impact some groups and individuals more than others. Dating back as far as 1869, balls were part of the underground Queer scene in New York City (Haider, 2018). Black members of the 2SLGBTQ communities (the majority of whom were assigned male at birth) engaged in performative expressions of gender through what is now commonly referred to as drag. Reading was first conceptualized within the context of ballroom culture as an artform of insult whereby a flaw was found and then exaggerated (Livingston, 1991). As an artform, reading was refined by way of its use in Queer spaces, such as ballroom competitions, but as a survival strategy, it could be employed to assess situations for potential threats. When "you've found a flaw and exaggerated it, then you've got a good read going" (Dorian Corey in Livingston, 1991). Ballroom culture is relevant to this study because it originates in Black Queer communities and served as an opportunity to transcend the limitations placed upon their everyday realities as poor Queer Black people who were intersectionally marginalized by American society and culture (Livingston, 1991). Balls were comprised of performances that aimed to convince the audience that if it were not for the racism, homophobia, Trans invisibility, and other structural marginalizations that constitute America's White supremacy, you would be a powerful executive, a socialite, member of a country club, or a supermodel working in Paris (Livingston, 1991).

A read begins with finding a flaw. Within the context of this study, participants found flaws at intrapersonal levels in themselves, interpersonal levels in others, and contextual levels including institutions, and society. Through resolving histories and the layering of pasts, presents, and futures, flaws can become exaggerated for some while others may have little awareness that such problems exist. Participants identified flaws at the individual level and then exaggerated them to gain insight into how power works through stigma. In addition to their impact on how individuals are brought up, the home of their family of origin was often cited as the context in which many sexual and gender minorities first perceived threats for being viewed as flawed by others. For many, conditional acceptance from one's own family was a situation they needed to survive because it was where they came to believe they were flawed. Taylor (2SLGBTQ HSU) illustrates how they constructed themselves as flawed within what they describe as a "strict family mold". Instead of coming out, Taylor remains closeted to their family to this day.

> When I was in school, I knew I wasn't Straight, but I thought that there was something wrong with me. And then it had to be a secret that was kept. And so, I wouldn't describe myself as being out to my family now, but they know that I am an ally and part of the community. I came from a very… not even religious, but just like, Straight is the only

> way. […] I knew that there were other Queer kids at school. And I sort of knew them a little bit. But I was afraid to interact with them. I was afraid what my family would think.

Sam (2SLGBTQ HSU) continues to struggle with the internalization of stigma she experiences as guilt from feeling like she is a disappointment to her parents, who practice a religion that constructs sexual and gender minorities as flawed.

> I was always different from them. I am a Lesbian. […] [A]t least they're a lot better with me now than they were. [...] You always feel that [...], it's like a disappointed feeling from my parents. […] The relationship is so strained and like, if I see my parents… this is awful, but I feel… sick to my stomach because I'm waiting for them to say something awful to me.

Sam illustrates what Taylor feared would happen if they came out to their family – that they would be treated differently due to heteronormative views that construct sexual and gender minorities as flawed. Constructing minorities as flawed fails to exaggerate the flaw. In this sense, we can see how hegemonic power relations work and are reproduced through stigma to construct non-dominant groups as flawed. This illustrates how structural stigma fuctions in such a way that individuals who are constructed as flawed may be able to do little to minimize their threat of being stigmatized and so they internalize the flaw, keep it undisclosed like Taylor or have to go through the arduous process of working through internalized stigma as well as that which continues to be enacted upon you. In Sam's situation, she wants her parents' support and love, but she has learned to accept that they will not choose their child over a god. "When you grow up into something… they really make you think so many things are wrong. And you have to deal with that slowly. Like, I'm not a bad person. I'm a good person." She has an "internal guilt" that she is “always affected by” and “still dealing with” because her family and the community she grew up in automatically labels her as a bad person simply because she is a Woman who loves Women.

Keeping parts of oneself that are constructed as flawed concealed is a survival strategy used by many sexual and gender minorities. Reading skills can be used to assess for risks of being constructed as flawed. Emmanuelle (2SLGBTQ HSU) illustrates how she reads people to assess whether someone poses a threat to her being constructed as flawed because of her sexual orientation. She explains how she does this by disclosing facts about herself in such a way that allows her to read others’ reactions.

> I can usually tell when […] I'm having a conversation with them. I don't miss it. Sometimes I'll drop the fact that I have female partners. That's a way I'll do that… just to see if they flinch or if I get a raised eyebrow, just to see if I get anything like that. […] [I]f I'm getting a weird vibration from somebody, I'll do that. […] And also, sometimes in the language that they use and how they refer to people and the tone that they use. […] So, I sort of feel out how people express things and how they talk about things and then I can get a feeling of like, okay, this person would be safe.

Emmanuelle reads others’ non-verbal language after she discloses something about herself that is constructed as flawed within society, such as same sex partnering. She also reads verbal cues to figure out whether they are a potential safety risk. When individuals are constructed as flawed, they learn to know what to look for in others whose views could construct them as such. This interpersonal level threat to being constructed as flawed is another way that power relations work through (and can be influenced by intervening upon) stigma. Depending on how the situation is being read by the individuals involved, power relations can be reproduced, disrupted, or even transformed thus mediating negative impacts of stigma. Stigma at the interpersonal level can be read and expanded upon by way of exaggeration to appreciate the influence of the broader context. Sam's parents' views on sexual minorities serves to illustrate this point. They reproduce power relations that negatively impact their daughter at the interpersonal level, but this is made possible by way of power relations being reproduced by them at the intrapersonal level through their religious beliefs. Sam's parents have internalized stigma by way of their religion and externalize it by way of stigmatizing their daughter. Reading flaws as such allows for an exploration of the ways that power relations work through stigma and can be carried out at multiple levels by way of institutions, such as the church. Sam recognizes that it is in fact her parents' and their religion's views that are flawed, but the harmful things they have said in the past is something that she continues to work through.

Eli has been negatively impacted by power relations working through stigma in healthcare settings by individuals involved in delivering their health services. Eli is often questioned about what is perceived as a flaw: the discrepancy between their gender presentation and their legally documented gender marker.

> [S]ince I came out as Trans and Non-Binary, there's always a lot of question like, 'Okay, so your ID says, you're female, but you don't present as female.' Like, what does that mean? You don't know how to mark me down? Like, I don't care. I'm a person. Knowing that I have the anatomy that I have. Not that… I guess in this weird range of gender, it's like, I don't functionally care. I'm not going to be offended if you call me, she. Don't do it consistently, but if you call me, she, like, whatever, it happens.

Eli finds that others make a big deal about what they perceive as an error, which is not untrue, but the error is not the discrepancy in an individual's medical record. The flaw can be situated within a broader context whereby the gender binary can be called into question. No wonder Joy refuses to ask people about their gender and feels that it is wrong to ask an HSU about their gender during intake adjacent to a waiting room that compromises confidentiality. Her decision to refuse asking questions is due to her belief that some things should be asked by the provider, "who they're supposed to trust with that information". What might seem like a small thing to others is not to Joy because she appreciates that there are implications that carry a disproportionately negative impact for some HSUs. She found a flaw and exaggerated it. To protect the relationship between the HSU and HSP, Joy uses her judgement in what questions she asks and does not do so simply because the drop-down choices exist.

When stigma is being worked through, power relations are at play. When a discrepancy such as that which Eli describes is found, the flaw can be exaggerated so it can be identified in the system, not the individual. Through reading, flaws can be exaggerated as such so that power relations working through stigma can be recognized, challenged, and disrupted with transformation in mind. Eli's gender presentation in relation to their legal gender marker reveals the flawed nature of gender norms and how they are taken up into the health system in ways that perpetuate the underservicing of stigmatized populations. Eli's identity is constituted by multiple stigmas, including the stigmatization of Blackness admist White supremacy. Power relations work through each stigma differently.

When you cannot hide your difference, the risks of stigmatization are omnipresent. Nailah has to read individuals and situations to mediate the negative impacts of power relations working through stigma. "[B]eing a Black Woman, I can't really escape the stigma. I am [stigmatized], no matter what. There's lots of assumptions. Even from different cultural points of view because Blackness is across all cultures." Systemic flaws are thus exaggerated for some, often through relations with those who are unaware of their role in perpetuating and benefiting from constructing others as flawed.

> Even my family doctor tells me he's racist because of the way that he's interacted with me. […] I could tell that his assumptions on the cultural level impact the way he views me as a person, and that's going to impact a lot of care he gives me and it's not something he's ever like explicitly said, but it's heard, it's felt. So, I can't downplay it, no matter what. I can't just be invisible. And I'm like, a visibly marginalized person. It's just not going to happen. I'm always going to be stigmatized. As soon as people see me. Whatever assumption, even if they fight it, even if they counter it, it's always there. That knee jerk, subconscious reaction to Black people, particularly for a Black Woman… comes out right away.

Nailah makes broader connections because she is unable to downplay the problematic assumptions that are made about her. As such, she finds the flaw and exaggerates it. She makes connections between her racist physician, what society has taught him to think about her, and describes the interplay of power relations working through stigma, converging, and overlapping in ways that create barriers to accessing primary care.

> [Blackness] trumps other identities because they're going to always just come from that. Even if I tell them that I have these other identities, they're not going to really care. It's always going to be – you're a Black Woman. So, this is the type of care you're supposed to get because of the assumptions or the way that society has taught this doctor, this person to interact with me or even what they've accumulated through their own thinking, knowledge, and culture about me.

Participants identified many flaws in the health system. Within the context of this study, a read like Nailah's, where a flaw was found, often identified at the individual level, was then expanded upon by way of exaggeration to appreciate the influence of broader social factors.

Power relations that disproportionately burden some to the advantage of others expose flawed social arrangements. Participants talked about barriers created by gatekeeping that carried a disproportionate burden for populations who were already being underserved in health care, and the loss of trust they experienced when they stepped into the HSU role from that of an HSP. Jade is treated with mistrust as a patient, which contrasts with how she experiences the same context as an HSP. She explains that when she comes into her place of work without her employee identification or scrubs and is within the role of HSU, she explains that she is "not believed in the same way when it comes to issues relating to my health. […] I'm not believed about pain. In terms of blood pressure issues, I will run a higher blood pressure than what is tolerated in another person." She explains that this is because we "have a medical system that has historically been anti-Black" and that in many ways "has been created on the backs of slaves". She attributes this to racist notions such that Black people do not feel pain in the same way as White people and cites the medical advancements that were possible because of unethical experimentation carried out upon Black populations, such as the Caesarian section. Jade feels there is a lack of understanding of the intergenerational trauma that these histories cause. "And what that means is when I walk into a healthcare institution, and I'm not wearing my badge that gives me this little bit of power. […] I am treated very differently. And that's in the building I work in, where people recognize my face." Jade experiences a flawed health system differently as an HSU than as an HSP and attributes this to an unconscious bias against Black people within the health system which means she is not trusted by other HSPs when she is within the HSU role as compared to when she is within her professional role. This mistrust is reciprocated and represents a flaw in the health system that carries a disproportionate burden for Black people. As a Black Queer person, Jade bears a larger burden as a result of how power relations work through multiple stigmas within a system that is flawed in terms of how it serves 2SLGBTQ and Black populations.

Stanley regards Nova Scotia Medical Services Insurance (MSI) as flawed in terms of how it makes gender-affirming services available to Trans and gender diverse populations. This has far-reaching impacts. He explains how MSI creates barriers, not just for HSUs, but HSPs too.

> It makes it really hard to access things, even for physicians to navigate the system for patients. When it comes to billing and various tests in general, they have to jump a lot of hoops and call a lot of people just to get care for this one person. And it deters a lot of providers who didn't want to take on these patients because it's just so much harder for them. It's so much more work for them, and they're afraid of not getting paid. And they don't understand enough about it.

MSI's policies and rigid interpretations of WPATH Standards of Care (World Professional Association for Transgender Health, 2011), were identified as flaws in the system by several participants who provide care to Trans and gender diverse populations. Obviously, this carries a disproportionate burden for Trans and gender diverse patients, but as Stanley poignantly states, it places HSPs who provide care to these populations at a disadvantage as well. This illustrates how power relations work through stigma in the health system, which not only negatively impacts those who are stigmatized, but has a negative impact on their associates. A family physician participant (2SLGBTQ HSP) described the approval forms for gender-affirming health services as flawed and the amounts of paperwork as obscene. Another family physician (non-2SLGBTQ

HSP) sees the necessity to send her patients to a specialist to fulfill one of the requirements to gain MSI approval on gender-affirming surgeries as evidence of a flawed system and highlights power relations working through stigma in health care that inadvertently prioritizes specialists' opinions over those of general practitioners who are positioned to build trust with HSUs over time within primary care settings. She explains the difference in risks for top versus bottom surgeries and that it is an insult to have to send a patient that needs top surgery to a specialist who does not even know them, just to sign-off on a low-risk surgical procedure. "We know the increase in mental health and suicidality when people have decided that they want to access this treatment and then they have to, I mean waitlists right now are 9-12 months and I'm like…god… that harm that's being caused." She further exaggerates the flaw and gets a good read going by explaining that these policies create longer wait times for people who "actually need to see the endocrinologist" illustrating that in some ways, everyone is being negatively impacted by power relations working through stigma in health care, but that Trans and gender diverse HSUs are disproportionately negatively impacted.

4.3.2 Engaging That Survival Apparatus

Engaging that survival apparatus means triggering the survival instinct. Avoidance, shutting down, protecting self and others, and defensiveness are all cues that one's survival instinct has been triggered and their survival apparatus engaged. "That survival apparatus" references a Maya Angelou poem, *We Wear the Mask* (*Maya Angelou Live and Unplugged*, 1987), which I discovered after a follow-up interview with one of the participants. I had finished conducting initial interviews and was struggling with the emergence of what eventually became the concept of surviving the situation and its sub concepts. When I described the properties and characteristics of the concept in this follow-up interview, the participant remarked that it sounded like some sort of survival apparatus at work. “Survival apparatus” is language used by Angelou in a recording, prior to her reading *We Wear the Mask.* In the introduction, she explains how what is often perceived as laughing by people who do not know about Black features is a survival tool. She explains that the poem she is about to read is about a Black Woman who lives in New York City. She watched the Woman for nine months on the bus. The Woman would extend her mouth and make a sound that many would read as laughing, but Angelou recognized it as “that survival apparatus” (*Maya Angelou Live and Unplugged*, 1987). She describes it as a mask that has a purpose which, to me, feels relatable to the function of the closet for Queer people. That survival apparatus is a tool that is used to survive the situation. The data show HSPs feeling a need to think about what they can do to make it easier for people to navigate the delivery of health services because structural stigma places everyone at risk for being negatively impacted by power relations working through stigma in health care. This is explained by the idea of a survival apparatus that was at risk for becoming engaged when health services were accessed by stigmatized populations, and not just 2SLGBTQ populations.

Participants all appreciated the impact that access to health services had on health outcomes. Data illustrated how barriers to care that were created by power relations working through stigma negatively impact the survival of HSUs due to adverse health outcomes. Reading situations for risk of harm was a strategy used to diminish the extent that one’s survival apparatus was engaged, but the ways in which power relations work through stigma is contextual and relational. Laverne explains that power relations working through stigma can negatively impact medication adherence.

> [S]tigma would come up because a lot of the medications themselves represent this disease [HIV] and was like a daily reminder of this just horrible condition that they have

> that has brought so much stigma on them and they live in... is somebody going to see the pill bottles, you know, whenever I travel somewhere, am I going to be allowed in this country or that country?

Laverne believes stigma plays a role in medication adherence because people become tired of negotiating power relations working through stigma, particularly when their survival instinct is routinely triggered. “It doesn't matter what you do, where you go, it's just this constant hiding.” She explains that for some, it might mean losing their job if their medication shows up on an insurance claim and they work for a small company. For a condition like HIV, medication adherence is necessary for survival. Laverne has seen many HSUs become avoidant with regards to their treatment to protect themselves despite the negative long-term implications of doing so because it diminishes the extent to which their survival apparatus is engaged in the short term. It helps them to cope with a situation to get through it, but getting through moments in time as such can negatively impact the length of their lifetime.

Nailah explains how her survival apparatus was engaged by her family physician and that she avoids him altogether to protect herself.

> I had a really bad experience with my family doctor. After that, I was like, I can't. I'll just access my health care through mental health. […] I don't look forward to going to a doctor to be invalidated. Because a lot of things are invalidated, especially being a Woman either invalidated just because of gender as well. And then on top of the Black Woman, that's a double-edged sword... and then if I would bring out even another identity, then forget it. Like, it's almost like that's way too much to even bring up. [...] Yeah, it's just too much risk and I hate being gaslighted. […] I also don't like the fact that I'll have to teach a doctor about whatever it is.

Interestingly, Nailah experiences accessing health services through the mental health system as less stigmatizing than primary care because of how hegemonic power relations have been reproduced through stigma by her family physician in the past. Her experience is as such that her survival instinct is not triggered by the mental health system like it was in primary care.

Artie discusses how some may look for alternate routes to avoid engaging that survival apparatus. Taking indirect routes are something that many underserved populations are used to because the direct route may have so many barriers that it is simply easier to go around.

> [T]rying to find ways around instead of the most direct route is something I feel a lot of Queer folks go through that the same way as anybody who might be neurodivergent, gender diverse, culturally different as well, because it's just… there's so many things to do [to take] the direct route that it’s exhausting versus going around. And sometimes when you go around, it's a lot more dangerous. And in the long run, it's a lot more effort.

Artie illustrates that the extra steps taken by individuals who are attempting to avoid harm in the present can have adverse consequences in the future. Those who struggle to survive in the everyday are not necessarily looking into the future due to perceived immediate threats. An example that Artie uses to illustrate their point is that someone who is newly transitioning might need to go to the store to get food, but if they have experienced harassment when taking that route in the past, then they might choose to take a different route. Even if the store that sells food is directly across the street, if there is a perceived threat, they might choose to order their food online, which takes much longer, but they have avoided engaging that survival apparatus.

Steve (2SLGBTQ HSP) protects himself from having his survival apparatus engaged, but not by taking alternate routes. Rather, he creates barriers within himself to protect himself because he has concerns that he will burn-out as a 2SLGBTQ HSP negotiating the power relations working through stigma within primary care. “[Y]ou have to compartmentalize. If not, you take it home with you […]. If you want to last a long time in this profession, you’ve got to protect yourself.” For Steve, the issues that his 2SLGBTQ patients face are close to home and can trigger his survival apparatus. As such, power relations working through stigma have a disproportionately negative impact on 2SLGBTQ HSPs; the stigma they experience as sexual and/or gender minorities in their personal lives is compounded when they encounter those issues in their clinical practice. Other 2SLGBTQ HSPs recognized that many of their non-2SLGBTQ colleagues develop a fear of unintentionally hurting HSUs, which can cause them to protect themselves by avoiding training (such as learning how to initiate and/or maintain gender affirming hormone therapy) that would better prepare them to deliver equitable care to stigmatized groups that are historically underserved in health care.

Other participants described feeling protective of others, which is exemplified by Noelle (non-2SLGBTQ HSU) when she talks about her son, who is Gay.

> I would never change who he is. He's the most wonderful, caring, spirited, kind person in the world. I would never change that he's Gay. I would change the world, so that I don't have to be fearful that anybody would treat him badly because of it.

Noelle remembers when her son was a baby, holding him in her arms as she watched an interview with Matthew Sheppard’s mother after the brutal beating that resulted in her son’s death. Noelle recalls thinking to herself at the time, “[I]f anyone ever hurt my child, because of who they are…” She was never one of those parents who needed to reconcile the fact that their child was Gay. Her concerns were always about how to “navigate the fear of what could happen to my child based on ignorant, bigoted people.” She was afraid of how her son would be negatively impacted, who came out around the same time as Scott Jones was attacked in New

Glasgow, Nova Scotia, and left paralyzed from being stabbed in the back by an ignorant, bigoted person. It is terrifying for her that these things still happen.

Noelle's insight into power relations working through stigma in healthcare extends beyond her own nursing practice. She went to an appointment with her son when he first came out. She recalls a situation where her son was seeking health care from their former family physician. Until this experience Noelle had always thought the family physician was "quite lovely", he delivered both of her children, and she trusted him because she thought he was a good person, despite being "very overtly Catholic". When the subject of her son's sexual orientation came up (after her son had left the room), the family physician made a remark that she should not be concerned because "kids experiment with a lot of things". It struck Noelle because she had not expressed any concern.

> Implying that he was changing his hair color or something. […] [F]or him to try to make me feel like there was something wrong with my child. And he was supposed to be his provider. He was supposed to be his advocate. […] [T]hat really tainted him in my eyes. And I never did say anything to my son about that comment because I wanted him to feel like he could reach out to the physician if he needed to, but that was the end of my feeling good about that relationship with him.

Noelle read her family physician as a threat to her son's wellbeing, which engaged her survival apparatus because she felt a suggestion that there was something wrong with being Gay. This perceived threat caused Noelle to feel protective towards her son.

Defensiveness was a way that participants adapted to anticipating stigmatization and served as evidence that one's survival apparatus has been engaged. "I always come at it with a defensive feeling," says Phoenix. "What assumptions are going to come out of this and what am

I going to have to fight back on or point out in a nice way?" Sorrel explains that you can get used to anything if you practice it enough and the defensiveness subsides as a result of that survival apparatus being engaged enough to be conditioned to the threat. Sorrel says that at the very least, you get used to what to expect.

Participants shared how they have got used to having their survival apparatus engaged. Kourtney did not come out as Trans until she had left school, so she avoided the bullying that many adolescents who identify as Trans experience from their peers. She did however have to assume a defensive stance when "dealing with people in public". Despite never really caring what people thought, "it's still uncomfortable to have people staring at you and wondering and looking instead of just asking you." She lives in rural Nova Scotia, so recognizes that she is disrupting a norm that many around her have never questioned.

> That's why they stare. I know that they don't realize they're not controlling it. They actually physically keep looking at me until they can't anymore. [...] Always makes me feel uncomfortable. Sometimes you never want to go outside. But you just do it anyway. You get used to it.

Knowing how to make someone comfortable was recognized by all participants as important when delivering health services, particularly in primary care settings when working with HSUs who may feel threatened and become defensive as a result. Knowing when to make someone comfortable was a skill that one 2SLGBTQ HSP discussed:

> I think the art of medicine is knowing when it's a time to make someone comfortable and not make this an unpleasant experience. To show them that you're in their camp, and that your objective is their health.

Letting someone know that you are in their camp is a way to engage HSUs in ways that minimizes the risk of engaging their survival apparatus, so they do not feel threatened and in need of defending themselves.

Siyanda does not trust people who dead name them, a sure-fire way to engage the survival apparatus of individuals who are Trans and gender diverse. Artie provides an example of how HSUs become defensive when their survival apparatus was engaged. An HSU came into their workplace with surgical complications, provided their pronouns, and then "launched into an explanation" about the discrepancy between their preferred name and what was on their medical record. This prompted their support person to come forward with "all the legal documentation" to reconcile the discrepancy and avoid the issues that this may have caused in the past. Artie explained that it was fine, they understood (and as a gender minority they brought an appreciation that others in the past may not have had), but that they regretfully had to put their dead name on the paperwork for processing.

> [T]hey didn't have to go through any explanation with me. I would have just accepted it. But because of what they've had to go through… the hurdles they've had to get through to get where they are now. It's just like, the initial reaction to be like, I'm sorry that I'm a problem. But here's all my documentation. It's just like… ahhhh, it kills me. And like, there was a relief that you could see and feel after I was like, 'I need your dead name'. Because usually folks don't use that term unless you're also Queer or Trans. So, by just throwing that terminology out there, they knew that they could say whatever, to me. Anyways, that kind of killed me. […] [P]eople probably just grit their teeth through it. Because it's so difficult to access healthcare. And even if you do access health care, like by the end of it, you're probably like, well, I'm never going to go back there again. Yeah,

> so it's super shitty, which is why we have a high population of Queer folk, right, who health-wise, are not doing great because they either don't want to, or they can't access health care.

Like other 2SLGBTQ participants, Artie illustrates an understanding of why HSUs delay accessing health care in the future and the importance of showing them that you know what kind of support to work through the stigma that lies between them and the care they need. As a defense mechanism, HSUs delaying access to health services serves as a way to survive, even though it can have deleterious impacts on their health.

4.4 Summary

When working through stigma, everything depends upon the situatedness of individuals and the relationships they have with(in) society. Identity is a means by which power relations can work through stigma, but through resolving histories, individuals can work through stigma in ways that appreciate the ongoing and accumulating processes by which interactions between individuals in various contexts take place. As such, working through stigma is an opportunity for change to come about in primary care, and a means by which the relationship between stigmatized populations and the health system can be healed. Figure 10 is a representation of the substantive theory on working through stigma, grounded in the data collected in this study (see Appendix G for a larger version without shading). It shows the three concepts feeding into and mutually constituting each other and represents a theoretical understanding of the ongoing social processes that reproduce hegemonic power relations, which can be challenged, disrupted, and transformed by intervening upon stigma within the context of primary care in Nova Scotia in ways that change the conditions under which health services are delivered.

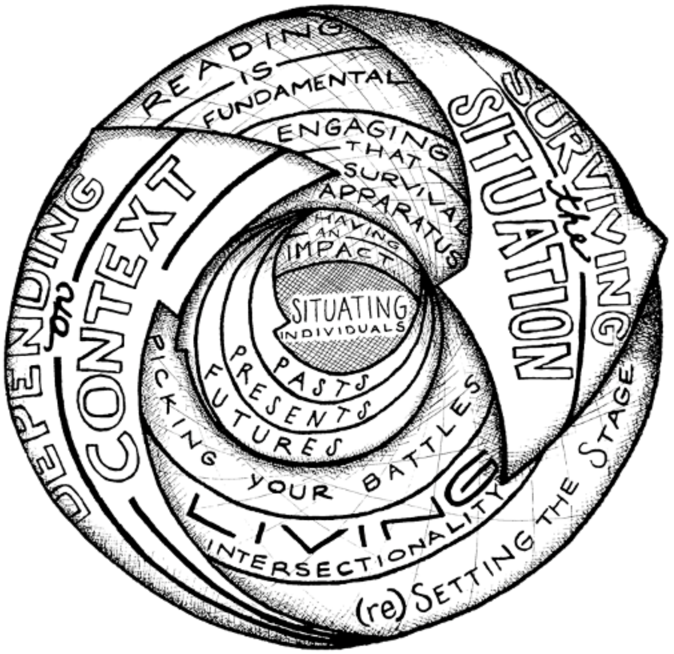

Figure 10. Diagram of a theory on working through stigma

CHAPTER FIVE – DISCUSSION

Stigma emerged as significant to participants frequently and consistently from the onset of data collection. The objective of this study was to generate theory that works to further understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia; however, participants described stigmatization of their identity beyond the context of the health system and that of their sexual orientation and gender. The stigmatization of non-White skin, being (Dis)Abled, an Immigrant, or Refugee, having a mental illness, as well as stigmatization in relation to poverty, abortion, substance use, obesity, and living with HIV are stigmas that are not inherently Queer, but were among the stigmas that power relations worked through with varying impacts on the participants in this study (2SLGBTQ and non-2SLGBTQ identified). Participants who are members of the 2SLGBTQ communities with additional stigmatized aspects of their identity, including individuals who self-identified as Black, Indigenous, and other people of colour, obese individuals, those in need of abortion services, using substances, with (dis)abilities, mental illness, or housing insecurity, and living in poverty explained how stigmas overlapped and the various strategies they employed to negotiate power relations working through and overlapping by way of stigma. It became clear that participants talked about how they worked through the stigma that many described as being everywhere and impacting everything. In so far as primary care represents a part of the healthcare system where health service users have more autonomy (as compared to other health care settings, such as, in-patient hospital units within institutionalized settings), there may be more opportunities in primary care to build trust with populations who are negatively impacted by power relations working through stigma by way of community engagement and collaboration (McClelland et al., 2012; Whitehall et al., 2021).

Investments in primary care within NS, growing numbers of nurse practitioners, and collaborative health centres across the province suggest the infrastructure exists to support a shift in how health services are delivered, not just to 2SLGBTQ populations, but any groups and individuals who experience stigma(s). Stigma thus emerged as a broadly inclusive construct that was not only significant to participants, but applicable to all populations when reframed as an opportunity to conceive and deliver equitable care.

5.1 Principal Findings

Working through stigma is a way of thinking through structurally stigmatizing conditions to change current practice and address social inequalities in ways that promote equitable access to and delivery of health services. Increasing access to primary care may work to alleviate unprecedented strains currently placed on health systems because of the COVID-19 pandemic in addition to promote better health outcomes for historically underserved populations. Working through stigma requires a broadly inclusive approach whereby social categories of identity can be used to recognize power relations, challenge and disrupt them, and create opportunities for transformation that would bring about equitable change in health care. Social categories of identity can thus serve as analytic tools to be used as they were in this study as a conduit for exploring power relations that work through stigma. Through an intersectional lens, individual differences can be reconceived into broader categories to facilitate points of comparison for an intricate understanding of complex social issues. In so far as stigma is a structural process, it highlights intrapersonal, interpersonal, and contextual levels of intervention that individuals, institutions, and governments can use to change current practices and influence power relations that negatively impact stigmatized groups and individuals and those who are positioned to help them, such as HSPs. As such, power relations can be transformed by individuals who anticipate the negative impacts of stigma and change practices constituting social structures that maintain social distinctions and inequalities (Bourdieu, 1977; Verovšek, 2019).

Participant interviews revealed the scale by which power relations are working through stigma and impacting them directly or indirectly. Stigma is thus conceived as something that is constantly being worked through at intrapersonal, interpersonal, and contextual levels. The stigmatized and those who interact with stigmatized groups or individuals are always working through stigma in some way or another. No one is outside of stigma, but impact depends on context. The processes by which stigma operates are parts of complex systems of beliefs held by dominant groups that are grounded in social inequalities that reproduce power relations that serve the interests of individuals who can then achieve their goals, sometimes without any intention in doing so because there are socio-structural factors that maintain social divisions and the organization of groups and individuals (Link & Phelan, 2014).

Stigma is often recognizable in public discourse, yet decontextualized from the root causes of illness because it "frequently serves as a means of giving short shrift to power social inequalities that are much harder to identity and conceptualize" (Castro & Farmer, 2005, p. 53). As such, the experiences of individuals, such as HSUs and HSPs in primary care settings, are divorced from broader social issues in ways that make it difficult to support positive change. There are shared features of stigma that can be broadly conceived and explored by managing the intersectional complexities that emerge from social distinctions that impact individuals differently within and and across cultural contexts (Hutchinson & Bhugra, 2000; Kleinman & Hall-Clifford, 2009). Contextual understandings of stigma thus require a consideration of power relations that shape social interactions within and across cultures by exploring differences in experiences according to social categories of identity that can then be negotiated by individuals according to subject positions at intrapersonal and interpersonal levels (Castro & Farmer, 2005; Doane & Varcoe, 2015; Hutchinson & Bhugra, 2000). Otherwise, differences between groups and individuals may be the focus, and opportunities to recognize common experiences, underlying power relations, and specific strategies for intervening upon stigma unrealized (Adorno, 1973; Agger, 2006; Hutchinson & Bhugra, 2000). This can lead to a form of victim-blaming that conceives the efforts (or failure) of individuals to protect themselves from and reproduction of the power relations that negatively impact them (Castro & Farmer, 2005). Link and Phelan (2014) inadvertently engage in this form of victim-blaming when they state, "[those] who are disadvantaged by the exercise of symbolic power are often influenced, sometimes without realizing it, to accept cultural assessments of their value and rightful (lower) place in the social order" (p. 3). The findings from this study would challenge this position in so far as individuals with relatively more power, who may be unknowingly benefiting from contextual power relations, are not held to account for accepting cultural assessments that construct them as superior. Stigma is thus something that everyone can work through to transform social structures.

Participants described how stigma is enacted by way of layers that intersect, overlap, and shift across contexts and social categories of identity. This middle-range theory is explicit in its effort to search for underlying power relations that influence health-related educational and institutional structures, systems, processes, and decision-making. As such, this theory of ***working through stigma*** furthers understanding of what can be done to influence power relations in primary care settings by way of illustrating the work that participants do when health services are being delivered under structurally stigmatizing conditions. The theory generated on working through stigma outlined in the findings chapter was comprised of three concepts: (1) depending on context, (2) resolving histories, and (3) surviving the situation. There is no beginning or end to the overall process of working through stigma because as a structural process, stigma is always present, even though it may look and act differently across cultures. The ongoing process of working through stigma is theoretically understood through concepts that illustrate a complex, mutually reinforcing system of domination that functions through social structures that are internalized by individuals and externalized through practice that reinforce social inequalities. For example, an individual's upbringing (depending upon context) will shape the lens through which they situate themselves and others (resolving histories), which will impact how/if their survival apparatus becomes engaged (surviving the situation) under a given set of circumstances. If power relatiosn are working in such a way that one's survival apparatus is engaged, then it makes it harder to focus on anything other than getting through whatever situation caused one to go into survival mode. Survival thus becomes about getting through the moment and hinders individuals' abilities to engage in future-oriented thinking, such as health-promoting behaviour.

The theory of working through stigma means that stigma is something that needs to be worked through and as a result, skills are required to influence power relations, diminish barriers to care, and identify opportunities to mitigate the impacts of stigma, such as the risk of stigma-related stress. This is not to say the responsibility sits with those who are negatively impacted by power relations that work through stigma; however, there is a shared responsibility to collectively work through stigma to dismantle the stigmatizing structures and behaviours that reproduce those power relations. Considering equity, this means that more work needs to be done by those who are currently benefitting from and therefore have relatively more power as a result of stigmatizing structures and behaviours. HSUs and HSPs experience different negative impacts by power relations that work through stigma; omissions in training around stigmatized groups, such as, but not limited to, 2SLGBTQ populations serve to illustrate how power relations work through stigma to have different impacts. The approach cited by many HSP participants in this study, to take a neutral and non-judgemental approach, is not wrong but it is not enough to offset the negatively impacts of power relations on historically stigmatized groups when working under structurally stigmatizing conditions. It is, however, something that HSP participants in this study have learned to do and are able to do, despite the limitations that are place on them from working under stigmatizing conditions. Without developing specific skills on *how* to work through stigma in learners in professional health education and training, health disparities have persisted and are likely to continue to follow trend.

5.2 Strengths and Limitations

Grounded Theory is a rigorous qualitative research methodology that offers a systematic approach to generating theoretical knowledge (Glaser & Strauss, 2017; Rieger, 2019). By using Intersectionality Theory to extend CGT methods, the generation of theoretical knowledge was strengthened by way of subjective differences in participants' experiences of health service delivery in primary care settings, according to their diversely held subject positions. By using Critical Theory to extend CGT methods, the generation of theoretical knowledge was strengthened by way of broadly reconceiving socially constructed differences into oppostitional categories (those who experience stigma in relation to their sexual orientation and/or gender (2SLGBTQ HSUs and HSPs) versus those who do not (non-2SLGBTQ HSPs)) to explore power relations and the various strategies participants employed to negotiate their impacts. A rigorous and nuanced rendering of power relations was thus possible by using social categories of identity as analytic tools and creating a starting point for my research by using stigma as a sensitizing concept. By exploring the social interactions between individuals when health services are being delivered under structurally stigmatizing conditions a robust theory on various ways of working through stigma was generated.

To my knowledge, this is the first study of its kind to conceptualize stigma in a way that is broadly inclusive, not by way of generalizations, but through an appreciation of the potential for differences within and between subjective realities. Structural stigma is acknowledged in the literature as an "underrecognized mechanism producing health inequalities" (Hatzenbuehler, 2014, p. 742) that operates in ways that carry disadvantages for some and recommendations are often individual focused. There are differences between and among HSUs and HSPs in how structural stigma impacts social interactions in primary care settings and beyond. For example, HSUs and HSPs are negatively impacted in different ways by the inadequate health education and training in relation to 2SLGBTQ populations in professional health education and training. This example of institutionalized stigma emanates from social structures but is carried out by individuals in practice settings with diverse impacts. This study's findings illuminate the complexity of stigma, how it functions at multiple levels in an ongoing manner, and what HSUs and HSPs are up against when working in health care, under conditions that are structurally stigmatizing.

A strength of this study was the purposive recruitment of a diverse sample facilitating points of comparison and negative case analysis by being inclusive of subjectivities (or cases) belonging to individuals whose identities would place them beyond, and therefore do not "fit" with the norms of dominant cultures, which negatively construct them. Negative case analysis as such promoted the creation of points of comparison and thus the identification of points of view that enhanced qualitative trustworthiness. Using Critical and Intersectional lenses enhanced negative case analysis because the level of abstraction was raised through participants' identities and the power relations their subject positions to explore health-related educational and institutional structures, systems, processes, and decision-making that influence the conditions under which health services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Negative case analysis began with being purposive in recruitment, meaning that more points of comparison were created to enhance qualitative analysis by way of diverse representation across five intersections of identity (sexual orientation, gender, race, ability, citizenship), at least one participant from every NSH management zone, and at least one participant from the HSP subgroups for each of the professions/roles being recruited (family physician, nurse practitioner, registered nurse, pharmacist, paramedic, management, administrative/clerical). This promoted the uncovering of underrepresented perspectives within the context of the research as well as the broader social contexts because there was an overrepresentation of historically underrepresented groups in the sample population. Perspectives that confirmed or challenged what had been uncovered through data collection and analysis were thus explored through negative case analysis.

While there was at least one participant from each NSH management zone from the overall sample population, each subgroup did not have geographical representation across the entire province. There were no 2SLGBTQ HSPs from Northern Zone, nor were there any HSUs or non-2SLGBTQ HSPs from Eastern Zone. Furthermore, there was a lack of racial diversity in the non-2SLGBTQ HSP subgroup (no one disclosed being (Dis)Abled in this subgroup either) and no participants were 75 years of age or older. Despite these limitations, data analysis did not suggest that theoretical sampling from subject positions underrepresented in the sample population was necessary; the grounded theory generated was robust in terms of having concepts with well-defined properties and characteristics.

The limitation that has been stated throughout (that it is impossible to capture the full range of diversity that a social category of identity could possibly represent) is restated here to highlight the utility of Intersectionality Theory in research involving diverse 2SLGBTQ populations in confronting identity and power relations simultaneously. Memberchecking between participants throughout the interview process also strengthened the constant comparison method, conducting follow-up interviews with several participants, and then reviewing the late-stage analysis with several other participants also contributed to maintaining qualitative trustworthiness. This allowed for a complicated appreciation of the scale of work that needs to be done to access health services under structurally stigmatizing conditions. Such an understanding is particularly important in primary care settings because it is the part of primary health care that is focused on delivering health services that promote health, prevents illness, diagnoses, and treats illness and injury (Health Canada, 2005). Primary care is the point of entry for referrals to specialized services and site by which the health disparities of populations historically underserved in health care can be addressed within the community and over time so that trust can be built. While it is undeniably important to look at the impact of structural stigma in all areas, including specialized services areas to further explore the barriers to care that are created in primary care settings by stigma may bolster efforts to bring about change across the health system and beyond.

Limitations include a sample that was comprised of individuals who, as one participant said, “have some skin in the game”. Many who were non-2SLGBTQ identified wanted to invest themselves in this study by participating because they had loved ones who were members of the 2SLGBTQ communities. Others experienced stigmatization that they compared to that of members of 2SLGBTQ populations (aside from their sexual orientation and/or gender), such as participants who are racialized. Many HSP participants stated the importance of this study and wanted to contribute to a research project that sought to address the barriers they recognized in their own practice. While this was pointed out as a limitation of the study by a minority of participants, it was regarded as a strength by others in the sense that these participants had insight into what it was like to work through stigma that those who did not see the need to invest themselves in a study like this would not have.

5.3 Discussion of Findings

This study complicates the exploration of power relations by way of its repurposing of social categories of identity using Intersectionality Theory to gain a contextual appreciation of how stigma overlaps and converges upon individuals. This furthers understandings of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia because the creation of multiple points of comparison promoted a complex analysis of power relations working through stigma and the various ways that participants negotiated their impacts. Stigma complicates the processes by which health services are delivered to 2SLGBTQ populations in Nova Scotia, particularly when identities beyond sexual orientation and gender are considered, because it creates opportunities for power relations to be reproduced, challenged, disrupted, or transformed at intrapersonal, interpersonal, and contextual levels. The delivery of health services is a social interaction which requires a working through of stigma that depends on the context of the situation, including subject positions of individuals involved and power relations therein. How stigma is worked through depends on contextual factors that shape ongoing and accumulating structural inequalities that are perpetuated by way of reifying socially constructed differences into social categories of identity.

5.3.1 Depending on Context

Findings from this study illustrate how stigma, as a socio-structural process, sets the stage for how individuals are taught to think about stigmatized individuals and groups, which informs practices and behaviour, and shapes outcomes. By way of maximizing points of comparison in the sample by purposively recruiting a diverse sample, the limitations of which were described across five categories of identity: sexual orientation, gender, race, (dis)ability, and citizenship, I was able to gain perspective on how how power relations influence health-related educational and institutional structures, systems, processes, and decision-making within primary care. Strategies used by individuals to negotiate power relations working through stigma have in literature that notes the significance of socio-structural factors such as "social policy, laws, institutional practices, or negative attitudinal social contexts" (p. 4) in serving the interests of dominant individuals (Link & Phelan, 2014). By using Bourdieu's understanding of symbolic power, which is when an individual is empowered use social divisions to legitimate their subjective reality and at the expense of others, Link & Phelan (2014) argue that stigma is a form of symbolic power that is exercised at the expense of those who are negatively constructed. Stigma is thus a resource that is used by members of dominant groups to serve their interests at the expense of those who are stigmatized (Link & Phelan, 2014). They are critical of the overly individualistic approaches of stigma research and in doing so, contributed to a shift in how traditional sociological concepts; such as, power, classification, structures, and institutions could be conceived in relation to social inequalities (Link & Phelan, 2014; Tyler & Slater, 2018). Recognition of shared and unique impacts of stigma across cultural contexts (Kleinman & Hall-Clifford, 2009) and that stigma is embedded in social structures (Hutchinson & Bhugra, 2000) too often remains an abstract conception that fails to recognize the ways that power relations are working through stigma to reproduce themselves (Tyler & Slater, 2018).

Historically, stigma has set the stage by giving advantages to individuals from (or perceived to be members of) dominant cultures at the expense of others and the institutionalization of heteronormativity in health care serves to illustrate how outcomes are shaped by power relations that are influenced by socio-structural factors. Recent questions have been asked as to what sustains practices that construct people who are stigmatized as other, when so many people could relate to what Goffman (1963) described as “the situation of the individual who is disqualified from full social acceptance” (Goffman in Hermaszewska et al., 2022, p. 1). Statements that question the long term impacts of interpersonal strategies for reducing stigma (Hermaszewska et al., 2022) highlight the unique contribution that this study makes to the literature because it uses Intersectionality and Critical Theories to explore underlying power relations that work through stigma and converge upon individuals whose identities can be used as analytic tools for recognizing and appreciating socially constructed differences in ways that are broadly inclusive. In doing so, stigma is reframed as a resource that can be used to support positive change at contextual levels, thus intervening at a level that may support sustainable transformation within contexts, carrying benefits for individuals at intrapersonal and interpersonal levels (Doane & Varcoe, 2015). For this to happen, dominant cultures’ definitions of stigma must be rejected, and the construct needs to be redefined as a structurally embedded resource that can be worked through in ways that carry benefits for those whose differences place them at risk for being stigmatized.

When power relations are being reproduced through stigma in ways that uphold the beliefs and practices of dominant cultures, stigma is a resource that can be used by members of dominant groups at the expense of those who are stigmatized (Link & Phelan, 2014). When power relations are influenced by working through stigma in ways that level the playing field, stigma can be used as a resource for transforming social contexts to support equitable change. Where there is stigma, opportunities exist to intervene in ways that can reproduce, disrupt, or transform power relations. Leo's description of his experiences in health care as being "a dream" illustrates the point that stigma can be used as a resource for transforming power relations. As a person living with HIV, Leo is working through stigma to gain access to health services. Within the context of the AIDS crisis and the impacts of the stigmatization of Gay Men during that historical period, power relations that uphold the supremacy of Heterosexuality worked through stigma in devastating ways with far-reaching impacts. For example, stigma was used as a resource by researchers who intervened and influenced power relations in ways that carried benefits for HSUs like Leo. The scale of the AIDS crisis and the research and activism that its history brought forth provided context for Leo's health needs to be understood by healthcare professionals. Stigma seemed to have impacted power relations in ways that positively impact Leo's access to health services and thus constitutes a "dream" experience in primary care settings for an HSU who lives with HIV and self-identifies as a White Gay Man. Leo explained how these benefits were not necessarily extended to others and provided the example of his friend who is often questioned about how she became HIV positive, which is something that he does not experience because, as he explained, he fits the mold of what HSPs expect because he is a Gay Man. In so far as Gay Men were stigmatized to such a degree during the AIDS crisis, it set the stage for how HIV related health services are delivered today because stigma was intervened upon, and power relations were influenced to construct conditions that supported positive change. The body of research available on HIV speaks for itself and has and will continue to inform the relationships between HSPs and HSUs living with HIV and AIDS.

Connecting everyday distinctions that are grounded in the stigmatization of subject positions to state-level politics permits a recognition of complex factors that shape individuals' ability to respond (i.e. agency) by way of structural inequalities (Škobla & Filčák, 2020; Tuğal, 2021). Working through stigma thus requires a rejection of the false separation between structure and agency if a complicated understanding of the barriers to accessing health services will be achieved. Living intersectionality is therefore a means by which stigma can be worked through to appreciate contextual factors and mediate the associated barriers. Without connecting HSUs' everyday lives to the health services being delivered, intersectionality is being lived in ways that reproduce hegemonic power relations working through stigma, disadvantages that arise from stigma reinforced, and there is a disproportionate amount of work for stigmatized HSUs to do to gain access to the care they need. When Jade describes the diversity within Black communities in Nova Scotia and how their experiences within the health system vary accordingly, we should appreciate how stigma operates at a contextual level that reproduces power relations through cultural, economic, historical, political, and social practices and socially constructed differences that uniquely shape opportunities and outcomes. As such, conceiving individuals' perceived ability to act, react, think, and feel within a given context as inextricably linked to social structures and the various practices that thereby reproduce power relations promotes the achievement of complicated understandings of barriers to health services.

Decision-making can make health service delivery to Trans and gender diverse persons more complicated, such as the MSI approval processes for gender-affirming surgeries. There were HSPs in this study who achieved a complicated understanding of how to deliver care that affirms Trans and gender diverse identities. They called attention to obscene amounts of paperwork and obstacles to providing care that are so difficult to change that one HSP explained it was like banging her head off the wall trying to get the government to make it easier for her to work through all the layers of stigma that hinder her within her role. This highlights a problem with policies that claims to bring about change when in actuality, vulnerability can be increased (Black et al., 2019). The Nova Scotia government put policies into place that claim to benefit Trans and gender diverse populations by way of increasing access to gender-affirming health services (CBC News, 2014), but HSPs are not properly supported in their roles and approval processes are so complicated that it is not uncommon for them to refuse care to Trans and gender diverse HSUs. HSU participants in this study expressed a fear of being refused care for this reason and/or being asked to bridge knowledge gaps, such as testosterone levels.

Stigma creates unequal opportunities; the best available option for one person might be completely unattainable for someone else. Decision making processes that underlie the delivery of health services mirror power relations and are determined by a myriad of factors that HSPs are up against within institutions that make it harder to work through stigma with HSUs from historically stigmatized populations. Discriminatory practices uphold cultural supremacies and impact decision making at various levels (DeMeester et al., 2016; Donald et al., 2017; Fredriksen-Goldsen et al., 2014; Lerner, 2021; Metzl, 2012). Decision making processes are thus determined by the context in which they are carried out. Discriminatory practices represent ways that power works through stigma to make it harder for those who are stigmatized to achieve the same outcomes as those with relatively more power. There are underlying factors that shape health-related decision making at every level, including intrapersonal, interpersonal, and contextual that impact communities, institutions, organizations, governments, and societies globally. Underlying factors work in concert with stigma to create differential access to health services and require consideration to understand what informs decision making processes and the implications of decisions made (Cuinhane et al., 2018; DeMeester et al., 2016). Best available options thus depend on context.

Stigma creates opportunities for HSPs and HSUs to work together, connect social inequalities to everyday barriers, and come to an understanding of what underlies each others' decision-making processes. Participants who were HSPs (2SLGBTQ and non-2SLGBTQ) provided insight into how to pick battles in relation to their understanding of the constraints placed on them within their roles. The battles they chose to fight were shaped by the barriers they experienced due to ways that power relations were working through stigma and reflected an understanding of the health system that was more nuanced than HSU participants. This may be attributed to the fact that working through the stigma in health care is an everyday reality for healthcare workers. Participants called for change in broad terms (eg. better education, policy change, more funding), while others gave specific recommendations (changing EMRs, using informed consent models for GAH, holding lunch and learns, and writing inclusive exam questions). Grounded in experiences of working through stigma, participants described how they sought to bring about positive change by way of their professional roles, volunteer work, and activism. Consideration was given to contextual factors that shaped behaviours of and interactions between HSUs and HSPs, which have been identified elsewhere in the literature and include the processes through which health services are delivered, such as day-to-day operations (patient flow), methods of information exchange (EMRs), and organizational structure/culture (DeMeester et al., 2016). Participants learned how to work through stigma, and in doing so, gained an appreciation for the complexity of identity and how the structuring of subject positions is socially constructed and decision making by individuals, institutions, and governments are informed according to the needs of dominant groups. They described ways they used this appreciation to inform their ability to engage in shared decision making. Level of appreciation gained seemed to depend on everything that has led up to the moment in time a decision is being made. Similarly, picking which battles were worth fighting depends on how the stage has been set. Depending on context is thus a conceptual rendering of what informs the processes by which decisions are made when stigma is being worked through. Depending on context represents an opportunity for those involved in delivering health services under structurally stigmatizing conditions to pick battles that will benefit those who they intend to benefit because the implications have been collaboratively explored and the factors that determine available options are appreciated.

5.3.2 Resolving Histories

The concept of resolving histories highlights the scale of work that needs to be done to reset the stage so that stigma can be recast as something that creates opportunities for shared decision making. The extent of work that has and continues to be done through stigma can also be appreciated by way of the concept of resolving histories. Structural processes, such as stigma, that influence power relations give rise to resolving histories, which simultaneously operate on multiple levels and can converge upon individuals, communities, and within institutions, organizations, and nations in complex ways. Resolving histories rejects falsely separating social realities that represent collective experiences and shared histories because they “outline past events, present spaces, the future, [and] the properties of persons or objects, relations, events, [and] transformations” (Törrönen, 2001, p. 320). Resolving histories connect us all, in the present, and through shared pasts and futures.

The concept of resolving histories is illustrated by psychiatry's established pattern of attempts to address the perceived societal threat of diverse sexual orientations and genders to dominant views on human sexuality and gender, was traced for the reader from the first through to the current version of the DSM in the background section, and in relation to the broader social context of Canadian society. The DSM thus adds a layer of stigma that needs to be worked through, particularly within psychiatric care settings, because it reproduces historical power relations that are maintained by way of pathologizing diverse sexual orientations and genders. We can see this manifest in WPATH's recommendation of having Trans and gender diverse individuals requiring a diagnosis of gender dysphoria to gain access to GAC. This increases the risk of triggering individuals' survival instinct, and it increases wait times to access life-saving health services. Resolving histories is a concept that invites reflection around and supports actions that anticipate the impact of historical power imbalances on access to health services that perpetuate health disparities. The history of pathologizing those with diverse sexual orientations and/or genders represents a relational process between the health system and broader context of society whereby stigma is being worked through, reciprocated, and mutually constituted (Selg & Ventsel, 2020). Impacts of such things as conversion therapy as a recommended treatment for homosexuality outlined in the DSM-II remain unresolved today as we witness federal and provincial governments in Canada continue to undo the impact of the psychiatric discipline on members of 2SLGBTQ communities (Drescher, 2015b; Gorman, 2018; D. of J. Government of Canada, 2021).

The psychiatric discipline continues to take a role in reinforcing and legitimating cultural norms that uphold the values and beliefs of heteropatriarchal societies. Medicine reveals numerous examples of the ways in which social norms and cultural supremacies are rooted in power relations that are mutually constituted and reproduced by and within health systems and societies; biased clinical practices reveal knowledge gaps that are grounded in colonialism, racism, ableism, and nationalism that maintain socially constructed differences within broader social contexts. Unresolved historical injustices have far-reaching impacts that continue to shape the processes and factors that influence the conditions under which health services are delivered to stigmatized populations, thus influencing health outcomes of individuals and populations. This is illustrated at a global level, whereby Western scientific norms have been disseminated by way of reforms to medical training that have shaped accreditation standards across the globe (Weisz & Nannestad, 2021). Attempts to resolve discrepancies in international medical education have not reconciled disparities between standardized medical training and regional needs (Weisz & Nannestad, 2021). There are knowledge gaps that remain to obscure the implications of histories that aim to resolve discrepancies between dominant cultures and those which are non-dominant, highlighting a social binary grounded in hegemonic power relations that carry disadvantages for the global South and non-Western societies. Resolving histories account for pasts, presents, and futures that impact how individuals relate to themselves (intrapersonal) and others (interpersonal) as well as the impact of actions that intend to solve complex social issues using approaches that are grounded in the beliefs and values of dominant cultures (contextual), thus failing to attend to specific needs of groups and individuals who remain underserved.

Individuals situate themselves and put others into categories, often without a full appreciation of another's lived context. Resolving histories are the processes by which social transformation could come about and presents as an opportunity to reframe the inherently negative impacts of stigma. As such, *how* we situate ourselves and others matters because this is a means by which we can learn what "lane" is ours, the importance of operating within its boundaries, the consequences of working outside one's own knowledge and experience, and how to demonstrate the skill of staying in your lane by helping others to understand you by relating to them in ways that are expected. If stigma is actively worked through, power relations disrupted, and their impacts transformed, then the impacts of cultural dominance will also change (Arrey et al., 2017; Poon & Ho, 2008). Resolving histories help us to understand *what* needs to be worked through and *how* to intervene upon stigma to bring about positive change with individuals, communities, within institutions, nations, and across the globe. If an individual has managed to avoid power relations working through stigma at the interpersonal level, through resolving histories, we can appreciate contextual level impacts of stigma across time. In the context of health care, resolving histories helps us to appreciate socio-structural determinants of health, not simply within the context of an individual's lived reality, but the impact of power relations between an HSP and HSU and what brought each to this place in time.

Individuals are situated within broader social contexts by way of resolving histories and relationships are shaped by cultural norms, legislation, and social policies (or a lack thereof). Having an impact is thus a sub concept of resolving histories in so far as the constructing and reconstructing of social divisions influence the structuring of subject positions and exposes the opportunities that arise from stigmatizing processes to reproduce, disrupt, and transform power relations by and within groups, institutions, nations, and even globally. When one steps out of their lane, there can be unforeseen or unintended consequences. There are negative impacts that stigmatized groups and individuals experience that those with relatively more power may not have awareness that they exist, but through resolving histories, policy makers and advocates can intervene upon structural stigma in ways that work to lessen the workload downstream and avoids further marginalizing those who are already underserved within social institutions (Price et al., 2020).

Resolving histories are central to working through stigma because this concept offers perspective on *how* survival is contextually dependent. Resolving histories is thus a rendering of the relationships and histories that need to be worked through to intervene upon social inequalities that result in the underservicing of stigmatized populations in health care. Resolving histories promotes critique of normativitiy and cultural dominance by confronting identity and power simultaneously with the aim to resolve specific and historical social injustices. Resolving histories is a concept that promotes the questioning of established ways of working through stigma to reorganize social arrangements so that the traditions of dominant cultures result in the backburnering of the needs of individuals from non-dominant cultures. The concept of resolving histories thus frames extant literature that highlights the ways in which social norms and cultural supremacies are rooted in power relations that are mutually constituted by health system and society and serves as a means by which heterosexism, homophobia, cissexism, transphobia, colonialism, racism, ableism, and nationalism can be called into question.

5.3.3 Surviving the Situation

Surviving the situation acknowledges coping behaviour as an adaptive set of practices that aim to promote survival; negative coping strategies are externalizations of stigma(s) internalized that could become positive coping strategies if contexts were transformed so conditions supported such a shift. Survival depends on one’s ability to identify threats and cope with the threats they encounter as they attempt to gain access to resources needed to survive. Surviving the situation conceptualizes the ways that individuals negotiate power relations working through stigma in relation to social categories of identity (reified subject positions) to consider how they read their surroundings and what strategies are employed to survive threats encountered. Bourdieu's (1977) understanding of social structures conceives surviving the situation as a theoretical representation of how identity can be used to understand behaviours and practices as an externalization of internalized social structures that are shaped by power relations that can be inclusively confronted at intrapersonal, interpersonal, and contextual levels within institutions, organizations, nations, and globally. By way of the concept of surviving the situation, this study expands upon existing intersectional research on minority stress due to its complicated appreciation of identity, by acknowledging that HSPs are positioned to mediate structural stigma at the interpersonal level in ways that could mitigate its impacts despite also being impacted by stigma within their professional roles, and highlighting a need to intervene at contextual levels to bring about reforms that would reduce barriers to accessing services, such as those within the health system. Institutions and organizations are similarly hindered by structural stigma and how power relations are reproduced therein; findings from this study suggest that structural inequalities can be addressed at contextual levels so that institutions, organizations, and individuals can be more effective in disrupting and transforming power relations that are working through stigma with deleterious impacts.

By way of the broadly inclusive approach taken in recruitment to explore social processes and contextual factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia, this study extends existing literature that employs an intersectional lens and MST to further understandings of individual psychopathologies and coping strategies (Beese & Tasker, 2021; Candrian & Hinrichs, 2021; K. Clark et al., 2021; K. A. Clark et al., 2021; Dyar et al., 2020; English et al., 2018; Everett et al., 2019; Gessner et al., 2020; Ghabrial, 2017, 2017; Goldberg et al., 2020; Hammond et al., 2020;

Jackson et al., 2020; Marshall et al., 2021; Mijas et al., 2020; Rivas-Koehl et al., 2021; Sarno et al., 2021; Schmitz et al., 2019, 2020; Shangani et al., 2020; Swann et al., 2021; Vigna et al., 2018, 2020). The theory generated in this study provides a practical way of thinking about how the impact of structural stigma can be mediated in healthcare settings. Survival for those who experience overlapping stigmas that whose survival apparatus is routinely engaged may be more about getting through day to day living, which precludes individuals from engaging in future-oriented health-seeking behaviour because delaying and avoiding access to health care out of fear of discrimination presents itself as a better option than accessing health services (Craig et al., 2018; Dubreucq et al., 2021; Ecker & Lykins, 2021; Gu et al., 2021; Massaroni et al., 2022; Partow et al., 2021; Rodriguez-Hart et al., 2021; Subu et al., 2021; Yassin et al., 2021; Yu et al., 2021). If stigma was worked through in ways that disrupted the reproduction of hegemonic power relations and transformed social structures in ways that brought about equitable change, then its impact could be mitigated by engaging in broadly inclusive practices that intervened upon stigma. In doing so, the negative impacts of structural stigma could be anticipated and appreciated as an intersectional experience that causes individuals to confront power relations that can threaten their survival. The impact of structural stigma could then be mitigated by working through it at the interpersonal level through broadly inclusive practices that are universally accessible, thus changing the conditions under which health services are delivered to historically stigmatized populations in Nova Scotia and beyond.

Individuals, regardless of their identities and roles, are included as partners in mediating or contributing to how power relations work through stigma. Intersectional approaches in recent research on minority stress, a known risk for negatively impacting stigmatized populations at multiple levels, address an identified gap in the literature and tend toward greater specificity among racialized sexual minorities; while they call for attention to differences within groups, many remain focused on individuals and groups who experience multiple stigmas (Dyar et al., 2020; English et al., 2018; Everett et al., 2019; Ghabrial, 2017; Jackson et al., 2020; Marshall et al., 2021; McConnell et al., 2018; Sarno et al., 2021; Schmitz et al., 2019, 2020; Swann et al., 2021; Vigna et al., 2018, 2020). There were no studies found that conceptualized a sample population across five categories of identity as this study did; minority stress at the intersection of sexual and/or gender and race is explored more than (dis)ability (Beese & Tasker, 2021) and citizenship (K. Clark et al., 2021; K. A. Clark et al., 2021) and rarely in intersection with other aspects of identity, such as socio-economic status (Shangani et al., 2020). This study integrates multiple intersections of identity in a way that promotes a complex way of thinking about interlocking systems of privilege and oppression and how they converge upon individuals within primary care settings so that barriers to accessing health services can be appreciated as infinitely complex by those delivering care. Such a complex understanding can assist HSPs in working with HSUs who experience stigma(s), so they can demonstrate their knowledge (read as aware of the negative impacts of stigma) and avoid causing HSUs to go into survival mode, particularly those whose survival apparatus is routinely.

Intersectional applications of MST demonstrate a proclivity to focus on multiple marginalized identities without attending to those that confer advantages, which reduces diversity to oppression, fails to attend to the complexity of identity, and oversimplifies power relations. Reductive applications of intersectionality theory obscure common experiences and underlying power relations that could reveal important nuances in how power relations operate in intersection and hinders the identification of opportunities for social transformation (Adorno, 1973; Bourdieu, 1977; Cho et al., 2013; Collins & Bilge, 2020; Crenshaw, 1991). The differences in how minority stress is experienced are illustrated by other studies that explored power relations within groups of sexual and gender minorities. For example, one study determined that racialized sexual and gender minorities reported structural discrimination at a contextual level with 2-3 times greater frequency than their non-racialized counterparts; however, the latter reported more interpersonal discrimination in the form of bullying (Vigna et al., 2020). This added to previous research that found racialized sexual and gender minorities reported increased rates of stigma experiences while their non-racialized counterparts reported more concerns about mental health (Vigna et al., 2018).

The usefulness of confronting identity and power relations simultaneously by exploring the differences in how stigma is experienced between and within groups was further illustrated in the literature when relationships between masculine and feminine identities were explored; masculine presentation was associated with lower levels of stress among racialized sexual and/or gender minorities, but higher among non-racialized sexual and/or gender minorities (Everett et al., 2019). An intersectional lens was used in this study to explore power relations by way of its attention to and conceptualization of identity and the creation of diverse points of comparison. This study contributes to extant literature on stigma-related stress through its exploration of participants' ways of working through stigma that depend on infinite combinations of ways that power relations work through stigma, which can never be fully appreciated. This study thus shifts the narrative in health research from being about the impacts of stigma on various stigmatized populations to an exploration of what can be done to anticipate its impact.

Stigma is experienced differently, depending on the context of the encounter and relevant histories, which mediates the impact of structural stigma, health outcomes, and ultimately, the survival strategies that are available to each person. How individuals experience stigma is contextual and because it operates at multiple levels, participants in this study were hindered by stigma in various ways and had adaptive ways of negotiating power relations to mitigate negative impacts and perceived threats. Preparing HSPs to deliver care that mediates the negative impacts of stigma at interpersonal levels would be a way of intervening upon it, but conditions need to support individuals in disrupting and transforming hegemonic power relations; institutions and organizations need to better support individuals in bringing about positive changes by taking multi-level and person-centred approaches to working through stigma and create opportunities to anticipate perceived threats, reduce the negative impacts of stigma, and cultivate environments that promote broad inclusion and simultaneously confront power relations that undermine the delivery of equitable care to stigmatized populations, including but not limited to diverse 2SLGBTQ populations.

5.4 Recommendations for Practice

Anticipating the negative impacts of stigma is a means by which hegemonic power relations can be disrupted and transformed, but the benefits that can come from working through stigma are limited if the responsibility to bring about positive change lays primarily with individuals. The findings from the current study promote a complicated view on how power relations work through stigma that could transform how HSPs are trained to deliver health services. HSPs could be trained to deliver health services to stigmatized populations in ways that account for the differences in how structurally stigmatizing conditions are experienced by individuals and groups. A complicated conceptualization of power relations beyond the interpersonal level is needed to anticipate their impact on 2SLGBTQ populations *and those who interact with them*. Upstream interventions can and must happen to make strides towards addressing barriers to health services that are created and maintained by power relations that work through stigma and the cascading impacts on individuals working under structurally stigmatizing conditions who can be unsupported within their roles and faced with insurmountable challenges to bringing about change.

Teaching learners about stigma, how to explore personal biases that are informed by stigma, and how hegemonic power relations are reproduced through stigmatizing practices and behaviours is a means by which historically underrepresented groups can be included in curricula in ways that can promote equitable change in healthcare settings. Personal exploration as such is a necessary step in learning how to stay in your lane and why doing so minimizes the unintended negative impacts that those with relatively more power have on those with relatively less. Learners can gain an appreciation for how stigma can be intervened upon in broadly inclusive ways and mediate its impacts by picking battles that are relevant to HSUs' lived realities and respecting the decision-making processes of those who have to live with the consequences. In doing so, learners would recognize ways to disrupt hegemonic power relations by engaging in practices that intervene upon stigma and mitigates its impact at the interpersonal level. Universities prepare future HSPs to practice in the health system and as a result, are part of that system. The institutionalization of stigma by way of heteronormativity in health care that perpetuates negative health outcomes among stigmatized populations, not "just" 2SLGBTQ populations, can undergo upstream intervention within university settings. Teaching to the gaps in knowledge that are maintained by stigma would also work to address the challenges that educators face in trying to be inclusive of all groups who are historically underrepresented, the intersecting oppressions, and the health disparities that persist, which is an impossible task if done by addressing these populations as if they exist in isolation from each other. Stigma could be worked through in ways that possibilities for equitable change are co-created, health issues addressed so that symptoms resolve, and better outcomes are had, but the burden cannot be placed on individuals. Accreditation standards can be developed to address barriers that constrain individuals within their roles so that institutions can be supported in their efforts to bring about sustainable change by changing practice. Governments are positioned to work through stigma with institutions to develop policies that support positive change so that changing practice transforms health-related structures, systems, processes, and decision-making. As such, stigma can be worked through at intrapersonal, interpersonal, and contextual levels to influence power relations so that HSPs' learning experiences and HSUs' care recipient experiences are impacted in ways that promote better health-related outcomes.

I have argued elsewhere that marginalization causes structural trauma, which is different than other trauma- and stress-related disorders such as post-traumatic stress disorder, because the exposing events are ongoing and lifelong, causing members of the 2SLGBTQ communities to expect harm and anticipate exclusion (Searle, 2019). Historically marginalized populations experience structural trauma; they cope with and adapt to the engagement of their survival apparatus and read into interactions to detect and avoid threats. With this in mind, HSPs can be taught to engage HSUs in ways that convey safety through validation and locate them socially by way of critical and trauma-informed strategies that assess situations and conditions that shape outcomes. Such strategies can follow the same steps as physical assessments by way of inspection, palpation, percussion, and auscultation (Searle et al., 2017).

Before engaging with another individual who is working through unknown stigmas, one must inspect their own social location. ***Inspection*** begins with a consideration of one's identity, how they live intersectionality, and the development of circumstances that have shaped their outcomes, availability of choices, and taken-for-granted assumptions that influence their understanding of social worlds. Where trauma-informed assessments go depend on the context in which interactions take place, those involved, and the impacts of histories leading up to, coming together, and shaping interactions; the implications of which can be concealed and undetectable. Inspection would also include an interrogation of one's communication skills, particularly use of language, to uncover hidden assumptions that might be read as unsafe by those being assessed. ***Palpation*** includes asking questions to feel out situations (Searle et al., 2017). What and how questions are asked and answered impact how a situation is read by those involved. Palpation involves locating a person and building trust; it can convey safety or lack thereof, and it impacts how information is shared and health services accessed. For example, using neutral language might demonstrate competency in creating safer spaces, signal awareness of stigma, and promote disclosures that contextualize health outcomes and needs. Using neutral language to ask questions to an HSU who identifies as a Woman might promote use of same sex pronouns for their partner. This would create an opportunity for an HSP to validate and normalize the disclosure of same-sex partnering, which is stigmatized within broader social contexts. ***Percussion*** is responding with follow-up questions that validate and normalize stigmatized disclosures with the intent of demonstrating an appreciation for contexts shaping health outcomes. If tenderness is found on palpation, then percussion would involve further exploration of that finding. Percussion questions should be asked after trust is built by asking enough palpation questions to gain an appreciation of contexts shaping outcomes so that the negative impacts of stigma are being mediated throughout the assessment. ***Auscultation*** is about active listening and interpreting individual outcomes in relation to broader social contexts (Searle, 2017) to demonstrate a capacity to build and maintain trust while working through stigma. If the negative impacts of stigma are anticipated, then it can be intervened upon and used as a resource embedded in structures, systems, processes, and decision-making that can reshape conditions, practices, behaviours, and outcomes. Such an approach has implications for practice and promoting the delivery of patient-centred care because HSPs are positioned to recast stigma as a resource for reshaping outcomes. This is because validating differences stigmatized in broader social contexts as normal variations is not possible without stigma.

Implications for practice include graduating practice-ready healthcare professionals who have had skills-based learning in how to work through stigma in ways that interactions result in the best possible outcomes according to HSUs. Knowing where to take a trauma-informed assessment requires skill and practice. Assessing situations and how people cope to survive changing sets of circumstances with accumulating consequences that require mediation and shape outcomes requires skill that should receive equal attention to clinical skills-based learning because patient-centred care is about more than intervening clinically. Medicine serves the purpose of dominant cultures because it "is a key social institution through which social categories are constructed, produced, and reified – as well as (potentially) challenged and redefined" (Paine, 2018, p. 353). Clinical interventions that do not account for the negative impacts of stigma thus promote it because they deny the significance of its impact and fail to intervene upon it. This is cultural domination disguising itself as science (Horkeimer, 2002; Nietzsche, 2003) and an opportunity to disrupt the unquestioned meaning of stigma. Dominant cultures' definitions of stigma can be challenged and redefined as a resource that is used to benefit those who are at risk for being negatively constructed. Stigmas are merely differences that dominant groups use to construct themselves as superior and serve their interests for the purpose of domination (Adorno, 1973; Bourdieu, 1989; Nietzsche, 2003). Anticipating stigma in practice settings and using it as a means by which trust can be built between HSPs and HSUs makes it a resource that can be used to benefit individuals experiencing lifelong and ongoing stressors secondary to structural marginalization. As such, structural inequalities are intervened upon by way of stigma, a resource that catalyzes the intent to deliver patient-centred care, and its negative impacts are anticipated so characteristics that have been a source of shame can be validated as a normal variation. In doing so, trust can be built over time, and the impacts of stigma addressed in ways that promote, support, and sustain equitable change.

5.5 Recommendations for Research

I conceived a diverse sample population with the intent of avoiding reductive conceptualizations of an infinitely diverse population so findings would address the complexity of 2SLGBTQ HSUs' health needs. As such, the application of principles of equity, diversity, and inclusion (EDI) were substantiated in the design of this research because the sampling method used in this study promoted an overrepresentation of historically underrepresented perspectives in the sample population. This promoted the emergence of common themes by way of different subject positions and subjective realities that were conscious of power relations as mutually constituted systems of relationships between groups and individuals (Charmaz, 2014; Collins & Bilge, 2020). Researchers exploring issues related to social injustice can use Intersectionality Theory to conceive a diverse sample population across social categories of identity that are relevant to the studied context. As such, creating points of comparison contributes to qualitative trustworthiness because it informs purposive sampling for maximum variation, thus enhancing theoretical sampling and saturation later during data analysis. There is utility in this sampling method to broadly explore common experiences, such as those shaped by stigma; by paying attention to diverse perspectives, creating points of comparison to tease out differences in how conditions within a studied context are experienced, and then reconceiving those differences as similar under broader social categories (such as 2SLGBTQ and non-2SLGBTQ). As such, the principles of EDI can be substantiated in qualitative research design (Lane, 2021).

More research is needed to understand how pedagogical strategies can be developed that would achieve learning objectives around identifying personal biases that cause a lack of awareness around unique and collective roles taken in reproducing hegemonic power relations when working under structurally stigmatizing conditions. To support pre-licensure education/training as such, interventions also need to happen at the institutional level within the health system so that HSPs are supported post-licensure in working through stigma to disrupt and transform hegemonic power relations. A larger sample population that purposively recruited more health service managers and expanded to include directors in health and health-related educational institutions and public servants who are involved in health-related decision making, particularly the Department of Health and Wellness, is recommended to build upon the findings from this study. Purposively recruiting across additional social categories of identity (beyond sexual orientation, gender, race, (dis)ability, and citizenship); such as, socioeconomic status, age, culture, language use/mastery, and religious affiliation could provide more complexity to the findings of this study. Conducting a mixed-methods study that purposively recruits across additional social categories of identity and expands to other provinces could provide insight into regional factors that may identify possibilities for change within Nova Scotia and beyond.

More research is needed on *how* power relations work through stigma at contextual levels, not the negative impacts. Research as such may illuminate strategies for intervening upon stigma to address barriers that many HSUs are left working through on their own when accessing health services from HSPs who do not appreciate the role they take in reproducing hegemonic power relations when working under structurally stigmatizing conditions. Participants from the

2SLGBTQ HSP subgroup perceived differences in how they were treated as patients as compared to when they were in their professional roles and when comparing their professional experiences to that of their non-2SLGBTQ colleagues, which could be further explored through more research. Trust was central to working through stigma and undermined by the negative impacts of hegemonic power relations; HSPs experienced this mistrust as well, but when power relations were working through stigma by way of institutional policies, a lack of education on stigmatized populations, and other such contextual factors, stigma carried disproportionately negative impacts for 2SLGBTQ participants (HSUs and HSPs). Primary health care is fundamental to population health and primary care settings offer an opportunity to build trust over time within the health system and society more broadly. More research can be done to understand how stigma can be worked through in primary care and find ways of promoting better health outcomes for stigmatized populations across the health system because it could be the point of entry for all individuals to gain access to equitable health services.

5.6 Knowledge Mobilization

Knowledge mobilization (KM) refers to activities that promote the reciprocal and complementary uptake and flow of research knowledge within and beyond academia between knowledge produces and knowledge users (S. S. and H. R. C. Government of Canada, 2012, 2012). KM plans seek to inform, advance, and/or improve research, theory, or methods within academia; or beyond academia, inform public debate, policies, and/or practice; enhance or improve services (S. S. and H. R. C. Government of Canada, 2012). Despite recommendations from The United Nations High Commissioner for Human Rights (2011) and the Canadian House of Commons Standing Committee on Health (House of Commons of Canada, 2019) for healthcare professionals to be educated on 2SLGBTQ health issues, a lack of 2SLGBTQ-related content within professional health education remains a salient issue in advancing health equity for 2SLGBTQ populations (Greene et al., 2018; Knight et al., 2014). Learners within the medical and health professions can be taught to think about social inequalities that have become institutionalized over time and how to anticipate them by engaging in broadly inclusive practices that promote shared decision making, enhancing how health services are delivered to historically underserved populations. Such an approach might foster allied perspectives within the medical and health professions and build capacity therein to operate in solidarity with underserved populations in health care. It could also promote skills in patient advocacy among medical and health professionals, healthcare workers, and managers to bring about equitable policy change and make 2SLGBTQ health equity an achievable goal within Nova Scotia and beyond.

This KM plan is informed by Metzl & Hansen's (2014) structural competency framework and outlined in detail in table 3. The structural competency framework is relevant to developing a KM plan because it can be applied in such a way that promotes structural intervention across systems and disciplines that respond to marginalizing conditions and perpetuate social and structural inequalities (Nova Scotia Health Authority, 2017). Metzl et al. (2018) found the structural competency framework to be effective in teaching learners within pre-health undergraduate programs to consider their role in perpetuating health disparities (as compared to traditional curricula). Translating findings from this study will thus aim to foster broader considerations of 2SLGBTQ stigmatization as not only impacting treatment decisions, but the perceived ability to influence power relations that are inherent to healthcare settings. Such an approach promotes systems level change (Doane & Varcoe, 2015; Eliason & Chinn, 2018) with an aim to impact various knowledge users within the identified audiences in ways that they can not only understand the conditions under which health services are being delivered, but engage in equitable, broadly inclusive practices that change those conditions and promote better health outcomes among diverse 2SLGBTQ populations.

This study has produced an Open Access methodological paper on ANCA in *The International Journal of Qualitative Methods*, outlining an advancement in the method of negative case analysis. Findings will be translated into at least one additional peer-reviewed publication, conference presentations (depending on COVID-19 restrictions and funding), information sharing sessions, a final report, and an unfolding patient scenario (that will be made into a video project if funding can be obtained), that outline a more nuanced understanding of health and social issues that impact 2SLGBTQ populations in Nova Scotia than what is currently available. KM strategies will target participants and the public to seek feedback from those who contributed to the study as well as those who might benefit from its findings. The scale on which these initiatives happen will depend on funding and other financial considerations.

I have submitted an abstract and have funding to attend the 2022 Canadian Student Health Research Forum to disseminate my findings. Findings from the proposed study will undergo further knowledge mobilization to develop information-sharing sessions according to target audience. There will be an information-sharing session that is promoted using social media (Facebook). Participants will receive an invitation to this event via email as many expressed an interest in learning about the results of the study. Another information-sharing session will be developed in collaboration with an existing contact of mine, a Clinical Nurse Educator at NSH, for educators on the Interprofessional Practice & Learning team and will include practice-related recommendations that are appropriate for post-licensure audiences. Another information-sharing session will be offered through existing contacts to managers within NSH, Emergency Health

Services, and the provincial Department of Health and Wellness and include systems-level recommendations.

In terms of pre-licensure audiences, I have been giving workshops to learners for over three years on an ongoing basis for various faculty members at Dalhousie University and NSH, but without the benefit of having research findings from a study that includes a KM plan that I have designed myself. There is a recognized need to inform the provision of health services, better meet the needs of diverse 2SLGBTQ populations, and promote action that brings about systemic change in the primary healthcare system in Nova Scotia. Rather than continuing work on an ad-hoc basis, I hope to develop an information sharing session (and if I can obtain funding, a video) that could be offered to faculty and staff at Dalhousie University within the Faculties of Health and Medicine through existing contacts (as well as existing contacts at NSH in the case that a video is made). Experiential learning opportunities actively engage learners, which enhances their ability to connect theory to practice (Powers, 2020). As such, I intend to develop an unfolding patient scenario that is appropriate for classroom settings, but also adaptable for patient simulation labs (during which the scenario could be acted out by actors who engage with students in person). The scenario will depict a situation where structural competency is being illustrated by working through (and thus intervening upon) stigma at intrapersonal, interpersonal, and contextual levels. If funding is available, a video will be created from the unfolding patient scenario, which could then be freely distributed for use in various educational settings of medical and health professionals. Classroom-based interventions and simulated patient scenarios have been shown to be efficacious in terms of meeting the learning needs of pre-licensure learners because they create opportunities to make connections between theoretical classroom content and patient care in the practice setting (Powers, 2020). Such an intervention would enable pre-licensure learners to engage in shared learning experiences, which has been shown to not only promote understanding about each other's roles and professional communication skills, but enhance collaborative competencies and comprehensive care plan development, thus improving patient care (Butcher et al., 2017). If medical and health professionals learned how to think about how social inequalities have become institutionalized over time and the ways in which they shape conditions under which health services are delivered, then they could work to bring about equitable change in practice settings. If educational opportunities made connections between classroom content that attends to the ways in which certain populations, such as diverse 2SLGBTQ populations, are impacted by power relations that shape institutions over time, then HSPs might be better equipped to operate in solidarity with diverse populations in the practice setting.

Table 3

Knowledge Mobilzation Strategies

Target Audience	**Partners/Resources**	**Implementation Tactics**	**Anticipated Outcomes**
Participants	- Researcher - Participants - Final report (PDF) - Zoom videoconferencing account - Facebook	- Email participants a final report that describes findings - Include in the email an invitation for participants to attend an online meeting via Zoom to review findings and answer any questions - Share event widely through the same channels used for recruitment	- Disseminate co-created knowledge, answer questions, encourage discussion - Engage participants in thoughtful discussion
Academic faculty, staff, and researchers	- Peer-reviewed journals with large and/or international readership	- Published methodological paper in the *International Journal of Qualitative Methods* (Open Access) - Develop a manuscript for publication that expands upon Metzl & Hansen's (2014) structural competency model	- Disseminate knowledge to academic audience - Contribute to existing literature on critical qualitative research methods and structural competency

Delegates of the 2022 Canadian Student Health Research Forum	- 2022 Canadian Student Health Research Forum - Funding through the Nursing Research Fund at Dalhousie University	- Abstract submission currently under review - Develop and deliver oral presentation disseminating findings and application of Intersectionality Theory	- Engage with the intellectual contributions of other health research students - Network with delegates
Interprofessional Practice & Learning (IPL) Educators at NSH	- Interprofessional Practice & Learning Team (knowledge brokers at NSH) - Staff to whom educators provide continuing education sessions - prideHealth	- Develop and deliver an information sharing session for IPL team that includes practical practice-related recommendations - Develop a one-page handout and provide electronic copy for knowledge dissemination to staff through continuing education sessions	- Support IPL educators in providing continuing education to staff within PHC portfolio that is inclusive of the health needs of diverse 2SLGBTQ populations - Inform practice through continuing education efforts in PHC portfolio at NSH
Health service managers/senior management at NSH in PHC portfolio, Emergency Medical Services, and Provincial Department of Health and Wellness	- PHC health services/senior managers at NSH - Managers at Emergency Medical Services - Contacts at DHW through prideHealth health services manager - NSH Library Services	- Develop and deliver an information sharing session that includes systems-level recommendations - Gain approval to upload the final report to 2SLGBTQ resources page through Library Services - Send follow-up email to invitees with link to the final report/ one-page handout	- Influence decision-making within PHC portfolio at NSH - Foster culture of inclusiveness at various levels of management within the organization
Faculty, staff, and students in the Faculty of Health at Dalhousie University	- Dalhousie University, Faculty of Health	- Develop a case study with an unfolding patient scenario that can be adapted for various experiential learning opportunities, uniprofessional as well as interprofessional - Produce a video asset (that uses the case above) - Offer guest lectures to educators in the Faculty of Health - Distribute video asset if created	- Build capacity within the Faculty of Health (among educators and students) to appreciate health disparities in relation to socio-structural determinants of health - Influence change in the health system by way of pre-licensure education that provides students with knowledge that will better equip them to deliver equitable care to diverse 2SLGBTQ populations when they enter practice settings

5.7 Conclusion

This study generated theory that worked to further understanding of the processes and factors that influence the conditions under which primary care services are delivered to diverse 2SLGBTQ populations in Nova Scotia. Working through stigma emerged as a process that accounts for socio-structural determinants, the ongoing and accumulating impacts of historical relations of power, and individual factors that shape the delivery of health services to diverse 2SLGBTQ populations in Nova Scotia. Stigma was recast as an opportunity to transform social structures by promoting practices that mitigate the negative impacts of stigma at multiple levels. Exploring power relations working through stigma and the behaviours and practices individuals used to mitigate its impacts revealed strategies for transforming social structures by changing how health services are delivered to historically stigmatized populations. Recommendations on how medical and health professionals and healthcare workers can be trained to engage in broadly inclusive practices to work through stigma in ways that disrupt the reproduction of power relations that negatively impact individuals from historically stigmatized groups were offered and a knowledge mobilization plan was described. Changes are needed and equitable reform will take time; trust can be built along the way.

This theory of working through stigma rejects the reification of cultural differences by way of social categories of identity while simultaneously using them to explore the construction of power relations under structurally stigmatizing conditions, such as those under which health services are delivered. Social categories of identity are rejected because it is impossible to fully capture the diversity of subject positions therein. Intersectionality Theory was employed to repurpose social categories of identity as analytic tools for investigating identity and power relations by way of simultaneous confrontation. As such, this study generated theoretical knowledge that can be used to think about the possibilities, outcomes, and opportunities of working through stigma in so far as it potentiates a complex appreciation for the conditions and circumstances that structure subject positions across time and space and influence access to health services.

Participants described their ways of working through stigma and how hegemonic power relations created barriers to delivering equitable health services to 2SLGBTQ populations in Nova Scotia, Canada. The inclusion of HSPs (2SLGBTQ and non-2SLGBTQ subgroups) brought forth perspectives on working through stigma and revealed that HSPs are constrained within their roles by contextual factors, such as omitting content on stigmatized populations from mandatory education (pre and post licensure), which contributes to their underservicing in the health system. Hegemonic power relations that work through stigma have had far-reaching and diverse implications that operate upon individuals by way of negative constructions that naturalize cultural supremacies, but can be influenced when stigma is intervened upon at intrapersonal, interpersonal, and contextual levels.

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APPENDIX A RECRUITMENT POSTERS

RESEARCH OPPORTUNITY

DO YOU IDENTIFY AS A MEMBER OF THE 2SLGBTQ COMMUNITIES?

HAVE YOU BEEN USING THE NOVA SCOTIA HEALTH SYSTEM FOR AT LEAST TWO YEARS?

I WANT TO HEAR FROM YOU!

REB File #1026178
Version 3
November 28, 2020

**If you or someone you may know might be interested,
please contact me or visit my website for more information:**

Jennifer Lane, Registered Nurse
Principal Investigator
(902) 489-7410
email: jesearle@dal.ca
website: https://2slgbtqhealthns.weebly.com

Jennifer is a PhD Candidate in the School of Nursing at Dalhousie University and is conducting this research as a partial requirement of her doctoral program.

Participants will receive a token of appreciation for their contribution to this study.

Lauréats KILLAM Laureates
nova scotia health
DALHOUSIE UNIVERSITY
Canadian Nurses Foundation
Fondation des infirmières et infirmiers du Canada

RESEARCH OPPORTUNITY

ARE YOU A HEALTH CARE PROVIDER/WORKER?

HAVE YOU BEEN WORKING WITHIN THE NOVA SCOTIA HEALTH SYSTEM FOR TWO YEARS?

I WANT TO HEAR FROM YOU!

REB File #1026178
Version 3
November 28, 2020

**If you or someone you may know might be interested,
please contact me or visit my website for more information:**

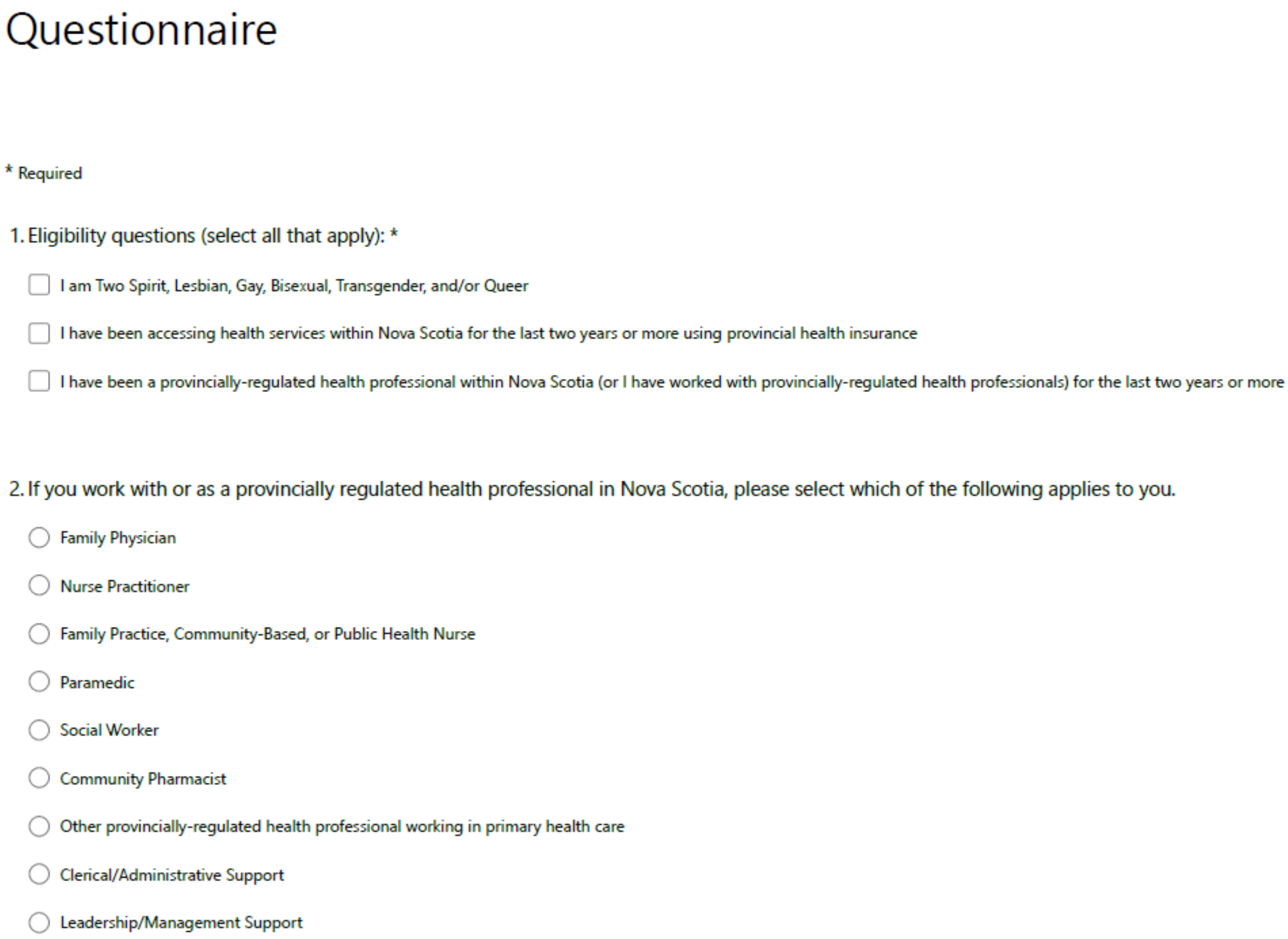
Jennifer Lane, Registered Nurse
Principal Investigator
(902) 489-7410
email: jesearle@dal.ca
website: https://2slgbtqhealthns.weebly.com//

Jennifer is a PhD Candidate in the School of Nursing at Dalhousie University and is conducting this research as a partial requirement of her doctoral program.

Participants will receive a token of appreciation for their contribution to this study.

Lauréats KILLAM Laureates
nova scotia health
DALHOUSIE UNIVERSITY
Canadian Nurses Foundation
Fondation des infirmières et infirmiers du Canada

APPENDIX B MICROSOFT FORM – RECRUITMENT QUESTIONNAIRE



Questionnaire

* Required

1. Eligibility questions (select all that apply): *

☐ I am Two Spirit, Lesbian, Gay, Bisexual, Transgender, and/or Queer

☐ I have been accessing health services within Nova Scotia for the last two years or more using provincial health insurance

☐ I have been a provincially-regulated health professional within Nova Scotia (or I have worked with provincially-regulated health professionals) for the last two years or more

2. If you work with or as a provincially regulated health professional in Nova Scotia, please select which of the following applies to you.

○ Family Physician

○ Nurse Practitioner

○ Family Practice, Community-Based, or Public Health Nurse

○ Paramedic

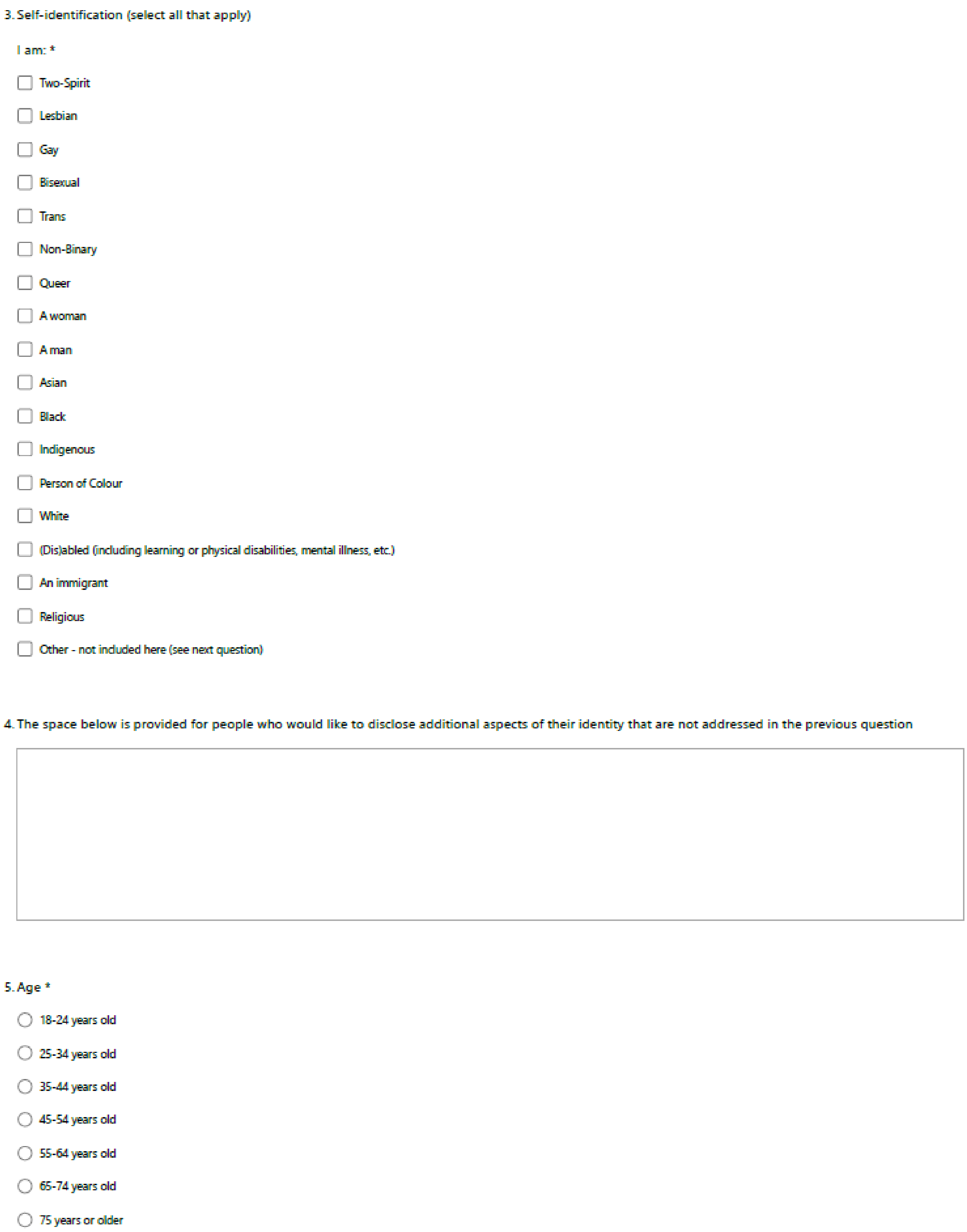
○ Social Worker

○ Community Pharmacist

○ Other provincially-regulated health professional working in primary health care

○ Clerical/Administrative Support

○ Leadership/Management Support



3. Self-identification (select all that apply)

I am: *

☐ Two-Spirit

☐ Lesbian

☐ Gay

☐ Bisexual

☐ Trans

☐ Non-Binary

☐ Queer

☐ A woman

☐ A man

☐ Asian

☐ Black

☐ Indigenous

☐ Person of Colour

☐ White

☐ (Dis)abled (including learning or physical disabilities, mental illness, etc.)

☐ An immigrant

☐ Religious

☐ Other - not included here (see next question)

4. The space below is provided for people who would like to disclose additional aspects of their identity that are not addressed in the previous question

5. Age *

○ 18-24 years old

○ 25-34 years old

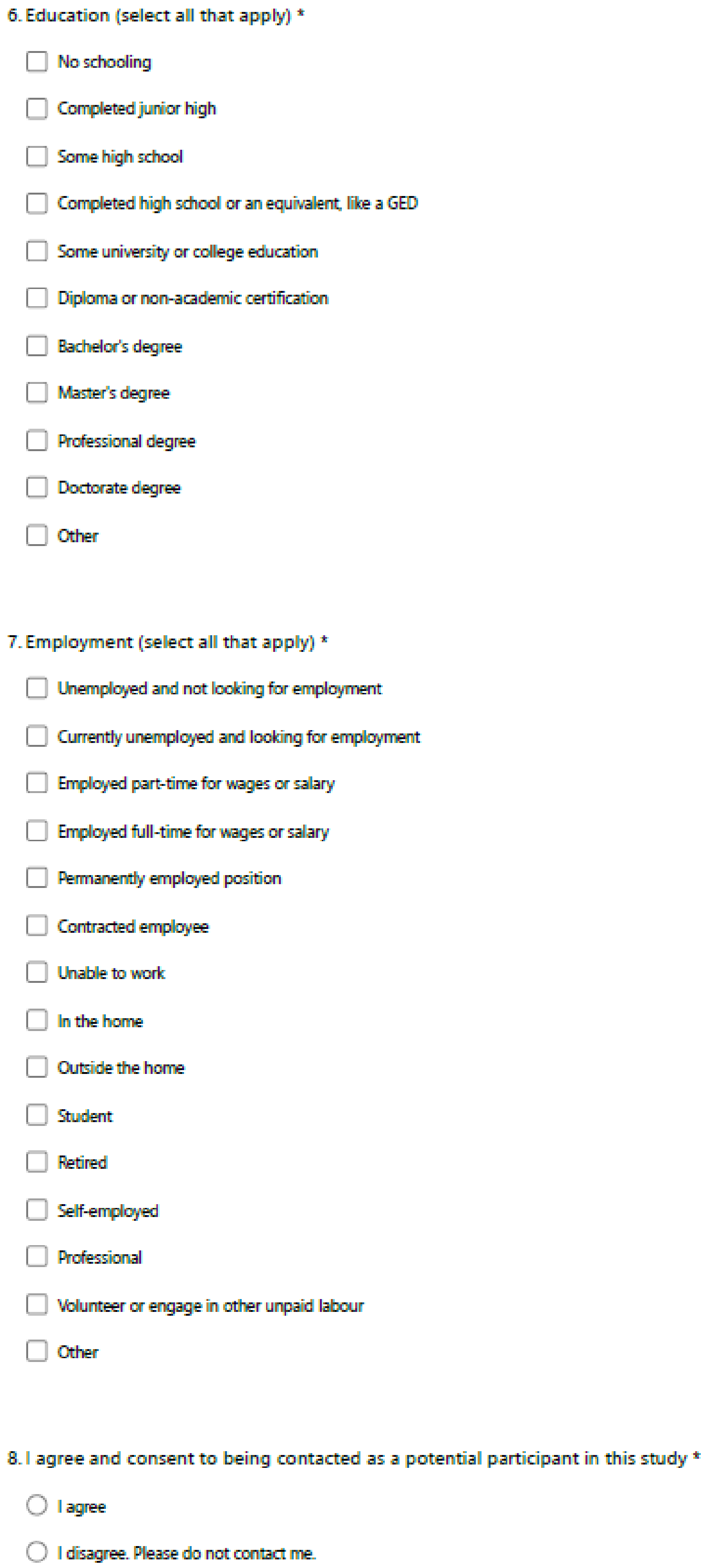
○ 35-44 years old

○ 45-54 years old

○ 55-64 years old

○ 65-74 years old

○ 75 years or older



6. Education (select all that apply) *

☐ No schooling

☐ Completed junior high

☐ Some high school

☐ Completed high school or an equivalent, like a GED

☐ Some university or college education

☐ Diploma or non-academic certification

☐ Bachelor's degree

☐ Master's degree

☐ Professional degree

☐ Doctorate degree

☐ Other

7. Employment (select all that apply) *

☐ Unemployed and not looking for employment

☐ Currently unemployed and looking for employment

☐ Employed part-time for wages or salary

☐ Employed full-time for wages or salary

☐ Permanently employed position

☐ Contracted employee

☐ Unable to work

☐ In the home

☐ Outside the home

☐ Student

☐ Retired

☐ Self-employed

☐ Professional

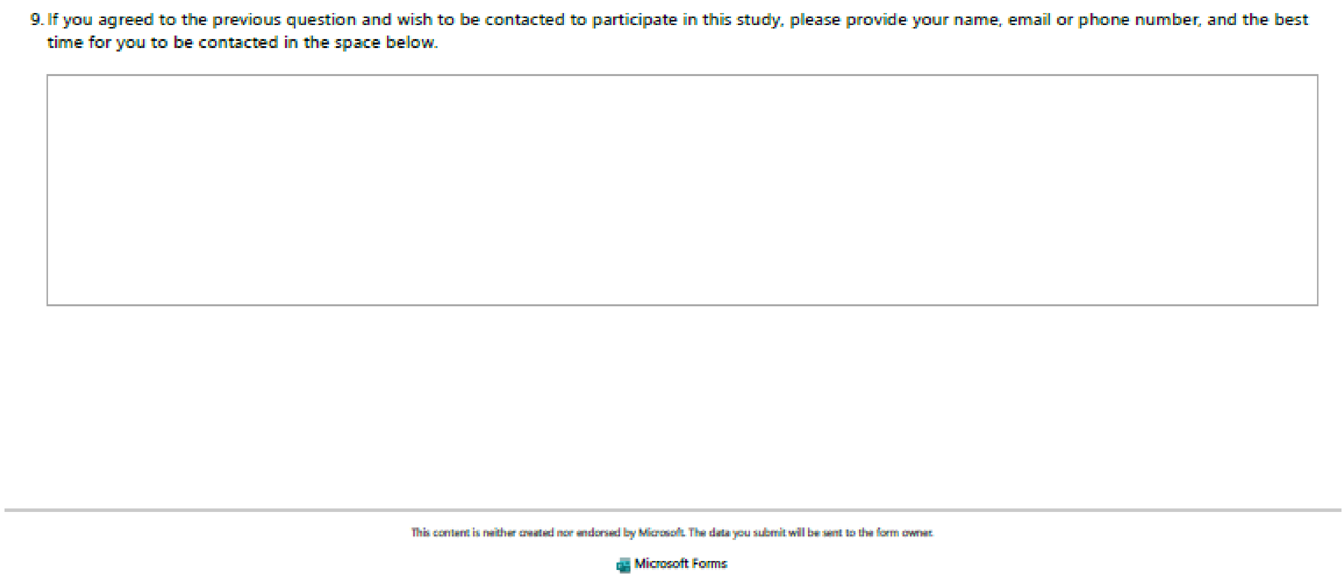
☐ Volunteer or engage in other unpaid labour

☐ Other

8. I agree and consent to being contacted as a potential participant in this study *

○ I agree

○ I disagree. Please do not contact me.



9. If you agreed to the previous question and wish to be contacted to participate in this study, please provide your name, email or phone number, and the best time for you to be contacted in the space below.

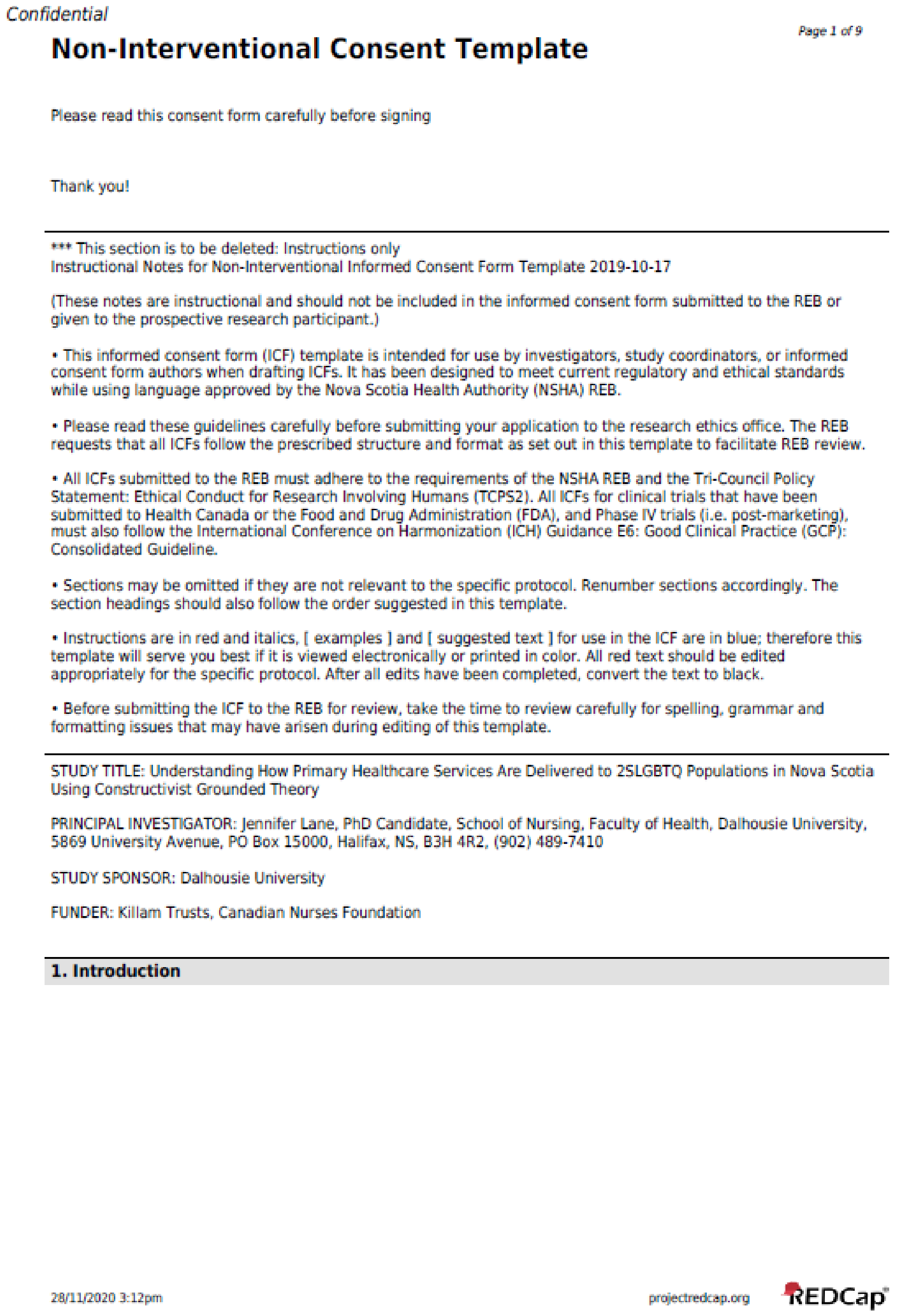
This content is neither created nor endorsed by Microsoft. The data you submit will be sent to the form owner.

APPENDIX C SAMPLE POPULATION – CHARACTERISTICS BY SUBPOPULATION

	Subgroups			
Category	HSUs	QHSPs	non-QHSPs	***Total***
Two Spirit	1	1		**2**
Lesbian	2	2		**4**
Gay	1	2		**3**
Bisexual	1	2		**3**
Trans	1	2		**3**
Queer	4	4		**8**
Non-Binary	3	1		**4**
Asexual	1	0		**1**
Grey Asexual	1	0		**1**
Pansexual	2	1		**3**
Demisexual	2	0		**2**
Boi	1	0		**1**
Woman	5	4	9	**18**
Man	1	4	1	**6**
Cisgender	5	7	10	**22**
Heterosexual	1		10	**10**
Indigenous	3	1	0	**4**
Black	4	1	0	**5**
White	6	5	8	**19**
Asian	0	2	1	**3**
"Mixed-race"	3	1	0	**4**
Other ethnic minority	0	0	2	**2**
Immigrant	1	1	1	**3**
Second/ third generation Immigrant	0	2	1	**3**
Acadian	0	1	1	**2**
(Dis)Abled	5	1	0	**6**
Western Zone	2	2	3	**7**
Eastern Zone	0	2	0	**2**
Northern Zone	1	0	1	**2**
Central Zone	7	5	5	**17**
Province-wide		1	1	**2**
18-24 years old	1	0	0	**1**
25-34 years old	5	3	2	**10**
35-44 years old	1	3	3	**7**
45-54 years old	2	1	4	**7**
55-64 years old	0	0	1	**1**
65-74 years old	1	1	0	**2**
Family Physician		3	2	**5**
Nurse Practitioner		2	1	**3**

Registered Nurse		3	2	**5**
Pharmacist		0	1	**1**
Social Worker		1	1	**2**
Paramedic		1	1	**2**
Manager/ Leadership		1	2	**3**
Clerical/ Administration		0	1	**1**

APPENDIX D INFORMED CONSENT FORM



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Non-Interventional Consent Template

Please read this consent form carefully before signing

Thank you!

*** This section is to be deleted: Instructions only
Instructional Notes for Non-Interventional Informed Consent Form Template 2019-10-17

(These notes are instructional and should not be included in the informed consent form submitted to the REB or given to the prospective research participant.)

- This informed consent form (ICF) template is intended for use by investigators, study coordinators, or informed consent form authors when drafting ICFs. It has been designed to meet current regulatory and ethical standards while using language approved by the Nova Scotia Health Authority (NSHA) REB.

- Please read these guidelines carefully before submitting your application to the research ethics office. The REB requests that all ICFs follow the prescribed structure and format as set out in this template to facilitate REB review.

- All ICFs submitted to the REB must adhere to the requirements of the NSHA REB and the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2). All ICFs for clinical trials that have been submitted to Health Canada or the Food and Drug Administration (FDA), and Phase IV trials (i.e. post-marketing), must also follow the International Conference on Harmonization (ICH) Guidance E6: Good Clinical Practice (GCP): Consolidated Guideline.

- Sections may be omitted if they are not relevant to the specific protocol. Renumber sections accordingly. The section headings should also follow the order suggested in this template.

- Instructions are in red and italics, [examples] and [suggested text] for use in the ICF are in blue; therefore this template will serve you best if it is viewed electronically or printed in color. All red text should be edited appropriately for the specific protocol. After all edits have been completed, convert the text to black.

- Before submitting the ICF to the REB for review, take the time to review carefully for spelling, grammar and formatting issues that may have arisen during editing of this template.

STUDY TITLE: Understanding How Primary Healthcare Services Are Delivered to 2SLGBTQ Populations in Nova Scotia Using Constructivist Grounded Theory

PRINCIPAL INVESTIGATOR: Jennifer Lane, PhD Candidate, School of Nursing, Faculty of Health, Dalhousie University, 5869 University Avenue, PO Box 15000, Halifax, NS, B3H 4R2, (902) 489-7410

STUDY SPONSOR: Dalhousie University

FUNDER: Killam Trusts, Canadian Nurses Foundation

1. Introduction

28/11/2020 3:12pm

projectredcap.org REDCap

You are invited to take part in a research project called "Understanding How Primary Healthcare Services Are Delivered to 2SLGBTQ Populations in Nova Scotia Using Constructivist Grounded Theory". This study is being done by Jennifer Lane, a PhD Candidate in the Faculty of Health at Dalhousie University in Halifax, Nova Scotia. This is a doctoral research project and it is being supervised by Dr. Ingrid Waldron. The information below tells you about the research and what you will be asked to do. It also tells you about benefits, risks, inconveniences, or discomforts you might expect to experience. Taking part in the research is entirely your choice and you can decide to leave the study at any time without the need to provide a reason.
Please ask for clarification on anything you would like to know more about or do not understand. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.
The researcher will:
Discuss the study with you Answer your questions Be available during the study to deal with problems and answer questions You are being asked to consider participating in this study because you are a health service provider who has practiced for at least 2 years in the Nova Scotia health system (or are a support worker for those who do) and/or you identify as a member of the Two-Spirit, Lesbian, Gay, Bisexual, Transgender, and Queer (2SLGBTQ) communities who has been accessing health services in the Nova Scotia health system for at least two years. This project is interested in exploring how primary health services are delivered to 2SLGBTQ populations in Nova Scotia. Sexual orientation and gender, as well as race, ethnicity, different abilities, age, class, and religion (among all other social identities) are recognized as valuable to understanding what kind of educational opportunities are needed to bring about the change that is necessary to better meet the health needs of diverse 2SLGBTQ populations.

This study is voluntary. I do not have to take part or can leave the study at any time and my usual health care and/or employment will not be affected.

○ True
○ False

TRUE: You do not have to take part in this study

○ Continue
○ No thanks, I am not interested

2. Why Is There A Need For This Study?

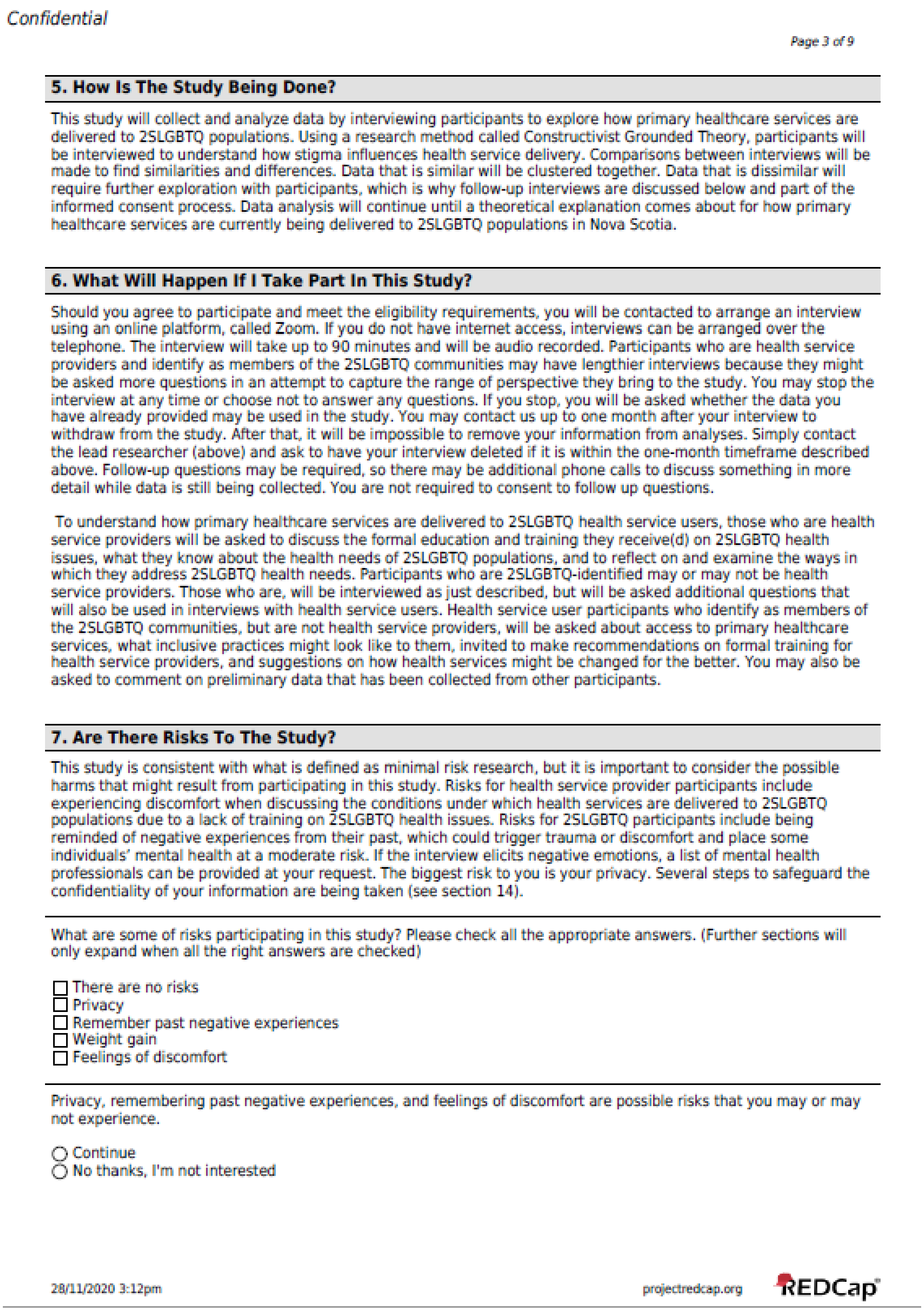
This project is informed by the researcher's lived experience as a registered nurse and Lesbian who recognizes that there is a lack of information regarding education for healthcare professionals to interact positively and decrease stigma for 2SLGBTQ populations. The purpose of the research is to explore health services as they relate to the health needs of 2SLGBTQ health service users. This study is important to understand what information is needed to develop better training for health service providers and enhance the experiences of 2SLGBTQ populations within the NS healthcare system.

3. How Long Will I Be In The Study?

The length of this study for participants is about 6 months from the time of recruitment to the end of data collection. The entire study is expected to take about one year and the results should be known in 18 months.

4. How Many People Will Take Place In This Study?

It is anticipated that about 25 people will participate in this study throughout Nova Scotia.



5. How Is The Study Being Done?

This study will collect and analyze data by interviewing participants to explore how primary healthcare services are delivered to 2SLGBTQ populations. Using a research method called Constructivist Grounded Theory, participants will be interviewed to understand how stigma influences health service delivery. Comparisons between interviews will be made to find similarities and differences. Data that is similar will be clustered together. Data that is dissimilar will require further exploration with participants, which is why follow-up interviews are discussed below and part of the informed consent process. Data analysis will continue until a theoretical explanation comes about for how primary healthcare services are currently being delivered to 2SLGBTQ populations in Nova Scotia.

6. What Will Happen If I Take Part In This Study?

Should you agree to participate and meet the eligibility requirements, you will be contacted to arrange an interview using an online platform, called Zoom. If you do not have internet access, interviews can be arranged over the telephone. The interview will take up to 90 minutes and will be audio recorded. Participants who are health service providers and identify as members of the 2SLGBTQ communities may have lengthier interviews because they might be asked more questions in an attempt to capture the range of perspective they bring to the study. You may stop the interview at any time or choose not to answer any questions. If you stop, you will be asked whether the data you have already provided may be used in the study. You may contact us up to one month after your interview to withdraw from the study. After that, it will be impossible to remove your information from analyses. Simply contact the lead researcher (above) and ask to have your interview deleted if it is within the one-month timeframe described above. Follow-up questions may be required, so there may be additional phone calls to discuss something in more detail while data is still being collected. You are not required to consent to follow up questions.

To understand how primary healthcare services are delivered to 2SLGBTQ health service users, those who are health service providers will be asked to discuss the formal education and training they receive(d) on 2SLGBTQ health issues, what they know about the health needs of 2SLGBTQ populations, and to reflect on and examine the ways in which they address 2SLGBTQ health needs. Participants who are 2SLGBTQ-identified may or may not be health service providers. Those who are, will be interviewed as just described, but will be asked additional questions that will also be used in interviews with health service users. Health service user participants who identify as members of the 2SLGBTQ communities, but are not health service providers, will be asked about access to primary healthcare services, what inclusive practices might look like to them, invited to make recommendations on formal training for health service providers, and suggestions on how health services might be changed for the better. You may also be asked to comment on preliminary data that has been collected from other participants.

7. Are There Risks To The Study?

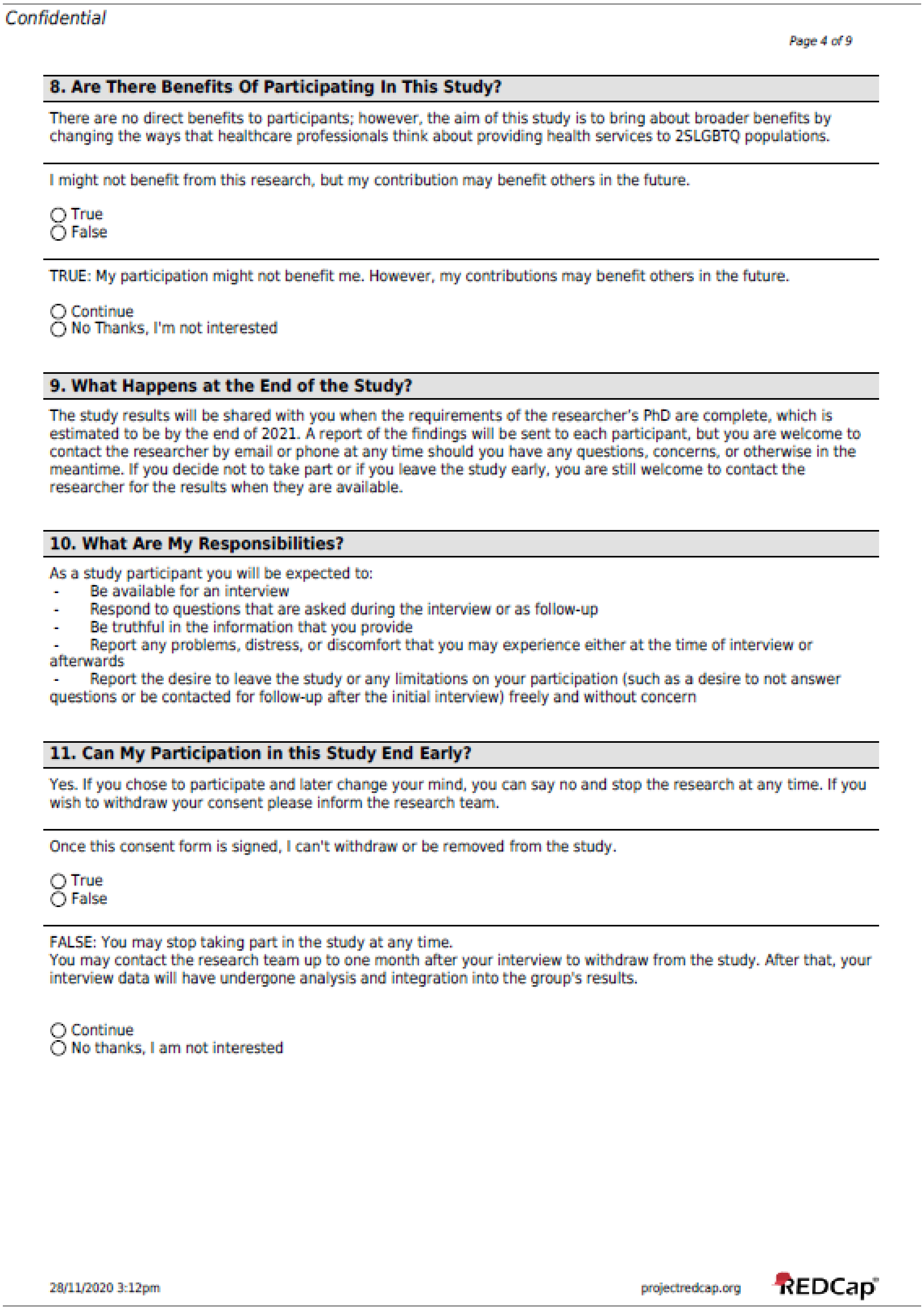
This study is consistent with what is defined as minimal risk research, but it is important to consider the possible harms that might result from participating in this study. Risks for health service provider participants include experiencing discomfort when discussing the conditions under which health services are delivered to 2SLGBTQ populations due to a lack of training on 2SLGBTQ health issues. Risks for 2SLGBTQ participants include being reminded of negative experiences from their past, which could trigger trauma or discomfort and place some individuals' mental health at a moderate risk. If the interview elicits negative emotions, a list of mental health professionals can be provided at your request. The biggest risk to you is your privacy. Several steps to safeguard the confidentiality of your information are being taken (see section 14).

What are some of risks participating in this study? Please check all the appropriate answers. (Further sections will only expand when all the right answers are checked)

☐ There are no risks
☐ Privacy
☐ Remember past negative experiences
☐ Weight gain
☐ Feelings of discomfort

Privacy, remembering past negative experiences, and feelings of discomfort are possible risks that you may or may not experience.

○ Continue
○ No thanks, I'm not interested



8. Are There Benefits Of Participating In This Study?

There are no direct benefits to participants; however, the aim of this study is to bring about broader benefits by changing the ways that healthcare professionals think about providing health services to 2SLGBTQ populations.

I might not benefit from this research, but my contribution may benefit others in the future.

○ True
○ False

TRUE: My participation might not benefit me. However, my contributions may benefit others in the future.

○ Continue
○ No Thanks, I'm not interested

9. What Happens at the End of the Study?

The study results will be shared with you when the requirements of the researcher's PhD are complete, which is estimated to be by the end of 2021. A report of the findings will be sent to each participant, but you are welcome to contact the researcher by email or phone at any time should you have any questions, concerns, or otherwise in the meantime. If you decide not to take part or if you leave the study early, you are still welcome to contact the researcher for the results when they are available.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Be available for an interview
- Respond to questions that are asked during the interview or as follow-up
- Be truthful in the information that you provide
- Report any problems, distress, or discomfort that you may experience either at the time of interview or afterwards
- Report the desire to leave the study or any limitations on your participation (such as a desire to not answer questions or be contacted for follow-up after the initial interview) freely and without concern

11. Can My Participation in this Study End Early?

Yes. If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the research team.

Once this consent form is signed, I can't withdraw or be removed from the study.

○ True
○ False

FALSE: You may stop taking part in the study at any time.
You may contact the research team up to one month after your interview to withdraw from the study. After that, your interview data will have undergone analysis and integration into the group's results.

○ Continue
○ No thanks, I am not interested

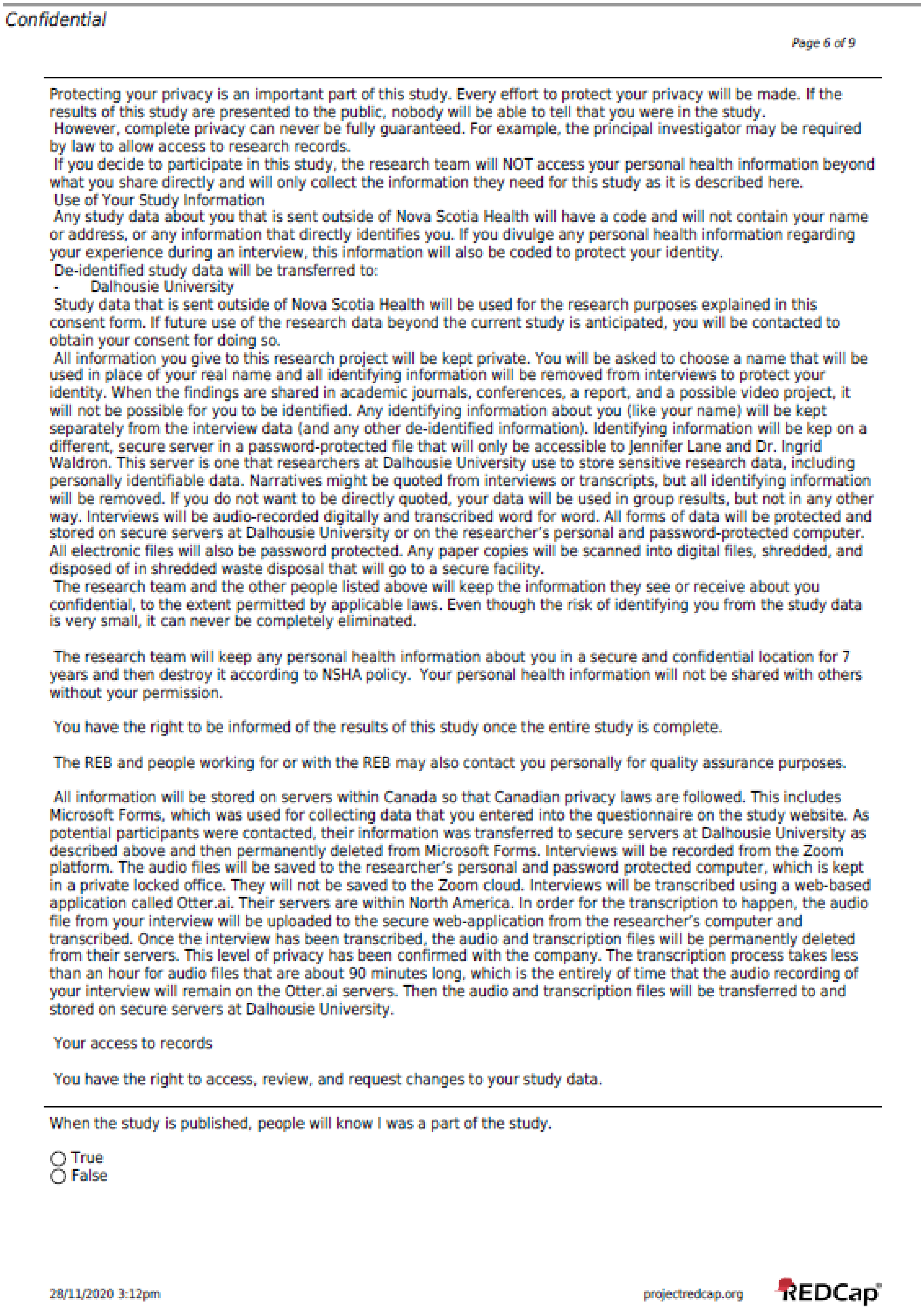
12. What About New Information?

You will be told about any other new information that might affect your willingness to stay in the study and will be asked whether you wish to continue taking part in the study or not.

13. Will It Cost Me Anything?

There are no out-of-pocket expenses required to participate in this study.
Compensation
Honoraria will be offered in the form of $25 VISA gift cards. If you wish to withdraw from the study and have already received the honorarium, you will not be expected to return it.
Research Related Injury
If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the principal investigator, the research staff, the study sponsor or involved institutions from their legal and professional responsibilities.

14. What About My Privacy and Confidentiality



Confidential

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Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, nobody will be able to tell that you were in the study.
However, complete privacy can never be fully guaranteed. For example, the principal investigator may be required by law to allow access to research records.
If you decide to participate in this study, the research team will NOT access your personal health information beyond what you share directly and will only collect the information they need for this study as it is described here.
Use of Your Study Information
Any study data about you that is sent outside of Nova Scotia Health will have a code and will not contain your name or address, or any information that directly identifies you. If you divulge any personal health information regarding your experience during an interview, this information will also be coded to protect your identity.
De-identified study data will be transferred to:

- Dalhousie University

Study data that is sent outside of Nova Scotia Health will be used for the research purposes explained in this consent form. If future use of the research data beyond the current study is anticipated, you will be contacted to obtain your consent for doing so.
All information you give to this research project will be kept private. You will be asked to choose a name that will be used in place of your real name and all identifying information will be removed from interviews to protect your identity. When the findings are shared in academic journals, conferences, a report, and a possible video project, it will not be possible for you to be identified. Any identifying information about you (like your name) will be kept separately from the interview data (and any other de-identified information). Identifying information will be kep on a different, secure server in a password-protected file that will only be accessible to Jennifer Lane and Dr. Ingrid Waldron. This server is one that researchers at Dalhousie University use to store sensitive research data, including personally identifiable data. Narratives might be quoted from interviews or transcripts, but all identifying information will be removed. If you do not want to be directly quoted, your data will be used in group results, but not in any other way. Interviews will be audio-recorded digitally and transcribed word for word. All forms of data will be protected and stored on secure servers at Dalhousie University or on the researcher's personal and password-protected computer. All electronic files will also be password protected. Any paper copies will be scanned into digital files, shredded, and disposed of in shredded waste disposal that will go to a secure facility.
The research team and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

The research team will keep any personal health information about you in a secure and confidential location for 7 years and then destroy it according to NSHA policy. Your personal health information will not be shared with others without your permission.

You have the right to be informed of the results of this study once the entire study is complete.

The REB and people working for or with the REB may also contact you personally for quality assurance purposes.

All information will be stored on servers within Canada so that Canadian privacy laws are followed. This includes Microsoft Forms, which was used for collecting data that you entered into the questionnaire on the study website. As potential participants were contacted, their information was transferred to secure servers at Dalhousie University as described above and then permanently deleted from Microsoft Forms. Interviews will be recorded from the Zoom platform. The audio files will be saved to the researcher's personal and password protected computer, which is kept in a private locked office. They will not be saved to the Zoom cloud. Interviews will be transcribed using a web-based application called Otter.ai. Their servers are within North America. In order for the transcription to happen, the audio file from your interview will be uploaded to the secure web-application from the researcher's computer and transcribed. Once the interview has been transcribed, the audio and transcription files will be permanently deleted from their servers. This level of privacy has been confirmed with the company. The transcription process takes less than an hour for audio files that are about 90 minutes long, which is the entirely of time that the audio recording of your interview will remain on the Otter.ai servers. Then the audio and transcription files will be transferred to and stored on secure servers at Dalhousie University.

Your access to records

You have the right to access, review, and request changes to your study data.

When the study is published, people will know I was a part of the study.

○ True
○ False

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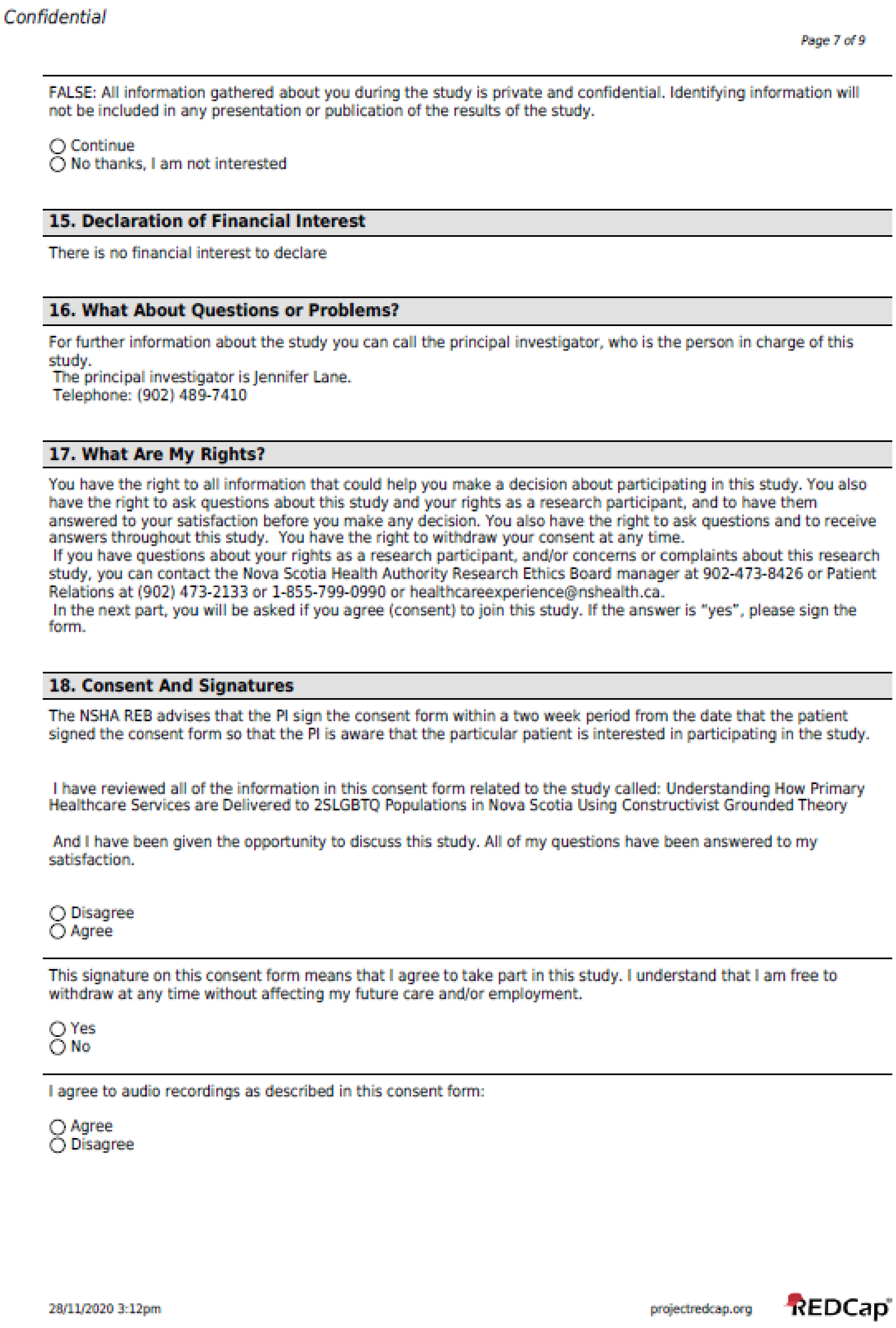


FALSE: All information gathered about you during the study is private and confidential. Identifying information will not be included in any presentation or publication of the results of the study.

○ Continue
○ No thanks, I am not interested

15. Declaration of Financial Interest

There is no financial interest to declare

16. What About Questions or Problems?

For further information about the study you can call the principal investigator, who is the person in charge of this study.
The principal investigator is Jennifer Lane.
Telephone: (902) 489-7410

17. What Are My Rights?

You have the right to all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision. You also have the right to ask questions and to receive answers throughout this study. You have the right to withdraw your consent at any time.
If you have questions about your rights as a research participant, and/or concerns or complaints about this research study, you can contact the Nova Scotia Health Authority Research Ethics Board manager at 902-473-8426 or Patient Relations at (902) 473-2133 or 1-855-799-0990 or healthcareexperience@nshealth.ca.
In the next part, you will be asked if you agree (consent) to join this study. If the answer is "yes", please sign the form.

18. Consent And Signatures

The NSHA REB advises that the PI sign the consent form within a two week period from the date that the patient signed the consent form so that the PI is aware that the particular patient is interested in participating in the study.

I have reviewed all of the information in this consent form related to the study called: Understanding How Primary Healthcare Services are Delivered to 2SLGBTQ Populations in Nova Scotia Using Constructivist Grounded Theory

And I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

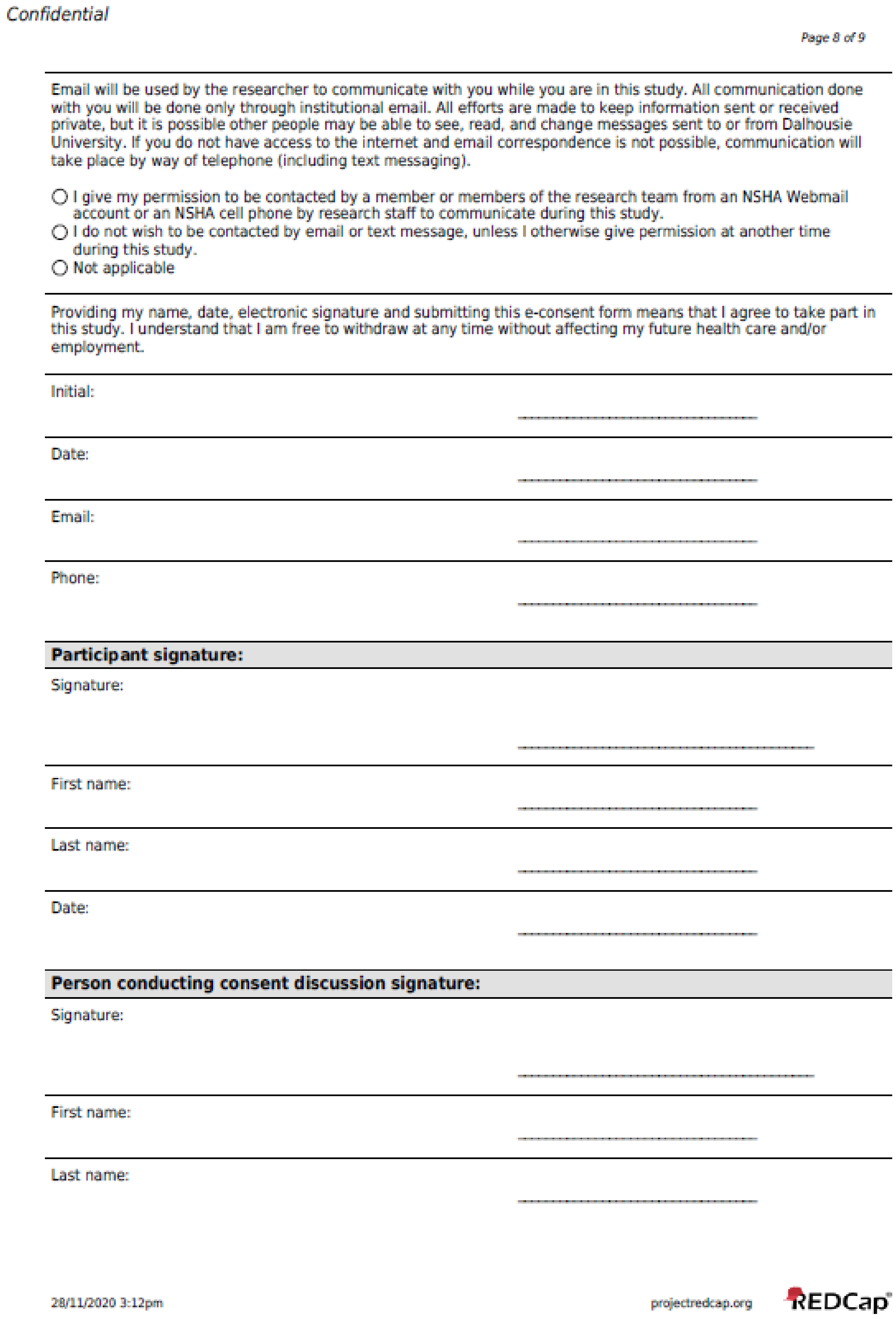
○ Disagree
○ Agree

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my future care and/or employment.

○ Yes
○ No

I agree to audio recordings as described in this consent form:

○ Agree
○ Disagree



Confidential

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Email will be used by the researcher to communicate with you while you are in this study. All communication done with you will be done only through institutional email. All efforts are made to keep information sent or received private, but it is possible other people may be able to see, read, and change messages sent to or from Dalhousie University. If you do not have access to the internet and email correspondence is not possible, communication will take place by way of telephone (including text messaging).

○ I give my permission to be contacted by a member or members of the research team from an NSHA Webmail account or an NSHA cell phone by research staff to communicate during this study.
○ I do not wish to be contacted by email or text message, unless I otherwise give permission at another time during this study.
○ Not applicable

Providing my name, date, electronic signature and submitting this e-consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my future health care and/or employment.

Initial: ______________________

Date: ______________________

Email: ______________________

Phone: ______________________

Participant signature:

Signature: ____________________________

First name: ______________________

Last name: ______________________

Date: ______________________

Person conducting consent discussion signature:

Signature: ____________________________

First name: ______________________

Last name: ______________________

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Date: ______________________

Principal Investigator signature:

[Attachment: "nova scotia health logo.jpg"]

APPENDIX E INTERVIEW GUIDES

There are three parts to this appendix. Part one is the beginning/introduction that did not change during data collection. Part two is the semi-structured questions asked early in the data collection process. Part three is the semi-structured questions asked in an interview later in the data collection process to illustrate how the guide changed for the purpose of theoretical sampling.

PART ONE

Semi-Structured Interview Guide

(adapted from Charmaz, 2014)

Beginning (prior to recording)

- Introduction, express gratitude for participating in the study, and offer honorarium
- Situate self; disclose that I am a Lesbian and nurse and what I feel this brings to the study
- Ask for pseudonym for confidentiality purposes
- Review informed consent, its signature, whether they are amenable to follow-up questions being asked at a later time, and if there are any questions about the informed consent process
- Confirm that 90 minutes is an acceptable length for an interview (if not, determine what is)
- Explain that the interview can stop at any time
- Confirm demographic information collected during recruitment process (and professional role for HSPs)
- Remind to avoid giving information that could reveal identity during interview
- Confirm consent to digital recording and begin recording

Introduction (after recording begins)

I have some questions that will help guide us through this interview. They are intended to explore how you experience primary health services in Nova Scotia and the conditions under which they are delivered. Primary health care is where most Nova Scotians experience the majority of their health care. It includes family doctors' offices, community health clinics, pharmacies, collaborative health centres, and even in the homes of Nova Scotians. Nova Scotia Health defines primary health care as "an approach to health that acknowledges the [socio-structural] determinants of health and the importance of healthy individuals and communities. It focuses on factors such as where people live, the state of the environment, education and income levels, genetics, and relationships with friends and family" (PHC NSHA, 2017, p. 3-4). In Nova Scotia, I have noticed that there is little attention given to the 2SLGBTQ communities within the context of primary health care, so I am interested in gaining insight into what changes might be made so that their population-specific health needs can be better addressed. I am also interested in exploring how identity influences health service delivery, as we know that social identities influence the way we interact socially. Remember that you do not have to respond to questions you do not wish to answer, and we can stop the interview at any time. Are there any questions or concerns that I can address before we start the interview itself?

PART TWO

Interview Questions – ***Early data collection***

1. Can you describe for me how you identify yourself in terms of your sexual orientation and/or gender? Can you tell me about the other parts of your identity that you feel are important to who you are as a person?

   Prompt:

   - What do you think about how the groups that you belong to are represented?

2. How do you think being a **[insert answer from previous]** has influenced the way you interact with others in healthcare settings?

Prompt:

- If there have been any assumptions or stereotypes that came into play for you within healthcare settings, what were they?
    - Where do you think assumptions and stereotypes like that come from?
- Tell me about a time that your identity became relevant during an interaction in a healthcare setting.

3. Is there anything that gets in the way of delivering health service to diverse 2SLGBTQ populations? What about things that help?

   Prompts:

   - Can you recall any specific examples where you were either providing or accessing health services and felt it went well?
   - What about one that didn't go so well?
       - What would you do (HSPs) / want done (HSUs) differently?
       - How do you think that would change the outcome?
   - What do you think should be considered when health services are being delivered to a diverse 2SLGBTQ patient?
       - How do you know that a person is diverse?
       - How do you deliver health services that account for identity-related health needs of patients and populations, such as those that originate from sexual orientation, gender, race, ethnicity, socioeconomic status, age, culture, citizenship, (dis)ability, language use/mastery, and religious affiliation?

4. What do you think makes patients from diverse 2SLGBTQ populations feel comfortable to share concerns about their health? Do you feel this is happening in healthcare settings?

Prompts:

  - In order to make this happen, what sorts of changes do you think would have to take place?
  - How might this improve the health care experiences of diverse 2SLGBTQ populations?
  - How might this improve how the health system functions for diverse 2SLGBTQ populations?

5. Describe for me what you think the patient-provider relationship should be like.

   Prompts:

   - What, if any, experiences might you have to share that would give me context on why you feel the patient-provider relationship should look like this?
   - How might your identity influence how you interact within patient-provider relationships? *Ask HSPs about their experiences as HSPs if they do not offer.*

6. What are some important health-related relationships, materials, and knowledge for diverse 2SLGBTQ populations?

   Prompts:

   - What is it about **[insert from previous]** that makes it important?
   - Tell me about a time where you recognized the importance of **[insert from previous]**.

7. What kind of learning do you feel needs to be done around diverse 2SLGBTQ populations by healthcare professionals/workers to better meet their primary health care needs?

   Prompts:

    - What is it about this learning that you feel would better prepare healthcare professionals/workers to meet the health needs of diverse 2SLGBTQ populations?
    - Do you have any ideas about how this learning might happen?
    - Can you tell me about a time where you saw this kind of learning happen?
8. If you could change anything about resources or supports that are relevant to the needs of diverse 2SLGBTQ populations, what would those changes look like?
    a. How would you go about making those changes?
    b. Tell me about what you would need to do this.

Conclusion: Thank you for participating in this study and sharing your experiences with me.

PART THREE

Interview Questions – ***Late in data collection***

1. Can you describe for me how you identify yourself in terms of your sexual orientation and gender?
2. I'm hoping you can tell me a bit about some other parts of your social identity. I see identity as way to describe relationships that we have with society. I'm a Lesbian Woman, but I'm also White. Because I'm a White person, the world perceives me in a way that gives me more opportunities than many racialized folks. So, it might be easier for me as a White sexual minority than a sexual minority who is also a POC. Can you tell me about how you identify yourself beyond being a **[response to question 1]**.

    Prompt:

    - What are some of the labels you've tried on over the years?
3. How were you brought up thinking about 2SLGBTQ people by your family, in school, or during any other part of your upbringing?

Prompt:

- Where did you grow up?

4. Can you tell me a bit about the role you take within the primary health care system in NS?

   Prompt:

   - How do 2SLGBTQ populations and primary health care overlap?
   - What kind of formal education have you been given on those things?
     - What are some things you do to make 2SLGBTQ patients feel comfortable? (This can be in direct patient care, but can also be for employees, in waiting rooms, etc.)
     - What are some things that can get in the way of doing this?

5. Something that is emerging in the data from this study is that stigma plays a role in how primary health services are delivered to 2SLGBTQ populations in NS, which is certainly not a surprise, but it seems that stigma is something that needs to be worked through in order to gain access to PHC in NS. You shared how you were brought up thinking about 2SLGBTQ populations. I'm seeing that as what you learned about 2SLGBTQ populations as you grew up. I'm seeing that learning as work that was done through stigma. Not everyone who works through stigma is learning. Some are not even aware that they are working through stigma. If a patient accesses health care and the provider makes an assumption about them, this study would see that as an example of having to work through stigma in health care. The patient now has to figure out how to work through stigma to get whatever service they need from this person who's just made an assumption about them that conveys a lack of awareness and therefore a lack of safety.

   - Given all that, do you have any more to share on what working through stigma might mean to you?

        1. Do you have any specific examples within primary health care in NS?
    - There are a number of processes emerging that are being used to work through stigma.
        1. What, if anything, does working through stigma by avoiding the problem mean to you?
            a. Within the context of PHC in NS?
        2. What , if anything, does working through stigma by rocking the boat mean to you?
            a. Within the context of PHC in NS?
        3. What , if anything, does working through stigma by confronting histories mean to you?
            a. Within the context of PHC in NS?

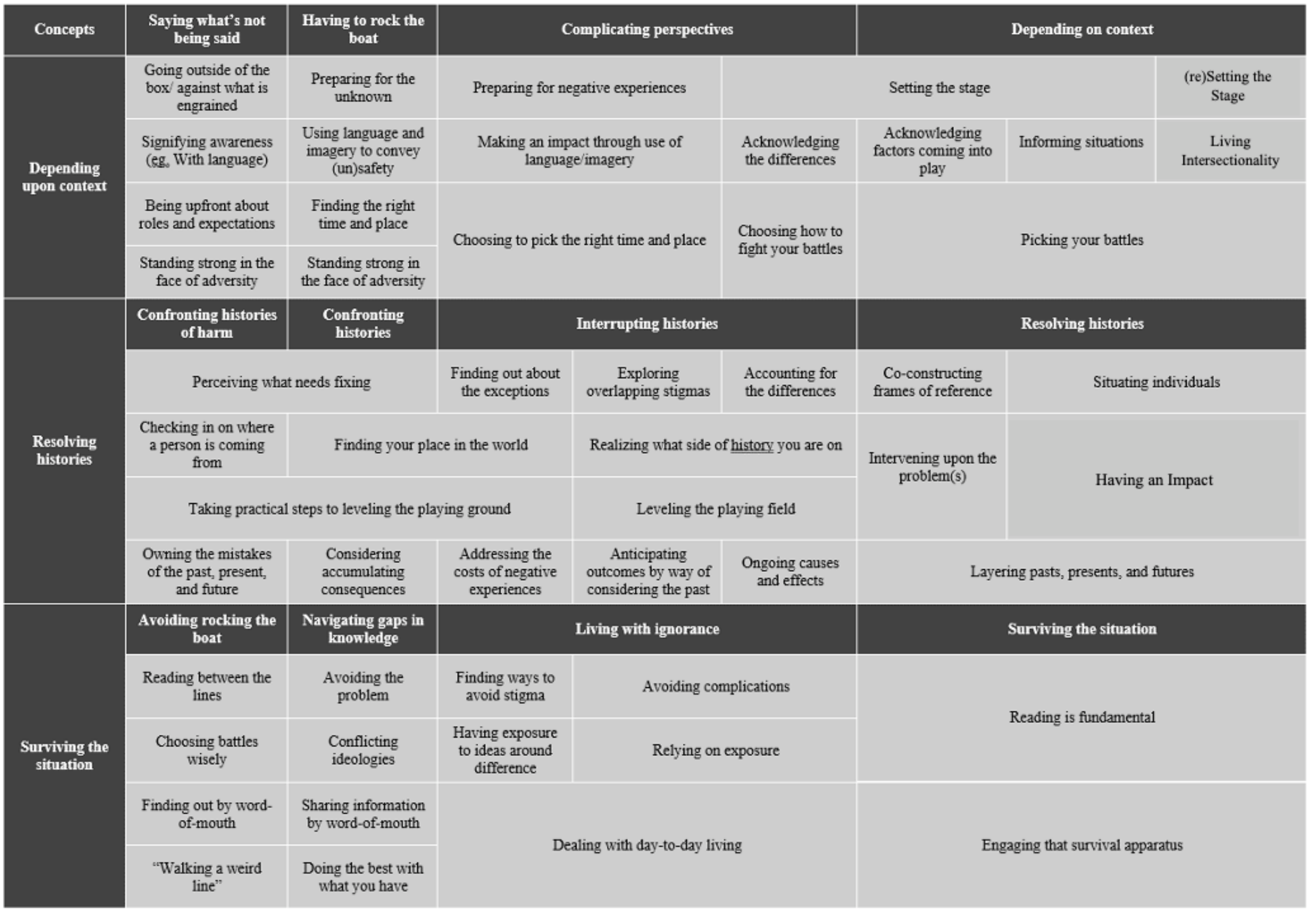
6. Is there anything I missed?

Conclusion: Thank you for participating in this study and sharing your experiences with me.

APPENDIX F OVERVIEW OF CO-CREATED CONCEPTS AND SUB CONCEPTS

Table 4

Overview of Co-created Concepts and Sub Concepts



<table>
<tr><th>Concepts</th><th>Saying what's not being said</th><th>Having to rock the boat</th><th colspan="3">Complicating perspectives</th><th colspan="3">Depending on context</th></tr>
<tr><td rowspan="4">Depending upon context</td><td>Going outside of the box/ against what is engrained</td><td>Preparing for the unknown</td><td colspan="2">Preparing for negative experiences</td><td colspan="3">Setting the stage</td><td>(re)Setting the Stage</td></tr>
<tr><td>Signifying awareness (eg. With language)</td><td>Using language and imagery to convey (un)safety</td><td colspan="2">Making an impact through use of language/imagery</td><td>Acknowledging the differences</td><td>Acknowledging factors coming into play</td><td>Informing situations</td><td>Living Intersectionality</td></tr>
<tr><td>Being upfront about roles and expectations</td><td>Finding the right time and place</td><td colspan="2" rowspan="2">Choosing to pick the right time and place</td><td rowspan="2">Choosing how to fight your battles</td><td colspan="3" rowspan="2">Picking your battles</td></tr>
<tr><td>Standing strong in the face of adversity</td><td>Standing strong in the face of adversity</td></tr>
<tr><td rowspan="5">Resolving histories</td><th>Confronting histories of harm</th><th>Confronting histories</th><th colspan="3">Interrupting histories</th><th colspan="3">Resolving histories</th></tr>
<tr><td colspan="2">Perceiving what needs fixing</td><td>Finding out about the exceptions</td><td>Exploring overlapping stigmas</td><td>Accounting for the differences</td><td>Co-constructing frames of reference</td><td colspan="2">Situating individuals</td></tr>
<tr><td>Checking in on where a person is coming from</td><td colspan="2">Finding your place in the world</td><td colspan="2">Realizing what side of history you are on</td><td rowspan="2">Intervening upon the problem(s)</td><td colspan="2" rowspan="2">Having an Impact</td></tr>
<tr><td colspan="3">Taking practical steps to leveling the playing ground</td><td colspan="2">Leveling the playing field</td></tr>
<tr><td>Owning the mistakes of the past, present, and future</td><td>Considering accumulating consequences</td><td>Addressing the costs of negative experiences</td><td>Anticipating outcomes by way of considering the past</td><td>Ongoing causes and effects</td><td colspan="3">Layering pasts, presents, and futures</td></tr>
<tr><td rowspan="5">Surviving the situation</td><th>Avoiding rocking the boat</th><th>Navigating gaps in knowledge</th><th colspan="3">Living with ignorance</th><th colspan="3">Surviving the situation</th></tr>
<tr><td>Reading between the lines</td><td>Avoiding the problem</td><td>Finding ways to avoid stigma</td><td colspan="2">Avoiding complications</td><td colspan="3" rowspan="2">Reading is fundamental</td></tr>
<tr><td>Choosing battles wisely</td><td>Conflicting ideologies</td><td>Having exposure to ideas around difference</td><td colspan="2">Relying on exposure</td></tr>
<tr><td>Finding out by word-of-mouth</td><td>Sharing information by word-of-mouth</td><td colspan="3" rowspan="2">Dealing with day-to-day living</td><td colspan="3" rowspan="2">Engaging that survival apparatus</td></tr>
<tr><td>"Walking a weird line"</td><td>Doing the best with what you have</td></tr>
</table>

APPENDIX G ENLARGED VERSION OF FIGURE 10