# “Nurses Can Do Better”: Experiences of LGBTQI+ Migrants with Nurses and Other Healthcare Professionals in Canada

by

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B.N., University of New Brunswick in Collaboration with Humber College, 2007

M.N., Ryerson University, 2013

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We acknowledge and respect the lək$^{w}$əŋən peoples on whose traditional territory the university stands, and the Songhees, Esquimalt, and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

This dissertation starts with a foreword chapter that discusses my situatedness in research which aims to understand the experiences of LGBTQI+ migrants with nurses and healthcare professionals in Canada. This is followed by an overview of literature on the experiences of LGBTQI+ people in their migration trajectories and interactions with social and healthcare professionals. I close the foreword chapter with a discussion of my methodology and research approach. I then present four manuscripts that I prepared for publication and an afterward chapter.

In the literature review, I discuss how, over the past two decades, some nurses, along with social and mental healthcare providers, child and youth workers, public service providers, and legal service professionals, in collaboration with migrants, LGBTQI+ people, or those at the intersection of identities, have strived to advance safe and affirming spaces for LGBTQI+ migrants. Despite the work of these scholars, practitioners, and activists, some nurses continue to have a limited understanding of the experiences of LGBTQI+ migrants in the Canadian context, and LGBTQI+ migrants continue to have troubling experiences with nurses. For this reason, the following question undergirds this dissertation: What have been the experiences of LGBTQI+ migrants in their interactions with nurses and other healthcare professionals (NHCPs) in Canada? Within my dissertation, I analyze LGBTQI+ migrants' encounters with NHCPs by applying a Gadamerian hermeneutic approach with intersectionality as an analytical lens. Utilizing this approach, I conducted 18 semi-structured, in-depth, individual interviews. Two groups of individuals participated in this study: (a) 16 LGBTQI+ migrants who received care from nurses and other healthcare professionals in Canada; and, (b) five nurses or nursing students who experienced, observed, heard, or witnessed the provision of nursing care to LGBTQI+ migrants.

Of the latter, three also identified as LGBTQI+ migrants. Three nurses identified as registered nurses, one nurse identified as a registered practical nurse (also known as licensed practical nurse in some provinces) as well as a student in a nursing degree program, and one nurse identified as an educator. Approaching analysis from an intersectional lens, I observed how LGBTQI+ migrants' experiences were shaped by considerations of physical, mental, and spiritual well-being, which intertwined with race, ethnicity, migration status, sexual orientation, gender identity, and gender expression. Furthermore, I found that migration status added another layer of complexity to the marginalization of LGBTQI+ people, which required intentional allyship from nurses.

Chapter two consists of the first manuscript, "Gadamerian Hermeneutics with Intersectionality as an Analytical Lens," in which I provide an account of the methodological research approach to understand experiences of underserved people, namely LGBTQI+ migrants. Chapter three includes the second manuscript, "Experiences of LGBTQI+ Migrants with Nurses and Other Healthcare Professionals in Canada," in which it becomes evident that LGBTQI+ migrants' experiences encompassed both challenges and supportive care in their encounters with nurses and other healthcare professionals. With attention to micro, meso, and macro health policies, the informants identified that feeling inferior to and unacknowledged by NHCPs often created challenges for them in navigating the healthcare system. This leads to the fourth chapter, titled "'If You Can Just Break the Stigma Around It': LGBTQI+ Migrants' Experiences of Stigma and Mental Health." In this manuscript, I illustrate the multiple forms of stigma that negatively affected LGBTQI+ migrants' mental health. Here, three themes are discussed: (a) the intersectional experience of stigma, (b) stigma related to fear and safety, and (c) participants' calls for affirming practices that promote inclusive health services and supports. Given the

contextual utility of these findings, I build on existing literature which corroborate that changes in nursing education, practice, and policy need to occur to provide diverse LGBTQI+ migrants with care that addresses trauma-informed and violence-informed practices. In chapter five, the title of "'Ally Theatre is a Problem': LGBTQI+ Migrants' Experiences with Nurses in Canada" arose directly from some informants' concerns about performative allyship.

In the final chapter, or *afterward*, I provide a synthesis of the dissertation, including implications of its findings for nursing practice, education, policy, and research. Intentionally, the final chapter is called an after*ward*, and not after*word*, because I cannot claim that the chapter will outline my final words, since it acts, instead, as a bridge for future scholarship. Here, I elucidate how LGBTQI+ migrants addressed trauma and accessed resources with resiliency, even while they encountered barriers to accessing much-needed healthcare services. This dissertation centres on the voices of an understudied population, LGBTQI+ migrants, receiving nursing and health care in Canada.

Table of Contents

## List of Tables

## List of Figure

**Acknowledgement**

I embarked on this journey and saw it to completion because of the presence of many individuals who encouraged me to move forward. I would like to start by acknowledging and thanking informants, who identified as LGBTQI+ migrants and nurses, for sharing their knowledge, experience, perspectives, and stories, since they made invaluable contributions to understanding the experiences of LGBTQI+ migrants with nurses in Canada. I extend my heartfelt thanks to the organizations and agencies that allowed me to share the call for this research with LGBTQI+ migrants and nurses within their organizations. To the one person whose life experience inspired me to do this research — you know who you are — thank you!

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*The real power of hermeneutical consciousness is our ability to see what is questionable*.

- Hans-Georg Gadamer (1976, p.13)

## Dedication

I would like to start by stating that it is because of the group sponsorship of my aunt Tahereh Zareian, her husband (Azamet), and her friends (Dr. Christopher Tom and Bahiyyih Zareian) that I have had the opportunity to work, study, and grow as a first-generation settler in the treaty lands and the territory of the Mississaugas of the Credit First Nation.

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*Benahayat motoshakeram* to my parents, Shahin and Reza Haghiri, who risked everything to escape with human smugglers from Iran to a transition country so that my brother and I could have better lives. Your hard work, strength, truthfulness, and selflessness is astonishing. I am thankful to my brother, Riaz, and my sister-in-law, Houriya, who listened to and encouraged my doctoral journey. Khanum Jaan *merci* for chanting prayers, ممنون که برای من دعا کردی, [written in Farsi because my grandma/khanum jaan does not speak English], when I just needed a soothing voice. My aunts, uncles, cousins (especially Negar Namaie and Erfan Mahboubi), nieces, and nephews, thank you for your warm hugs, in person and virtually.

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cheered me on and were genuinely present in this journey. No words can describe your unconditional love and support for me in this process. I feel extremely humble and privileged to be surrounded by the love and support of countless individuals.

## Introductory Chapter: Arriving at the Topic

In this chapter, I engage in a conversation with you, the reader, about how I have been drawn to the call of understanding the experiences of LGBTQI+ migrants with nurses and other healthcare professionals (NHCPs) in Canada. The term LGBTQI+ refers to lesbian, gay, bisexual, trans, queer, questioning, intersex, and "+" is inclusive of diverse sexual orientations (e.g., pansexual), gender identities, and gender expressions (e.g., nonbinary) that are not explicitly named in the initialism. The introduction to this doctoral dissertation includes a review of current literature and a discussion of relevant theory, as well as a conceptualization of how Gadamerian hermeneutics, with intersectionality as an analytical lens, contributed to my methodological approach in understanding the experiences of LGBTQI+ migrants' encounters with NHCPs in Canada.

In Canada, human rights laws prohibit discrimination against individuals based on sexual orientations, gender identities, and expressions (SOGIE) (*Rights of LGBTI Persons*, 2018). In 2021, in the case of *Nelson v. Goodberry Restaurant Group Ltd. dba Buono Osteria and others*, a human rights tribunal ruled in favour of Nelson and found misgendering to violate human rights in Canada (Factora, 2021; *Indexed as: Nelson v. Goodberry Restaurant Group Ltd. Dba Buono Osteria and Others, 2021 BCHRT 137*, 2021). Misgendering means referring to a person by the incorrect pronoun or other gendered terms (Registered Nurses' Association of Ontario, 2021). There are, however, countries such as Iran, Uganda, and many others, that impose severe punishments, which range from imprisonment to the death penalty, for those who do not conform to gendered, sex-based, and sexual orientation norms (*73 Countries Where Homosexuality Is Illegal*, 2021; Gamble et al., 2015). Due to the enforcement of human rights laws, and the Canadian federal government's recent commitment to increasing financial resources for refugees

and asylum seekers based on SOGIE, Canada has become a desired destination for migrants escaping from countries with discriminatory laws (AGIR, 2010; Alessi et al., 2017; Fobear, 2016; Huang, 2017; Kahn et al., 2017; Lee & Brotman, 2013; Rainbow Railroad, 2019).

In Canada, approximately 13% of asylum cases, between 2013 to 2015, were made by LGBTQI+ people escaping persecution or trauma in their countries of origin due to their SOGIE (Molnar, 2018). The exact statistical data on LGBTQI+ immigrants, refugees, and newcomers to Canada are unknown. In 2016, Statistics Canada indicated that 21.9% of Canadians are first-generation immigrants (Statistics Canada, 2018a). In Ontario, more than 3.8 million people are immigrants, and 201,200 are non-permanent residents, including refugees and those with work or study visas, of which 102,305 are reported as male and 98,895 are reported as female (Statistics Canada, 2018b). Similarly, of 3,852,145 who are immigrants, 1,814,665 are reported as male and 2,037,480 are reported as female. Such statistical data, however, are presented in a heteronormative and cis-normative manner,[1] in which data collectors assume that everyone falls within the binarized categories of male or female (Lee, 2019; Renaud, 2001; Singer, 1999). Nevertheless, as a result of actions and efforts by LGBTQI+ advocacy groups and communities, in addition to some NHCPs' allyship as well as public awareness about and sensitivity towards LGBTQI+ people, Statistics Canada is currently in consultation with experts to develop an inclusive approach to collecting data on SOGIE (Statistics Canada, 2021).

LGBTQI+ people represent a subset of migrants to Canada who may have experienced continuous exposure to discrimination and victimization prior to their transition to Canada, and

[1] Heteronormativity is defined as "the myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted, ordinary phenomenon" (Kitzinger, 2005, p. 478). Similarly, cis-normativity is the assumption that every individual's gender identity aligns with their biological sex.

may continue to experience social injustices, due to their SOGIE, race, ethnicity, and migration status during their resettlement and integration (AGIR, 2010; Alessi et al., 2017; Fobear, 2014, 2016; Fox et al., 2020; Gamble et al., 2015; Kahn et al., 2017; Kahn & Alessi, 2018; Karimi, 2019; Lee, 2021; C. D. Smith et al., 2021). I start this dissertation with the story of my friend, Fariba. This one account is personal; nonetheless, by sharing Fariba's story I articulate one of many diverse intersectional experiences of LGBTQI+ migrants. Following Fariba's account, I will describe a few personal encounters that I have had as a nurse and allude to how the call to understand the experiences of LGBTQI+ migrants with NHCPs was revealed to me. These stories, while distinctive, shed light on other collective experiences influenced by SOGIE, migration, race, ethnicity, religion, and mental health, as well as how some NHCPs in positions of privilege did not meet the unique needs of vulnerable people in their care. In the latter part of this section, I draw on current literature pertaining to LGBTQI+ migrants and offer an analysis of their complex lived experiences with migration and interactions with NHCPs.

## Responding to the Calls

The purpose of sharing the following experiences is not to conclude that the experiences of LGBTQI+ migrants result only from their diverse identities but to show the impact of systems of oppression on the care of a LGBTQI+ migrant person. For example, similar to the lack of freedom of expressing one's SOGIE, in some countries, such as in Iran and Saudi Arabia, religious persecution against individuals who follow a belief system different from the dominant religion is also practiced. These multiple experiences of SOGIE, race, culture, migration status, religion, and mental health are socially constructed identity categories that are intertwined with structures of power (Collins, 1993; Gamble et al., 2015; Lee, 2019).

**Lived Experience of Fariba**

The first case is about the experience of my friend Fariba, whose name, sexual orientation, and pronouns have been changed to protect her anonymity. Fariba's experiences demonstrate that intersecting oppressed identities influencing her health go beyond migration and SOGIE. Like me, Fariba was born in the Islamic Republic of Iran. While growing up, Fariba became aware of gender discrimination in her society. As well, Fariba feared for her life since her parents were practicing the Baha'i Faith, which the Islamic government aimed to extinguish. Fariba experienced oppression as a Baha'i and as an LGBTQI+ person. Fariba and I still remember the written signs on the streets against Baha'is and Bahaism, and anthems were sung on television and in schools to turn people against the Baha'is. One of the common signs and anthems was, "Marg bar Baha'i – marg bar Baha'i najes" [translation: Death to the Baha'i, death to the dirty Baha'i]. I remember being physically and emotionally discriminated against due to my parents' faith. In the early 2000s, Fariba fled Iran at a young age due to religious persecution. Fariba fled to Turkey as a refugee and later immigrated to Canada. Like Fariba, many Baha'is escaped and continue to flee Iran for fear of religious persecution and look for asylum in developed countries (Shishehgar et al., 2015; Talebi & Desjardins, 2012).

Over fifteen years ago, at the end of my four-year nursing degree in Canada, I learned that Fariba had been admitted to a psychiatric unit with suicidal ideation related to her non-heterosexual identity and compounded trauma. Initially, I pitied her for not being *straight.* At that time, my cultural understanding resulted in my limited knowledge, and I believed that LGBTQI+ people had a mental and hormonal imbalance that needed *fixing*. My nursing education did not contradict this biased understanding, since LGBTQI+ people were only referred to in the context of sexually transmitted infections and mental health illnesses. During

her stay at the psychiatric unit, Fariba encountered NHCPs who were aware of neither her complex experiences of persecution due to her religion nor her internal conflict with identifying as an immigrant lesbian Baha'i. A physician and nurses in a psychiatric unit made the following comment to her upon discharge: "So, you are gay, what's the big deal?" This statement reflects the NHCPs' lack of culturally safe as well as trauma- and violence-informed practices and was perceived as callous inconsideration. For Fariba, being lesbian was a "big deal" and given her culture, religion, and relocation to Canada, one that led to suicidal ideation. Subsequently, while still experiencing suicidal ideations, Fariba was discharged without a client-centered plan of care.

In the past decade, Fariba and I have had numerous discussions about her difficult transition to accepting her identity as an Iranian-born Canadian Baha'i lesbian. Only a few of her family members in Canada are aware that she is a lesbian, and her parents in Iran have never been told. Unlike other religions that criminalize homosexuality, the Baha'i faith calls for tolerance and acceptance of homosexuality but defines it as an illness requiring compassion (Bahá'u'lláh & Effendi, 1993). In the Baha'i faith, same-sex marriage is not allowed, and non-heterosexual people must not act upon "unnatural sexual desires" (Universal House of Justice, 2014). Even though the Baha'i faith urges followers not to show prejudice and discrimination against LGBTQI+ people (Bahá'u'lláh & Effendi, 1993; Universal House of Justice, 2014), I have had many personal experiences where the followers continue to act otherwise. Fariba has experienced oppression and fears being stigmatized by the Iranian and religious communities in Canada and being ostracized by family and friends due to her sexual orientation. Fariba's experience is validated by other members of the Iranian LGBTQI+ community in Toronto (Keung, 2014). Despite being persecuted for her faith and sexual orientation, Fariba also

feels privileged due to living in an urban area in Canada, but still does not feel safe to disclose her SOGIE to most friends and family.

**Roya's Journey to Understanding**

In addition to my conversations with Fariba, a few other experiences precipitated my desire to uncover the experiences of LGBTQI+ migrants with NHCPs in Canada. Although I am nostalgic about this next experience, it sheds light on the importance of highlighting personal values in relation to allyship and advocacy for individuals at the intersection of identities. Upon graduating with my nursing degree in 2007, I received the Registered Nurses' Association of Ontario (RNAO) membership package in mail. Within that package, there was information about various interest groups housed in the RNAO. Amongst the interest groups, one caught my attention: the new Rainbow Nursing Interest Group (RNIG). At that time, I did not join RNIG since I was afraid that any affiliation with LGBTQI+ people would make me an outcast in my cultural and religious communities. My fear demonstrated the notion that despite education on cultural safety and competence, there may be other nurses and healthcare professionals in educational, practice, policy making, and administrative roles across various organizations and institutions whose views on LGBTQI+ people may be clouded by their prejudices, including unintentional biases based on religion and culture (Brown et al., 2017; Dinkel et al., 2007; Henriquez et al., 2019; Lim & Hsu, 2016; Morris et al., 2019; Papadaki et al., 2015; Rowniak, 2015; Sachdej, 2021; Unlu et al., 2016). In particular, a few years ago, an Iranian-Canadian nurse, who was in an administrative role and claimed to be focused on advocacy for marginalized people in Canada, told me, "You should reconsider your topic, because it won't be safe to return to Iran for a visit by being engaged in this work!" I should add that this nurse had a visible "positive space" sign on her desk. This comment highlighted personal values that may

impact how nurses engage in allyship and advocacy. In contrast, MacDonnell (2007) reported on a collaboration in which a group of LGBTTTIQQ (initialism that the group used) identified nurses and allies affiliated with the Ontario Public Health Association developed a policy focusing on principles of ethical research with LGBTTTIQQ people. The decision to have collective authorship (the group) rather than naming individuals was in the recognition of some of the personal and professional challenges faced by some participants if they were to be identified as an advocate and group member associated with LGBTTTIQQ issues.

In sharing this past, I move forward to my experience at my first nursing career orientation. On my first day, a nurse who had been working at the unit for a long time asked me, "What is your religion?" I found it peculiar that a nurse who did not know me would ask this question. When I replied with "My parents practice the Baha'i faith," she stopped me and responded, "You know, you will go to hell because you are not Catholic!" I thought to myself, how does this nurse see her migrant patients who do not practice Catholicism? More importantly, I was reminded of my childhood trauma in Iran. I felt judged by her words and my chest felt heavy. I was nervous when we worked on the same shift. Yet, I never reported my conversation with this nurse because I felt vulnerable as a new nurse starting my career and felt marginalized as a racialized migrant nurse. Other authors have identified the presence of racism in the nursing profession (Clark & Saleh, 2019; Hilario et al., 2018; Thorne, 2017).

After a few months of working as a new nurse, a South American patient, who identified as a transgender person, was admitted to my unit for medical reasons. I overheard nurses mocking the patient at the nursing station:

> He is so concerned about his hormones, oh, EXCUSE me, SHE! She or he, I'm all confused, anyways, Alexandro [pseudonym] or whatever his name is, keeps stressing

about his “real name” and asking for his hormonal medications. Buddy, you are here for medical reason not for your trans hormones! These people, ey!

I contemplated speaking up, as I identified with the shared reality of othering and discrimination. I was unaware of how to advocate because I still had a lack of knowledge about LGBTQI+ people. In this scenario, sadly, I was a bystander when I heard the nurses’ derogatory and discriminatory comments about the client at the nursing station, and I did not advocate for the client (Fitzgerald et al., 2017). LGBTQI+ people experience stigma and discrimination in my Iranian culture, so I avoided using any evidence-informed resources to educate myself. After all, my religion also taught me that to identify as LGBTQI+ meant to be a “human failing,” so I decided to pray for this patient! A year after that incident, I was receiving a report from a nurse about a young adult patient who was admitted for blindness due to cytomegalovirus. With a judgmental attitude, the reporting nurse informed me that the patient was gay and had AIDS. The nurse advised me to “keep [my] distance and triple glove,” although the infection control team had provided no such guidelines. Over the next few days, while caring for him, I had the privilege to speak to him and his mother. I helped him shave his face so that he could be presentable for his visitors, and he was thankful for my simple acts of compassion. After caring for him, I became more aware of the stigma I harboured as perpetuated by my culture, religion, and nursing education. Thereafter, I chose an isolated computer at the hospital library where I was employed to surf evidence-informed databases to read about LGBTQI+ people. I learned about the challenges LGBTQI+ people have faced, and I felt ashamed for not speaking up and in some ways contributing to discrimination by being a silent bystander (Fitzgerald et al., 2017).

A few years later, I started the Master of Nursing degree program. I took an elective course on population health with Dr. Malone at Ryerson University. She pushed us to think

critically beyond the presented ideologies and encouraged us to strive to understand how institutional systems of power advantage some individuals over others. Upon reflection, it occurred to me that she was educating us about intersectionality. The capstone assignment for that course was to write about the applicability of one of the United Nations' Millennium Development Goals (MDGs) to nursing and population health. As I was reviewing the MDGs, I was reminded of the few calls that presented themselves to me in my nursing profession, in which I did not answer. I thought to myself "This is the opportunity!" This was another call to challenge my biased cultural beliefs and provoked additional interest in learning about LGBTQI+ people and their health care needs. I questioned and critiqued the lack of inclusion of LGBTQI+ people in the MDGs (Haghiri-Vijeh, 2013). Notably, some of my classmates, who were nurses, were still uncomfortable speaking openly about the health care needs of LGBTQI+ people. The inability to comfortably engage in discourse about LGBTQI+ people's health could be the result of complex institutional, cultural, and social stigma, as well as discrimination against people with diverse SOGIE (Hatzenbuehler et al., 2013; Logie et al., 2019; Stangl et al., 2019; Whitehead et al., 2016). Stigma is closely linked to discrimination and can be conceptualized as the lack of full social acceptance (Goffman, 1963).

One of my classmates privately approached me and said, "Well, it seems we have more LGBT people now, and I think it is because of social media and people wanting to do the next 'It Thing.'" By the "It Thing," she referred to some heterosexual and cisgender people "choosing" to be LGBTQI+ to gain recognition in social media. This perspective forced me to question systemic processes of understanding and to read the literature on gaining confidence in advocating for the rights of LGBTQI+ people among my family members and nursing colleagues. Both stigma and discrimination, including a lack of knowledge of and a sense of

discomfort in providing care to LGBTQI+ people, manifested themselves in my encounters with nurses, nursing students, faculty, and administrators. I heard comments such as, “They are in Canada now. It is safe here!” At the same time, I joined the RNAO’s Rainbow Nursing Interest Group and found opportunities to enhance my knowledge and be involved in the development of the first Best Practice Guideline (BPG) to promote health equity for diverse SOGIE people (Registered Nurses’ Association of Ontario, 2021).

With a small research grant from Centennial College, my colleagues and I conducted a mixed method pre-post quasi-experimental research study to measure social and health care students’ comfort in communicating with LGBTTQ+ people after a positive space training session (Haghiri-Vijeh et al., 2020).[2] The participants in the study found the training helpful and suggested more educational sessions. I started my doctoral program with the aim to repeat my previous study with a focus on nursing students. However, I realized that there was no discussion of the intersectional experiences of LGBTQI+ migrants in our positive space training or nursing curriculum. Upon reflection, it became evident to me that the exclusion of LGBTQI+ migrants is another form of systemic discrimination. These *preunderstandings* added to the stimulating conversations during the first year of my doctoral program.

I recognized that I needed to own my privileged and oppressed stories of past realities, and I could no longer be silent about the interactions between LGBTQI+ migrants and NHCPs. I have privileges by being a cisgender, heterosexual, middle-class, olive-skinned, Canadian citizen, and an academic. Admittedly, I experienced oppression in having no human rights as a Baha’i in Iran, being treated differently due to my gender as a woman, a non-status asylum seeker in the transition country of Pakistan, and a new immigrant to Canada. I experienced

[2] LGBTQQ+ was the initialism that we used in our research study.

trauma because as a child I witnessed my father being shot in front of my eyes in the transition country. As a young new immigrant, I experienced discrimination and bullying from other students while attending high school in Canada. I have a preunderstanding of the experiences of LGBTQI+ migrants with nurses through hearing nurses' LGBTQI+-phobic and racist comments.

I have heard personal stories of LGBTQI+ migrants' encounters with NHCPs in Canada. These preunderstandings, coupled with my discussions with Fariba and my experiences caring for other LGBTQI+ migrants in Canada, influenced my pursuit of knowledge in this field and served as the foundation for my doctoral work. At the beginning of my doctoral studies, I read about but had not thought about "performing" activism (MacDonnell, 2007, 2014; MacDonnell, Dastjerdi, Khanlou, et al., 2017). Instead of using this dissertation as a simple exploration of LGBTQI+ migrants' experiences with NHCPs, I hope to amplify the already existing voices and build on current NHCPs' discourses in creating safe and affirming spaces for LGBTQI+ migrants in their healthcare encounters. With the intentional goal of improving nurses' practices, the aim in this doctoral dissertation is to present a thunderous affirmation of nurse educators, practitioners, and policy makers who care for diverse populations at any point of care access, because LGBTQI+ migrants are everywhere. For this reason, the motivation for this doctoral dissertation is to understand the realities of LGBTQI+ migrants in their encounters with nurses and other health care professionals by using Gadamerian hermeneutics with intersectionality as an analytical lens.

## Conceptualizing Experiences of LGBTQI+ Migrants

Over the past two decades, some nurses, together with social and mental health care providers, child and youth workers, public service providers, and legal services professionals, in collaboration with migrants, LGBTQI+ people, or those at the intersection of identities, have

strived to advance safe and affirming spaces for LGBTQI+ migrants (Chinn et al., 2021; Daley et al., 2020; Fitzgerald et al., 2017; Gamble et al., 2015; Gapka & Raj et al., 2003; MacDonnell, Dastjerdi, Khanlou, et al., 2017; MacDonnell et al., 2015; Rainbow Nursing Interest Group, 2021). For example, in a 2003 Ontario-wide community consultation using community-based participatory action research, nurses collaborated with trans people and presented a position paper to the Ontario Public Health Association (Gapka & Raj et al., 2003). In this document, the research team outlined the challenges that migrant and racialized trans people may face, and provided recommendations for allyship and advocacy. Therefore, nursing advocacy and allyship existed decades prior to this doctoral dissertation. In these nursing advocacy works and collaborations, more spaces were created in nursing organizations. In particular, RNIG members had been advocating for development of a BPG for years. However, receiving funding to conduct research in this area adds another layer of complexity.

I speak to issues of funding from one of my personal experiences. About ten years ago, I had the privilege of being involved as a "knowledge user" on a committee that included Rainbow Health Ontario and RNAO, in which the principal investigators, in collaboration with several universities and organizations, applied for a Canadian Institute of Health Research (CIHR) grant to receive funding to conduct a systematic review about the healthcare needs of 2SLGBTQI+ people. Notwithstanding the work of the scholars, the application was highly ranked but was not successful. In 2018, RNAO received funding from the Government of Ontario and the work to develop a new best practice guideline began. In 2021, the RNAO published its first BPG to address health equity for 2SLGBTQI+ people and also noted the intersecting experiences of racialized 2SLGBTQI+ people in the healthcare sector (Registered Nurses' Association of Ontario, 2021).

Although the BPGs are to be used as a guide, the recommendations and suggestions are categorized as strong, moderate, low, or very low based on the certainty of evidence: scholars have critiqued the BPGs for this categorization of the certainty of evidence and the application of these recommendations to practice (Fleiszer et al., 2015; Holmes et al., 2008; MacLure et al., 2016; Ploeg et al., 2007). The low or very low certainty of evidence in the comprehensive and systemic review of literature may make it seem like the recommendations are not important; however, the panel members for this newly developed BPG provided feedback and suggestions on the importance of including the recommendations and suggestions. One of the other strictures of the systemic reviews for BPGs are the limits set for data search, such as date. For example, in this BPG, the data were collected from the years 2012 to 2018, which means the contributions of nursing and other scholars prior to 2012 and after 2019 were not integrated as evidence. This brings me to the next point: systemic reviews, in general, may not be representative of the scholarly work that researchers have conducted in this field and do not integrate position statements as well as other policy work that nurses are engaged in.

In the above summary, I named only a few examples, but I acknowledge the work of many white and BIPOC nurses who have passionately strived to improve nursing and other healthcare practices for LGBTQI+ people. Despite the work of nurses in education, practice, and policy in the Canadian context, there has been evidence of hetero-cis-normativity and non-affirming care in healthcare practices in relation to LGBTQI+ people and LGBTQI+ migrants (Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al., 2015; Kellett & Fitton, 2017; Lim et al., 2014; Registered Nurses' Association of Ontario, 2021; Röndahl, 2011; von Vogelsang et al., 2016). The RNAO defined affirming care and practices as "processes through which a health care system cares for and supports an individual, while recognizing and acknowledging their

sexual orientation, gender identity and expression" (2021, p. 141). In what is to follow, I provide an explanation for the use of the terminology of migrant, hetero-homo-cis-normativity, and LGBTQI+ people.

## Clarifying Terminology

An important initial step is to explain certain terms and phrases used in this dissertation. These words are migrant, hetero-homo-cis-normativity, and LGBTQI+ people.

### *Migrants*

The Canadian Council for Refugees' definition for the word *migrant* is used in this dissertation:

> A person who is outside their country of origin. Occasionally this term is used to cover everyone outside their country of birth (including people who have been Canadian citizens for decades). More often, it is used for people currently on the move or people with temporary status or no status at all in the country where they live. (2010, p. 2)

The word migrant can refer to individuals who relocate; for example, refugees, immigrants, newcomers, new settlers, and non-status residents from other countries or regions. Individuals' experiences of settlement may differ based on how they relocate to Canada (Fernandes, 2017). For example, the experiences of asylum seekers may differ as their applications may have been rejected and they may be deported back to their home country (Salami et al., 2019; Shuman & Hesford, 2014), while individuals with permanent residency status have more security (Jordan, 2009). However, during my literature review research, focusing on only one category of migrants to Canada yielded a limited number of articles; for example, the category "asylum seekers" may not capture the intersecting experiences of those who migrated to Canada for reasons other than their SOGIE. For instance, in Fariba's example, she migrated to Canada based on religious

discrimination; nonetheless, she encountered NHCPs who did not comprehend her mental health experience as a result of her complex identities of SOGIE, religion, migration status, race, ethnicity, and language barrier. The word migrant, as an umbrella term, includes diverse individuals, such as internal and international migrants, including refugees and internally displaced persons, who have relocated to arrive at another country or region (International Organization for Migration, 2004).

At the beginning of this doctoral research, I had included Two-Spirit (2S) individuals in all my recruitment documents, consent forms, and interview questions, as well as using the initialism 2SLGBTQI+. A common misconception is that Two-Spirit people should not be discussed in relation to migration. When I shared my research study's recruitment letter with one Canadian agency, the director questioned my use of language and stated, "Two-Spirit people are not migrants." Contrary to this limited understanding, Two-Spirit individuals may also identify as migrants by travelling across treaties, regions, borders, and through intra-racial marriages. Albert McLeod (A. McLeod, personal communication, November 26, 2019), a Knowledge Keeper from the Nisichawayasihk Cree Nations and the Métis community of Norway House, and Séan Kinsella, the director of Eight Fire at Centennial College (S. Kinsella, personal communication, April 6, 2021), informed me that Two-Spirit individuals may also identify as migrants. I initially started the initialism with 2S, which stands for Two-Spirit, in the 2SLGBTQI+ initialism. However, none of the informants in this research self-identified as Two-Spirit, and for this reason, the initialism was changed to LGBTQI+.

***Hetero-homo-cis-normativity***

Upon review of the literature about LGBTQI+ migrants, some authors shed light on the existence of heteronormativity, cis-normativity, and homonormativity, or a combination of these

normative views that systematically marginalized people (Gamble et al., 2015; Haghiri-Vijeh & Lepp, 2019; MacDonnell, 2014; Motschenbacher & Stegu, 2013; Mulé & Smith, 2014; C. D. Smith et al., 2021; Trans Care BC, 2021). These terms are dense concepts with much needed exploration; however, here, I will provide a summary. Heteronormativity is defined as "the myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted, ordinary phenomenon" (Kitzinger, 2005, p. 478). Similarly, cis-normativity is the assumption that every individual's gender identity aligns with their biological sex.

Homonormativity, a term coined by Lisa Duggan, follows the heteronormative ways of categorizing individuals into Western understandings of identifying and "presenting" as LGBTQI+ people (Gamble et al., 2015; Motschenbacher & Stegu, 2013; Provencher, 2014). Authors have argued that homonormativity is assimilation of LGBTQI+ people into heteronormative social constructed categories (Gamble et al., 2015; Robinson, 2016; A. Smith, 2010; C. D. Smith et al., 2021). Robinson (2016) underscores the challenges of homonormativity:

> Those sexual minorities who can or do assimilate into heteronormative structures and conforms to the congruent gender roles receive more rights and privileges than those who do not or cannot assimilate. For example, many transgender and other gender non-confirming individuals are often pushed to the periphery of LGBTQ communities for not confirming to the heteronormative gender roles in society. (p. 1)

This understanding of homonormativity is relevant to migrants who initiate asylum cases in Canada, in which they must prove their specific SOGIE to the Immigration and Refugee Board (IRB) officers but may be rejected and deported back to their country of birth because they do not conform to established understandings of gay or lesbian in the Canadian context (Gamble et

al., 2015; McDonald-Norman, 2017; Rinaldi & Fernando, 2019; Sin, 2015; C. D. Smith et al., 2021). LGBTQI+ migrants have shared that their existence, identities, and orientations were questioned in comparison to Western understandings of *normal* LGBTQI+ people during IRB hearings and by care providers in the shelters (Fobear, 2015, 2016). In this study, I use the term hetero-homo-cis-normativity to encapsulate these three normative ways of thinking.

### *LGBTQI+ Initialism*

As I explored the meaning of migrant and hetero-homo-cis-normativity, I also considered the categories and labels used for identifying SOGIE, which most likely will become dated in years to come. By using the LGBTQI+ initialism, I do not assume the vulnerability of groups but do categorize individuals for strategic essentialist reasons, in that it allows for the recognition of needs (McCall, 2005). The term *strategic essentialism* was coined by Gayatri Chakravorty Spivak, a post-colonial South Asian theorist and activist, and refers to the political position adopted in order to advocate for minority groups (Ritzer & Ryan, 2011; Spivak, 1996). In this dissertation, the term LGBTQI+ migrant is not used as a blanket term, and I need to underscore that this language is not meant to dismiss the diverse experiences of migration trajectories within the various LGBTQI+ communities. Instead, it is strategically crucial and advantageous to temporarily "essentialize" LGBTQI+ migrants as a group to understand their experiences with NHCPs and to inform practice, education, policy, and research (Massaquoi, 2020; Muelle & Ramírez, 2019).

I recognize that the process of naming, but not always, is for the purpose of liberation of the previously silenced. I agree that groups, such as lesbians, may be identified within a research study; conversely, it should not be assumed that all lesbians fit within a specific categorical box (McDonald et al., 2011). For example, the experiences of Iranians who identify as lesbians and

still live in Iran are different from those of Canadians who identify as lesbians; Iran is a country that imposes the death penalty on LGBTQI+ people (Ahmady, 2018). Moreover, I asked a gay non-migrant LGBT+ (an initialism he used) scholar and advocate about the rationale for not including "asexual" in the initialisms, and he explained, "Asexual people, historically, didn't experience the same trauma as us" (Anonymous, personal communication, February 2019). It became evident to me that due to our unexamined assumptions there may be further *othering* of those who are marginalized (Ahmed, 2006, 2012b). Othering has been defined in terms of racialization as "a relationship based on power—the power to define, contain and neutralize an other. Other is not a neutral category, but is understood as inferior, and the process of Othering is a process whereby the inferior position is sustained" (Berman & Jiwani, 2008, p. 138). In addition,

> "Othering" defines and secures one's own identity by distancing and stigmatising an(other). Its purpose is to reinforce notions of our own "normality," and to set up the difference of others as a point of deviance. The person or group being "othered" experiences this as a process of marginalisation, disempowerment and social exclusion. This effectively creates a separation between "us" and "them". (Grove & Zwi, 2006, p. 1933)

Othering results in categorization that leads to recognition and acceptance for some (Ahmed, 2006, 2012b; Butler, 1988, 1993b, 1993a; Foucault, 1978), for example, middle-class white gay men, and exclusion for others, like LGBTQI+ migrants. However, I am not using "+" to exclude individuals, rather I am reminded that SOGIE are fluid and diverse.

In this study, I utilized the term LGBTQI+ migrants to represent variation within this group (e.g., trans, non-binary, and gender nonconforming realities), to draw attention to common

experiences of marginalization among its members, and to highlight that complex and intersecting identities are not static. In addition, I recognize the initialism and language used by gender and sex minority people in the Global South may not reflect the West Eurocentric initialism of LGBTQI+. Other scholars have provided detailed definitions of various terminologies in gender, sex, and sexuality studies and research (Merryfeather, 2011; Merryfeather & Bruce, 2014; Schindel, 2008; Stryker, 2008); henceforward, I will not delve into definitions. In this dissertation, I will use the term LGBTQI+ people, unless researchers used different terminologies or initialism in their publications. Using the terms migrants, hetero-homo-cis-normativity, and LGBTQI+ people in this study is intended as a move toward inclusivity. In the next section, by drawing on the literature, I offer a summary of the tumultuous experiences of LGBTQI+ migrants prior to and post-transition to a host country. I then discuss NHCPs' roles in relation to migrants, LGBTQI+ people, and LGBTQI+ migrants.

**Conversing With the Literature**

In conducting the literature review, I utilized the University of Victoria's library database. An electronic search of articles that focused on key terms of nurs*, health care profession* or health care personal*, GLBT*, LGBT*, LGBTQ*, LGBTTQQI*, gender minority*, sexual minority*, newcomer*, refugee*, immigra*, migra*, stigma, discrimina*, microaggression*, trauma-informed, violence-informed, "cultural safety," and "cultural competence" was conducted using the ProQuest, CINHL, Google Scholar, PubMed, Sage, PsycINFO, and EbscoHost databases. The number of hits varied from 10 to 803,108 articles. The reference lists contained in articles were reviewed for additional sources. The inclusion criteria were the following: articles from the years between 2011 and 2021; full text studies that focused on Canada and United States of America (USA) and on various experiences of LGBTQI+ people

with NHCPs. The articles included discussion papers as well as studies using quantitative, qualitative, and mixed methodologies. The exclusion criteria were articles that did not focus on migrants or LGBTQI+ people.

Based on the current literature, Table 2 (please see Appendix F) provides a summary of the selected relevant articles. This table does not include books, policies, websites, or general articles used in this dissertation. Five articles highlighted LGBTQI+ peoples' experiences pre-migration, 18 post-migration, and 17 prior to and post migrations. Ten articles focused on counselling and mental health, four on legal studies, 18 on social service providers, and 33 on NHCPs more broadly. Ten articles were related to asylum seekers, seven to refugees, five to immigrants, two to newcomers, and seven to migrants. Fourteen articles were related to LGBTQI+ people who had migrated but did not identify the reason for migration. Pertaining to migrants' experiences in general, nine articles were written by nursing scholars and nine by other health and social care professionals. Regarding cultural safety, 19 nursing articles shed light on safety for LGBTQI+ people and necessary competencies. Based on this review, a limited literature exists that specifically highlights LGBTQI+ migrants' encounters with nurses in the Canadian context.

**Burdensome Life of LGBTQI+ Migrants**

Drawing on the literature from BAME/BIPOC (Black Asian and Minority Ethnic/Black, Indigenous, People of Colour), white people, migrants, LGBTQI+ people, and those at the intersection of identities, I present a conceptualization of the experiences of LGBTQI+ migrants. In the next few pages, I discuss how the literature in social services, legal studies, mental health, counselling, and nursing identifies the challenges experienced by LGBTQI+ migrants pre- and post-migration.

### *Prior to Migration*

The pre-migration experiences of LGBTQI+ people are diverse since the regulation of LGBTQI+ people varies between countries. For example, in Russia, "gay propaganda" is against the law (Oren & Gorshkov, 2021), and in Iran, any act by LGBTQI+ people is punishable by death (*73 Countries Where Homosexuality Is Illegal*, 2021). A LGBTQI+ person may have experienced imprisonment and torture while another person may have been called derogatory names on the streets (Ahmady, 2018). Moreover, in the pre-migration journey to Canada, migrants may have fled to a transition country; for example, a LGBTQI+ individual may have fled from Iran to Turkey (Cooney, 2007) and then arrived in Canada as an asylum seeker (Keung, 2014). Or, LGBTQI+ people may have come to Canada on a student visa and then applied to become a permanent resident on the human rights grounds of SOGIE (Huang, 2017).

Pre-migration, LGBTQI+ people may have experienced trauma and violence to various degrees and in different forms, and these have significant negative impacts on their physical and mental health and well-being (Lee & Brotman, 2011, 2013; Lewis & Naples, 2014; Salam et al., 2022). Alessi et al. (2017) asserted that LGBTQI+ people's mental health challenges are the result of continuous trauma and lack of support due to rigid gender roles that, for example, affect their agency or health conditions (MacDonnell et al., 2015). Another example is that pre-migration LGBTQI+ people may have experienced physical and sexual assault because they were perceived to be promiscuous or for "curative purposes," and were not protected by the authorities (Alessi et al., 2017, 2018; Gamble et al., 2015; C. D. Smith et al., 2021). When LGBTQI+ people complained to authorities, such as police, they were blamed for bringing these acts of verbal, physical, and sexual assaults upon themselves for not being "normal" (Alessi et al., 2017).

Prior to migration, many LGBTQI+ people's experiences of trauma began in childhood and continued to adulthood (Hopkinson et al., 2017). In their countries of birth, LGBTQI+ people may face trauma, violence, and victimization from neighbours, family members, friends, authorities such as police (Alessi et al., 2017; Cerezo et al., 2014; Sachdej, 2021), and NHCPs (Alessi et al., 2016; Bucar & Shirazi, 2012; Kahn et al., 2017). This is an important understanding because trauma is ongoing and compounded across the migration trajectory (Salam et al., 2022). For example, in Iran, same-sex relationships are punishable by death; however, to avoid the death penalty, a person must either identify as heterosexual or be forced to undergo sex reassignment surgery to become transsexual, in order to abide by hetero-cis-normative categories of male or female (Ahmady, 2018; Bucar & Shirazi, 2012). Another example is Colombia where being LGBTQI+ has not been criminalized since 1980, but the public violence against SOGIE diverse people continues, and these actions are not addressed at the political level (Muelle & Ramírez, 2019). To escape various forms of violence or discrimination, LGBTQI+ people have sought to flee their country of birth.

Escaping one's country of origin can result in other experiences of trauma and violence as some LGBTQI+ migrants have to take refuge in another country (Cerezo et al., 2014; Murphy, 2009; Rosenberg, 2015). These journeys can cause LGBTQI+ migrants additional trauma as they may have experienced discrimination, physical, emotional, or sexual abuse from residents and service providers in transition countries (Alessi et al., 2016, 2017, 2018; Jordan, 2009). One might assume that after migration to Canada, the challenges end; however, LGBTQI+ migrants have new hurdles to overcome (Logie et al., 2016, 2019; Marshall, 2021). In the following section, the experiences of LGBTQI+ people after migration are discussed.

### *Challenges Continue Post-Migration*

It is documented that upon arrival to Canada, some LGBTQI+ people have encountered hetero-homo-cis-normativity and racism when in contact with NHCPs and IRB members (Fobear, 2015, 2016; Gamble et al., 2015; Lam & Lepp, 2019; Lee, 2019; Lee et al., 2020; Lee & Brotman, 2013; Munro et al., 2013; Murray, 2014b, 2014a; Nicol et al., 2017; Rinaldi & Fernando, 2019; Silberholz et al., 2017). Some migrants also experienced microaggressions, including the fact that necessary information about education, health, and public services were not provided at all or in a timely manner (Munro et al., 2013). Sue (2010) defined microaggressions as "The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (p. 3).

In a Canadian study, Munro et al.'s (2013) findings elucidated the need to improve social service practices and policies when working with migrant LGBT youth. The authors' call for improvement in services is echoed in Tan and Weisbart (2021)'s study of the experiences of Asian-Canadian trans youth. In another large international community participatory research study led by Nancy Nicol (Gamble et al., 2015), the researchers, in collaboration with LGBTQI+ refugees and asylum seekers as well as service providers, identified several challenges for both the service users and providers. In Canada, the resettlement challenges experienced by LGBTQI+ migrants have included the refugee claim process, preparing evidence of SOGIE persecution for IRB hearings, accessing housing, employment, and health, as well as physical and mental health care services (Gamble et al., 2015; Salam et al., 2022). Likewise, C. D. Smith et al. (2021) highlighted a limited number of frontline service providers who specialize in providing legal and counselling services for LGBTQI+ refugees' claimant processes.

On the contrary, the need for supportive care from social service providers was noted as critical during the immigration process (Logie et al., 2016). For instance, LGBTQI+ migrants require counselling and supportive mental health care during IRB hearings for several reasons. First, LGBTQI+ people must revisit and prove past traumatic experiences to the IRB officer (Alessi et al., 2016; Alessi & Kahn, 2017; Kahn et al., 2017; Massaquoi, 2020; Murray, 2014c; Shuman & Bohmer, 2014; C. D. Smith et al., 2021). Second, LGBTQI+ people must substantiate current SOGIE by providing evidence that they belong to a LGBTQI+ category (Massaquoi, 2020; Mulé & Smith, 2014; Murray, 2014a; C. D. Smith et al., 2021; Vogler, 2016). Not all LGBTQI+ people who submit asylum claims will receive immigration status (Lee, 2019). LGBTQI+ people are at risk of having their refugee claims denied and being deported if the IRB does not deem their stories to be valid (Gamble et al., 2015; C. D. Smith et al., 2021). Affirming care was demonstrated when counsellors and legal and social service providers assisted LGBTQI+ people in preparing their narratives for their IRB hearings (Logie et al., 2016; Munro et al., 2013). Another form of support that LGBTQI+ people found helpful were group meetings. Peer groups, with one or two social service providers present during the meetings, enabled LGBTQI+ people to receive and share reliable information about housing (Logie et al., 2016), transportation, and culturally safe groups (Cerezo et al., 2014; Giwa & Greensmith, 2012). Moreover, in a study of trans women of colour living with HIV in Toronto, the authors found arts-based group workshops to be an effective method of instilling positive communal emotions and developing connections among participants who were at the margins of society (Logie et al., 2019). Hence, strategies have been implemented to increase support for LGBTQI+ migrants. Although LGBTQI+ people do not only migrate to urban centres, the majority of these studies focused on their experiences in large Canadian cities (Daley et al., 2020).

After relocation to Canada, studies suggest that LGBTQI+ people require affirming care and support from NHCPs due to pre- and post-migration experiences of systemic discrimination. First, in an effort to obtain immigration status, as mentioned above, LGBTQI+ people reexperience distress because they have to narrate their traumatic stories in detail to the IRB (Alessi & Kahn, 2017; Lee & Brotman, 2013). Second, some migrants encounter racism and othering from white LGBTQI+ people due to their religion, race, or inability to communicate in English (Alessi & Kahn, 2017; Ghabrial, 2017; Giwa & Greensmith, 2012; Munro et al., 2013; Nakamura et al., 2013), while others are sexually desired by white LGBTQI+ people, because they are deemed exotic and different (Giwa & Greensmith, 2012; Munro et al., 2013; Nakamura et al., 2013).

Third, similar to Fariba, many LGBTQI+ people faced discrimination and microaggressions from friends and family in Canada (Casey, 2019; Cerezo et al., 2014; Gamble et al., 2015; Lee & Brotman, 2011), and this caused them to avoid social gatherings with people from the same country (Ghabrial, 2017; O'Neill, 2010) or the same religion (Adur, 2018; Fensham, 2021; Mustafa, 2018; Nakamura et al., 2013). For example, Baha'i teachings inform followers not to show any prejudice toward LGBTQI+ people, but call for tolerance and understanding on human failings (Universal House of Justice, 2014). This labelling is a form of prejudice and perpetuation of hetero-cis-normativity (Haghiri-Vijeh, 2013) and may cause the LGBTQI+ migrants not to feel a sense of belonging in their own religious and cultural communities (Fensham, 2021; Kahn et al., 2017). Overall, systemic discrimination and limited affirming services for LGBTQI+ migrants from both NHCPs and legal services, as well as cultural stigma from people in their own communities in Canada, causes isolation. These forms of isolation may lead LGBTQI+ people to have mental and physical health challenges that

require affirming care from NHCPs (Abbas & García, 2021; Akibar & Langroudi, 2021; Lee et al., 2021; Sachdej, 2021; Sansfaçon et al., 2018; Williams & Serpas, 2021); nonetheless, trusting NHCPs is not an easy task for LGBTQI+ migrants.

LGBTQI+ migrants could have difficulty building trusting relationships with NHCPs and avoid health visits because of traumatic experiences with NHCPs in their countries of birth (Lee et al., 2020; Pollock et al., 2012; Tanner et al., 2014). Some LGBTQI+ migrants may have experienced forced medical interventions, such as shock therapy or forced sex reassignment surgery pre-migration (Bucar & Shirazi, 2012; Haghiri-Vijeh, 2013), which result in a lack of trust of NHCPs. There are several ramifications when LGBTQI+ people do not visit or follow-up with NHCPs, including poor mental and physical health outcomes (Durso & Meyer, 2013; Munro et al., 2013). LGBTQI+ migrants may have increased risk of anxiety and depression due to traumatic experiences pre- and post-migration (Alessi et al., 2016), which decrease their sense of self (Cerezo et al., 2014). When mental health challenges are not addressed, they will negatively impact physical well-being. For example, the stress of forced disclosure during the IRB hearings (Lee & Brotman, 2013) and not having a reliable NHCP has been known to lead LGBTQI+ people to have panic attacks, digestive disorders, and hair loss (Ghabrial, 2017; Lee et al., 2020).

Financial instability is another source of distress for LGBTQI+ people that negatively impacts their mental and physical well-being. Delays in receiving work permits and non-recognition of their educational degrees from their countries of origin prohibit people at the intersection of identities from obtaining safe and well-paid jobs (Karimi, 2019; Lam & Lepp, 2019; C. D. Smith et al., 2021). As noted in the literature, even with recognized credentials, unemployment can be a reality for marginalized people at the intersection of race, religion,

SOGIE, and migration status (Canadian Nursing Association, 2021; Clark & Vissandjée, 2019; Floyd & Sakellariou, 2017; Lam & Lepp, 2019; MacDonnell, Dastjerdi, Bokore, et al., 2017; Registered Nurses' Association of Ontario, 2021; Trans Care BC, 2021). To meet their daily financial needs, including the cost of rent and food, some migrants and people who identify as LGBTQI+ migrants were forced to become sex workers or stay in abusive relationships (Alessi & Kahn, 2017; Cerezo et al., 2014; Ghabrial, 2017; Giwa & Greensmith, 2012; Lam & Lepp, 2019).

For some LGBTQI+ migrants, arriving in North America creates the freedom to explore their sexuality; however, they may not have the necessary knowledge about safe sex practices (Adam et al., 2011; Lee et al., 2021; Strömdahl et al., 2017). Sex work and unprotected sexual activities increase the risk of acquiring and transmitting sexually transmitted infections (STIs). When LGBTQI+ people are not following up with NHCPs for assessment, diagnosis, and treatment, they may not receive accurate information about STIs (Cerezo et al., 2014; O'Neill, 2010; Tanner et al., 2014) and other health care needs. As a result, NHCPs have a crucial role to play in providing evidence-informed as well as trauma- and violence-informed care.

Some studies identified NHCPs' limited preparation to care for diverse migrants, which includes LGBTQI+ people (Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al., 2015; Kellett & Fitton, 2017; Lim et al., 2014, 2015; MacDonnell, 2007; Merryfeather, 2011; Rousseau et al., 2008; von Vogelsang et al., 2016). Other studies also show there is a lack of organizational support to ensure that NHCPs receive trauma- and violence-informed education and training to care for people at the intersection of migration status as well as LGBTQI+ status (Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015; Daley & MacDonnell, 2015; Klotzbaugh & Spencer, 2014; Lee et al., 2020; MacDonnell, 2007). As a result, the limited education of NHCPs

may lead to LGBTQI+ people receiving inadequate and discriminatory health care services (Merryfeather, 2011; Merryfeather & Bruce, 2014; Nama et al., 2017; Röndahl, 2011; S. K. Smith & Turell, 2017).

**Healthcare Professionals' Roles**

LGBTQI+ migrants may have selected Canada because of its liberal laws pertaining to SOGIE, the possibility of financial support, and positive experiences when visiting Canada (Huang, 2017; Munro et al., 2013). Yet, it is evident from the literature, as cited above, that LGBTQI+ peoples' experiences of systemic processes of othering, stigma, and discrimination can start prior to migration and continue thereafter. Munro et al. (2013) focused on improving policy and practice among social service workers in Canada. To address discrimination, the authors suggested specific "anti-homophobia and anti-racism training" (p. 146) for immigration service workers and the employment of staff who provide services to LGBTQI+ migrants. Similarly, Tan and Weisbart (2021) addressed the integration of bottom-up and top-down approaches in the formation of policy and services directed at people who are racialized and trans. This integration would require the expertise of policy makers and practitioners, while ensuring a bottom-up approach where there is the inclusion of the voices of LGBTQI+ migrants in the formation of health and social care policies (Potter et al., 2019). Alessi et al. (2017) and Lee et al. (2020) highlighted mental health care professionals' need to comprehend the pre-migration experiences of LGBTQI+ people that impact integration and relocation in Canada. In addition to mental health care professionals, LGBTQI+ people are in contact with other health care professionals, such as physicians and nurses. In addition to social service providers and mental health counsellors, nurses also have an important role to play in providing culturally safe

and affirming care to LGBTQI+ migrants in Canada (Chinn et al., 2021; Gamble et al., 2015; Registered Nurses' Association of Ontario, 2021; *Standards & Guidelines*, 2019).

**LGBTQI+ People's Experiences with NHCPs**

LGBTQI+ people have experienced discrimination at the hands of some NHCPs (Munro et al., 2013). Although changes are being implemented federally and provincially in Canada (Statistics Canada, 2021; Trans Care BC, 2021), one reason for discrimination is the use of hetero-homo-cis-normative language in governing bodies, such as Health Canada policies and documents (Mulé & Smith, 2014). Governing bodies' hetero-homo-cis-normative views may have influenced NHCPs' educational programs and in turn impacted attitudes (Stewart & Reilly, 2017). For example, the College of Nurses of Ontario (CNO), the regulatory body of nurses in Ontario, guides nurses to practice in accordance with cultural sensitivity standards and to centralize the needs of clients; yet the heteronormative pronouns of his or her, rather than neutral pronouns, are continuously used in standards of practice (*Standards & Guidelines*, 2019). As such, CNO documents that 193,626 registered nurses, nurse practitioners, registered practical nurses, and thousands of nursing students in Ontario are required to use contain hetero-cis-normative assumptions and exclude diverse SOGIE people (*Membership Totals at a Glance*, 2021).

Hetero-homo-cis-normativity in teaching material may contribute to a scarcity in education of NHCPs about LGBTQI+ people pre-licensure (Fergus et al., 2018; Kellett & Fitton, 2017; Keuroghlian et al., 2017; Nama et al., 2017; S. K. Smith & Turell, 2017; Stewart & Reilly, 2017) and post-licensure (MacDonnell & Daley, 2015; Munro et al., 2013; Silberholz et al., 2017; Stewart & Reilly, 2017). Many LGBTQI+ people have had to educate NHCPs about their needs and have felt frustrated with NHCPs' discriminatory comments and behaviours (Durso &

Meyer, 2013; Silberholz et al., 2017; Stewart & Reilly, 2017). When LGBTQI+ people are not able to receive affirming and safe care from NHCPs, they may avoid accessing health care services and supports, which could ultimately result in worse health outcomes. In a study of suicide among gay and bisexual men in Vancouver, Canada, participants felt the focus had been on "fixing" or "curing" the gay men, rather than changing social attitudes (Farlatte & Oliffe, 2019). Many of the participants shared that from a young age, they were told by society that being gay was "wrong" and "dirty" (p. 269–270). Many of the gay and bisexual men who participated in Farlatte and Oliffe's study asserted that they could not access health services because of NHCPs' homophobic attitudes, and this exacerbated their mental health conditions, leading to suicide attempts. Hence, it is imperative that NHCPs translate policy into practice which addresses the contextual and diverse experiences of LGBTQI+ people with racism, LGBTQI+-phobia, and xenophobia.

**Discourse on Culture**

Within the discourse of understanding culture in health care, there are several concepts: starting with cultural competence, then cultural sensitivity and humility, as well as cultural safety (Curtis et al., 2019; Gradellini et al., 2021; Potter et al., 2019). The common meaning of the word "competence" is that nurses have the knowledge, skill, and judgment to provide culturally competent care to diverse individuals (*Code of Ethics for Registered Nurses*, 2017). The Canadian Nurses Association (CNA) states that novice nurses must be culturally competent upon entry into practice and be reflective about their biases (*Cultural Competence and Safety Competencies*, 2019). The CNA (2019) asserts that cultural competence includes cultural awareness, sensitivity, and safety. However, practicing cultural safety requires nurses to be reflective and to understand their often taken-for-granted privileges and biases, including actions

to dismantle power relations that exist between them and clients (Nursing Council of New Zealand, 2011). It should not be assumed that all nurses and other healthcare professionals provide incompetent care intentionally (Curtis et al., 2019). It is found that when there is a lack of cultural humility and sensitivity, there is a paucity of respectful and safe care for the LGBTQI+ people (Lim & Hsu, 2016). Finally, cultural humility is concerned with the life-long praxis of being aware of personal biases, assumptions, and experiences, and how these inform practice (Worthington et al., 2017). However, a key difference between terminologies is that cultural safety requires healthcare practitioners to understand the influence of power when providing healthcare services (Bourque-Bearskin, 2011; Curtis et al., 2019; Gradellini et al., 2021).

To ensure cultural safety and affirming care in practice, nurses need to understand LGBTQI+ migrants' experiences in relation to others and how these positions of oppression are morphed contextually. In a panel presentation on decolonizing the nursing profession, Bourque Bearskin asserted that it is the nurses' responsibility to understand the impact of centuries of colonization across the globe that shapes how nurses provide care to diverse patients (Bourque Bearskin, 2021). In an article, Bourque Bearskin (2011) advocated for cultural safety and stated, "the strength of this concept lies in the fact that cultural safety is not about cultural practices; rather, it involves the recognition of the social, economic, and political position of certain groups" (p. 553). The health care system and nursing education operate according to binaries including men/women, heterosexual/homosexuals, right/wrong, and Canadian/other (Giwa & Greensmith, 2012; MacDonnell, 2014; Thorne et al., 2009). These complex binaries create misunderstandings in the context of providing culturally safe and affirming care to LGBTQI+ migrants; however, at a systemic level, changes are being made in increments.

Globally, in 1983, the International Council of Nurses established a position statement on "Health of migrants, refugees and displaced persons" (2018, p. 1). It was last updated in 2018 and includes the needs of migrants who identify with diverse "gender, [and] sexual orientations" (p. 2). In Ontario, the RNAO (2002) published a policy statement that highlighted issues of racism in healthcare practices. In 2020, after the inhumane murder of Mr. George Floyd, the Canadian Nurses Association committed to addressing racism in healthcare beyond nursing (Canadian Nurses Association, 2021). Similarly, Moorley et al. (2020) enthusiastically invited nurses to engage in anti-racism work in "the Year of Nursing." At a macro level, the World Health Organization celebrated the year of nursing and midwifery around the globe on Florence Nightingale's 200th birthday. Yet, Florence Nightingale is herself accused of racism because she supported the colonization of Indigenous children and communities (Stake-Doucet, 2020).

At the same time, the RNAO launched its Black Nurses Task Force (BNTF). This team consisted of 17 Black nurses and nursing students with a mandate to "actively reduce anti-Black racism and discrimination in nursing – including its organizations, regulatory bodies, associations, and the broader health-care system – that is targeted toward and experienced by Black nurses" (Cooper Brathwaite et al., 2022, p. 7). On February 8th, 2022, the BNTF presented their report, in which they identified 19 recommendations at micro, meso, and macro levels to reduce barriers in academic and workplace settings, increasing education and building awareness, as well as developing and implementing advocacy strategies. In this report, the BNTF, also provided 10 recommendations for allyship and solidarity at micro, meso, and macro levels. Following this background, in the next section I provide healthcare professionals' and migrants' perceptions of care in the Canadian context.

**Healthcare Professionals' and Migrants' Perceptions of Care**

In general, migrants face challenges as they transition to a new country (Kouri et al., 2022; Salam et al., 2022). Historically, migrants have experienced discrimination based on their race and ethnicity (Thurman et al., 2019), colour of skin (Huang, 2017), religion (Fensham, 2021; Talebi & Desjardins, 2012), and name or dress (Clark & Saleh, 2019). Pollock et al. (2012) examined migrants' experiences of NHCPs' racism and discrimination in southern Ontario, Canada. The authors found that 17 out of their 26 participants personally experienced at least one unfair or discriminatory action by NHCPs because the participants were racialized. Migrants may also face microaggressions from NHCPs as a form of rejection and discrimination (Pollock et al., 2012). Some NHCPs refused treatments to migrants because they suspected they could not speak or comprehend English and/or French (Clark & O'Mahony, 2021; Lee, 2019; Pollock et al., 2012; Shirpak et al., 2007; Silberholz et al., 2017). In some cases, NHCPs assumed that migrants did not have Canadian health insurance to pay for the services (Clark & O'Mahony, 2021; Gamble et al., 2015; Lee, 2019; Silberholz et al., 2017). In turn, many migrants did not follow up with NHCPs unless it was a medical emergency, went to clinics in urban areas to receive non-discriminatory services, or chose to return to their country of birth (Pollock et al., 2012). In addition, Pollock et al. (2012) found that a migrant in their study was asked by a healthcare professional to change their name to enable Canadian NHCPs to pronounce the name easily.

It is sometimes assumed that having NHCPs who speak the same languages would address migrants' healthcare needs (Salam et al., 2022). However, speaking the same language does not guarantee affirming and safe care. Dastjerdi (2012) examined perceptions of Iranian NHCPs in the Greater Toronto Area and analyzed the challenges and obstacles Iranian migrants

faced in accessing the Canadian health care system. The lack of a common language was noted as a challenge for NHCPs and clients. Even if the NHCPs spoke the same language, they may not understand recent idiom or phrases in Farsi. Moreover, the availability of proficient and reliable language interpreters may not always translate to culturally safe care or accurate interpretation when considering internal othering among ethnically diverse LGBTQI+ people, and this may lead to misdiagnosis and mistreatment of clients (Clark & Vissandjée, 2019; Salami et al., 2019; Tanner et al., 2014). Some terms may also be misunderstood; for example, the word هم‌جنس‌گرا or "hamjens gara" (Translation: homosexuals), is frequently used in Farsi in reference to LGBTQI+ people; however, not every LGBTQI+ person identifies with that term. A nurse's use of a word which an LGBTQI+ migrant does not identify with may result in a lack of effective communication and mistrust in care (Salami et al., 2019). LGBTQI+ migrants may feel judged, and this may result in avoiding follow-up appointments.

In general, racialized and LGBTQI+ migrants may experience compounded stress and ongoing traumas in comparison to the already known challenges related to relocation, change of culture and gender norms, financial burdens, and inability to fluently communicate (Islam et al., 2018; Khanlou et al., 2017; Kouri et al., 2022; Lee et al., 2021; MacDonnell et al., 2016; Mangrio & Sjögren Forss, 2017; Salam et al., 2022; Salami et al., 2019; Williams & Serpas, 2021). Dastjerdi (2012) and Zou (2019) noted that some migrants do not understand the Canadian health care system, for example the need to request specialists and the long wait-times. Another challenge is that migrants may experience somatization experiences, such as chest pains, headache, and other physical health challenges, leading to poor overall physical and mental health and the need for counselling (Islam et al., 2018; Salam et al., 2022; Salami et al., 2019; Shishehgar et al., 2015). However, migrants may initially refuse counselling and a referral to a

psychologist due to cultural stigmas about mental health and fear of exposure and being labelled (Dastjerdi et al., 2012; Salam et al., 2022; Salami et al., 2019). Some migrants felt rumors about their physical and mental health would spread in their ethnic communities (Salam et al., 2022). Islam et al. (2018) found that immigrants, compared to Canadians, were less likely to discuss mental health issues with NHCPs. Nonetheless, MacDonnell and colleagues found migrant women's activism could be a useful approach to addressing migrant women's mental health and well-being in their communities (MacDonnell, Dastjerdi, Bokore, et al., 2017; MacDonnell et al., 2012, 2016). In particular, the authors found that migrant women, including those who self-identified as lesbians or members of a sexual minority, engaged in everyday individual or collective activities, such as developing programs to meet their communities' needs, that challenged the status quo and demonstrated resilience. Overall, however, migrants' fear of the unknown and limited knowledge about Canadian health care impacted the services they received from NHCPs.

Access to care has been an issue for migrants and is more difficult for undocumented and uninsured people (Association of Women's Health, 2017; Khanlou et al., 2017; Tanner et al., 2014). In a pilot study with NHCPs and community organizations in Montreal, Rousseau et al. (2008) assessed how migrants were accessing care through the health care system. Due to systemic barriers to availability of care for migrants with no health insurance, clinicians who provided care to migrant families often did so discreetly. Migrants' high levels of morbidity enhanced the challenges in receiving care due to delays in seeking care, treatment, and poor follow up (Tanner et al., 2014).

### Closing the Literature Review

This review of the literature demonstrates that LGBTQI+ migrants are marginalized across intersecting dimensions of race (MacDonnell & Daley, 2015; Munro et al., 2013; Tanner et al., 2014), ethnicity, language, religion (Fensham, 2021; Munro et al., 2013; Talebi & Desjardins, 2012), migration status (Fobear, 2016; Ghabrial, 2017; Lee, 2019; Lee et al., 2021; Murray, 2014b, 2014a; Salam et al., 2022; Sansfaçon et al., 2018), as well as mental and physical health challenges (Gamble et al., 2015; Ghabrial, 2017; Lee et al., 2020; Salam et al., 2022). However, I do not claim that LGBTQI+ migrants are simply a marginalized group; rather attention to systemic structural hierarchies may show barriers that lead to oppressive LGBTQI+ experiences in Canada (Ahmed, 2012b, 2012a; Collins et al., 2021; Gamble et al., 2015; Khanlou et al., 2021; Massaquoi, 2020; C. D. Smith et al., 2021; Trans Care BC, 2021). There is a need for further research on the experiences of LGBTQI+ migrants, especially since, as discussed above, there is limited nursing research on understanding the experiences of LGBTQI+ migrants' interactions with nurses in Canada. The added value of applying an intersectional lens with Gadamerian hermeneutics is that it can include the experiences of LGBTQI+ migrants to address social injustices and to further inform nursing and health care practices on potential ways to mitigate systemic harms.

## Methodology: Intersectionality with Gadamerian Hermeneutics

In the methodology section, I discuss Gadamerian hermeneutics as a qualitative research approach to understanding LGBTQI+ migrants' experiences when they encounter NHCPs in Canada. Despite the obvious need for research on this topic, there is limited literature on the articulation of experiences of LGBTQI+ migrants' interactions with NHCPs in Canada. In this dissertation, I have followed the hermeneutics approach and used the word *informants* to refer to

interview participants and *inquirer* to refer to the researcher. The word informant implies that LGBTQI+ migrants will be informing me, the inquirer, about their experiences with nurses and other health care professionals in Canada (Cohen, 2000a). For this research, I conducted 18 semi-structured individual interviews with informants from October 2020 to June 2021.

Intersectionality has roots in feminism and will be utilized as an analytical lens to challenge dominant and privileged ways of identifying race, ethnicity, religion, class, age, and SOGIE as fixed, normal, or singular (Choby & Fischer, 2016; Loutfy et al., 2012; Squires, 2017). Even though there are competing tensions between and among Gadamerian hermeneutics and intersectional theories, the two are synergistic. Exploring the historical and conceptual ties between intersectionality and Gadamerian hermeneutics potentially yields new insights into both areas. Specifically, a more complex understanding of power will result in an important dialogue between these two methodologies in relation to LGBTQI+ migrants. Here, I present a non-reductionist view of intersecting identities that are shaped as a result of power structures and relationality (Collins et al., 2021). I start by examining the philosophical underpinnings of Gadamerian hermeneutics and then discuss the intersectional theory. Thereafter, in the methodology manuscript, I explore areas of contention and confluences between and among the two. Within each section, I share my understanding of the situatedness of LGBTQI+ migrants.

**Gadamerian Hermeneutics**

In this section, I briefly discuss the historical and disciplinary origins of Gadamerian hermeneutics. Historically, hermeneutics was known as the practice of interpreting sacred religious texts (Abram, 1996; Polit & Beck, 2017; West, 2010). The terms *hermeneutics* and *interpretive phenomenology* are often used interchangeably; however, there are some distinct differences between the scholars in phenomenology and those who study hermeneutics. Hans-

Georg Gadamer (1900–2002), a German philosopher in the continental tradition, asserted that in hermeneutics, language is not static and is changing with "fluid horizons of understanding" (Gadamer, 1976, p. xxxi). Language is a means of communicating understanding between people and is shaped by historical context. Drawing on Aristotle, the focus of Gadamerian hermeneutics is on developing a deep understanding of human experiences (Annells, 1996; de Witt et al., 2010; Dowling & Cooney, 2012; Gadamer, 2000, 2007b, 2009), and this requires knowledge of the prior, current, and future contexts of a situation (Crotty, 1998). Using this standpoint, the experiences of LGBTQI+ migrants will be viewed "as an inexhaustible source of possibilities of meaning rather than as a passive object of investigation" (Gadamer, 1976, p. xix). The philosophical underpinnings of Gadamerian hermeneutics are influenced by prominent scholars, such as Hegel, Schleiermacher, Dilthey, Wittgenstein, Husserl, and Heidegger. It is important to discuss the similarities and conflicting perspectives among scholars, their contributions to Gadamerian hermeneutics, and the philosophical turn from epistemology to ontology in the interpretive phenomenology research approach.

Georg Wilhelm Friedrich Hegel (1770 – 1831), a German philosopher, explored the notion of idealism between mind and nature (West, 2010). For Hegel, knowledge of the present is shaped and influenced by past understandings and experiences. Gadamer's *fusion of horizons* is borrowed from Hegel's discussion of knowledge being mediated from past to present. Hegel's treatise on past mediation to the present and self-reflection on that past have shaped Gadamer's philosophical discussion of prejudices.

Friedrich Schleiermacher (1768 – 1834), a theologian and philosopher of language, emphasized that understanding is achieved through systematic steps of knowing the subjects and their expressions. Schleiermacher concluded an understanding occurs in psychological

interpretation and rebuilding of the author's thought (Moules et al., 2015). For Schleiermacher, understanding and interpretation occurs in a hermeneutic circle through a precise sense of the individual and the context as "a mutual movement between part and whole" (Moules et al., 2015, p. 14). Schleiermacher's discussion of *grammatical interpretation* was taken up by Gadamer. Grammatical interpretation means when a word is not only based on its meaning, but it has meaning based on its place in context.

The philosophical turn during the late nineteenth century focused on historicism that went beyond the individual and text. Dilthey (1833 – 1911) was a German historian, psychologist, and sociologist, and introduced the concept of "lived experience" with a focus on understanding human experiences and lives through precise measures (Koch, 1995; Moules et al., 2015). An inquirer must consider the interrelated meaning of culture when understanding another person. Similar to Schleiermacher and Dilthey, Ludwig Wittgenstein (1889 – 1951), an Austrian philosopher, also attempted to establish concrete methodological steps and objectivity to achieve understanding (McCaffrey et al., 2012).

The next philosophical contributor to Gadamerian hermeneutics is Edmund Husserl (1859 – 1938), who established the school of phenomenology and focused on phenomenological reduction or the epoche of intentionality. This reduction was done by using epistemology and concrete steps to peel away superficial layers and reach the true nature of the *lifeworld* (Fleming et al., 2003; Moules et al., 2015). Lifeworld signifies that experiences exist and are in relation to the world. Husserl referred to intentionality as the existing thoughts and perceptions that lead to understanding. For pure thought or essence of understanding to be achieved, there is a need for the interpreter to bracket (Streubert & Carpenter, 2011; Tuohy et al., 2013). Bracketing is when the interpreter separates thoughts, emotions, and feelings from the subject (McCaffrey et al.,

2012). This emphasis on bracketing was critiqued by Heidegger and Gadamer because experiencing the world is an ontological movement. Gadamer concluded that bracketing should not be undertaken because doing so would refuse to acknowledge the prejudices or *pre*judgments in every understanding (Fleming et al., 2003).

Martin Heidegger (1889 – 1976) was Husserl's assistant from 1920 to 1923 (Laverty, 2003). Heidegger, who was Gadamer's mentor and teacher, contradicted Husserl, arguing that bracketing cannot occur because experiencing the world is an ontological movement. Heidegger referred to this experience with the world as Dasein or being. Heidegger inherited Husserl's discussion of lifeworld but emphasized Dasein cannot be separated from understanding the experience (Laverty, 2003). Heidegger did not see the world as fixed, but rather as "a set of interrelated and layered events that happen to us, that in turn, are revealed to us through our practical involvement" (Moules et al., 2015, p. 27). Heidegger stressed the term *sense* as the ability to recognize, make meaning, and question to reach self-understanding that becomes the *truth* (Fleming et al., 2003). Truth refers to disclosure and "un-concealment" of that which is not clearly apparent, and not as something that is absolute and fixed. Gadamer jettisoned Heidegger's subjectivity in hermeneutics and explained that the formation of meaning is constantly changing and indicated how language shapes and influences existence (West, 2010).

### *The Ontological Turn to Gadamerian Hermeneutics*

Here, I present Gadamer's focus on ontology, his views of universality in language, the importance of historicity, and the presence of prejudice and the hermeneutic circle. The ontology of Gadamerian hermeneutics is concerned with being and dwelling in the world and understanding through experiences (Ho et al., 2017). This ontological underpinning of Gadamerian hermeneutics requires an understanding of tradition, including culture, norm, and

history that are embedded in language and modes of communication (Lopez & Willis, 2004). These contextual traditions may have caused the dominance of one form of understanding over another. Jürgen Habermas, a German sociologist and philosopher in critical theory, has critiqued Gadamer for his focus on ontology and universality (Koch, 1995; Shaw & DeForge, 2014). In turn, Gadamer critiqued Habermas for his focus on the epistemological interest in social sciences. For Gadamer, it is not only about the epistemology of one's language, but also having an ontological presence in dialogue. Rather than only focusing on the epistemological meaning of the LGBTQI+ migrants' individual experiences, Gadamerian hermeneutics is also concerned with the formation of understanding by drawing ontologically on the present and past experiences of informants and the inquirer (Gadamer, 2007a). The ontology in Gadamerian hermeneutics illuminates multiple, evolving, and changing realities; therefore, understandings are varied and transient (Cohen et al., 2000a; Fleming et al., 2003; Gadamer, 1976). Understanding in Gadamerian hermeneutics is ontological, as it is shaped by universality and fluidity (Jardine, 1992).

Gadamer (1976) asserted that there is more than one meaning to one word and that this leads to diversity in language and understanding. For Gadamer, understanding occurred in where and how language is *communicated, interpreted, and understood*, and rejected *absolutizing*. Gadamer used Heidegger's discussion of the universality of language and delved into how universality impacts people's experiences in the world. Universality refers to the use of language to achieve comprehension of the existing world by searching for all that is said and not said (Moules et al., 2015). Universality in understanding is influenced by ontological existence, the informants' and inquirers' context, and the non-neutrality of language. Gadamer probed how one comes "to know" and "to recognize" (Moules et al., p. 14) and placed the principle of *occurrence*

as a focal point in universality. Occurrence involves the repetition of familiar experiences, the highlighting of strangeness, and the "broadening and enrichment of our own experience of the world" (Moules et al., p. 15). Gadamer (1976) stated,

> The phenomenon of understanding, then, shows the universality of human linguisticality as a limitless medium that carries everything within – not only the "culture" that has been handed down to us through language, but absolutely everything – because everything (in the world and out of it) is included in the realm of "understanding" and understandability in which we move. (p. 25)

The idea of understanding as always located within the history and context of the informant and inquirer is central to recognizing the contributions of intersectionality to furthering hermeneutic understanding. Inquirers in intersectionality theory claim analysis cannot be undertaken without attention to context at the micro, meso, and macro levels across identities (Hankivsky & Jordan-Zachery, 2019b). This also relates to the use of language to strategically essentialize LGBTQI+ migrants as a category while being attentive to their unique experiences.

According to Annells (1996), Gadamer noted that the hermeneutic circle is present when what has occurred in the past, when rediscovered, becomes new again, because it is influenced by each interpreter's context. More importantly, in order to deepen understanding, the hermeneutic circle is concerned with intertwined back and front movement from part to whole in a spiral and continuous motion. Gadamer (1976) underscored that the interpreter and informant's historicity influence the fluidity of understanding. In considering the experiences of LGBTQI+ migrants with NHCPs, Gadamerian hermeneutics is not merely the understanding of linguistics and how it is formed. Rather it is about understanding the symbolic activities in health care practice that LGBTQI+ migrants have faced (Cohen et al., 2000b; Gonzalez, 2016; Padgett,

2017). This approach assumes an ontological nature and places understanding within the historicity, the tradition, and the context of both informants and inquirer (Cohen, 2000b).

Gadamer (1976) emphasized that the hermeneutical situations of individuals are rooted in historical prejudices. In modern science, self-reflection is maintained through precise control, but Gadamer argued that this control causes alienation in understanding as it does not consider the interpreter's contextual positionality. The process of understanding in Gadamerian hermeneutics is influenced by affective history and projections. In the discussion of affective history, Gadamer highlighted that people are inseparable from their understandings because in dialogue, they always bring their different horizons together, shaped by past and present traditions (Johnson, 2000). The historicity of informant and inquirer shapes understanding, because of the finite ways of questioning and answering. Gadamer asserted, "every dialogue also has an inner infinity and no end" (Gadamer, 1976, p. 67). Borrowing from Heidegger, Gadamer related projection to the future and how one continues to exist non-statically. Understandings cannot be "prejudiceless" (p. XIVII) because with each understanding different horizons arise which inform the next line of communication. Dialogue and language are not neutral, and the process of understanding has prejudice and preunderstanding. This discussion of prejudices is aligned with intersectionality as an analytical lens because inquirers may use understandings to deepen current understanding rather than attempting to be passive to their past experiences (Collins et al., 2021; Massaquoi, 2020).

**Intersectionality: An Analytical Lens**

The core argument in intersectional theory is that dominant power and hierarchies have socially excluded individuals based on interlocking oppressed identities and orientations (Collins, 1993; Crenshaw, 1989). Hancock (2019) has argued that critical race theory, as

embedded in intersectional understandings, has created an avenue for legal studies to critique North American structural and institutional hierarchies that cause injustices, inequities, and marginalization. Although the discussion of intersectional theory originated among North American scholars, it is now applied by researchers, practitioners, and activists across the globe (Collins et al., 2021; Hankivsky & Cormier, 2019). There may be a misconception that intersectionality is only concerned with race, gender, sexuality, and class; however, its interwoven principles demonstrate that hierarchies of power and privilege cause social injustice and inequities along multiple lines (Collins & Bilge, 2016; Hankivsky et al., 2019). Consequently, scholars of intersectionality call for transformation, collaboration, and social justice.

### *Historical Background and Principles of Intersectionality*

Intersectionality started to gain recognition in the 1960s, rather than the commonly identified origin of the 1990s. Collin and Bilge (2016) have asserted that only focusing on the history of intersectionality beginning from the use of the word intersectionality erases the work of the women who had already been silenced based on race, ethnicity, gender, sex, sexuality, religion, class, and linguistics. In the 1960s, oppressed and marginalized women and men participated in various political and social movements to address social and human rights issues. By the beginning of the 1970's, North American women of colour recognized that their challenges were different from those of men of colour and white women. African American women, using a feminist lens, were aware that the identities of race, class, gender, or sexuality could not be addressed in silos; rather, experiences are shaped by intersecting oppressed identities. In addition to Black women, there were other feminists of colour comprised of "Chicanas and Latinas, Native American women, and Asian-American women" (Collins &

Bilge, 2016, p. 71) who became vocal about oppressive structural and social policies. In 1973, the members of the National Black Feminist Organization (NBFO) in Boston were the initial pioneers of Black feminist activism. However, Hancock (2019) has asserted that normative views within the NBFO caused other activists to address the invisibility of diverse SOGIE people. Ergo, in 1974, the Combahee River Collective, a Black lesbian organization, challenged homophobia and heterosexism, and argued that the experiences of Black non-heterosexual women were different than white women (Reed, n.d.). Building on these activist beginnings, scholars in the 1980s provided a space for examining the intersecting experiences of marginalized peoples.

In the 1980s, the term intersectionality started to be used, coinciding with the employment of women of colour and other previously oppressed groups in academia. The civil rights movements in the 1960s challenged the existing discriminations and exclusions that oppressed individuals faced in schools, jobs, housing, and administration. To answer this call for social justice, institutions, such as universities, began to hire individuals who were formerly excluded. In the United States of America in particular, Black feminists in academia found a new avenue to voice their concerns about social justice for those marginalized by the intersecting lines of SOGIE, race, and class. In this process, they met challenges and a lack of understanding of the lived experiences of marginalized, oppressed, and colonized groups in academia (Collins & Bilge, 2016). To further theorize these experiences, the term intersectionality was coined by legal studies scholar Kimberlé Crenshaw in 1989 (Crenshaw, 1989) and by sociologist Patricia Hills Collins in 1990 (Collins & Bilge, 2016; Hancock, 2019; Potter et al., 2019).

**What Are the Main Principles of Intersectionality?**

The first principle is that people's complex lived experiences cannot be reduced to only one identity, orientation, or character but that these intersect without prioritizing one over another (Crenshaw, 1991; Hankivsky et al., 2019). The second principle asserts that social categories and locations are not limited to SOGIE, race, ethnicity, class, ability, and religion, and that these categories are socially constructed (Hankivsky & de Leeuw, 2011). In other words, these categories are dynamic, diverse, intertwined, and in continuous interaction with one another, and understanding them should not follow normative binarization (Hankivsky et al., 2019; Hay et al., 2019; Heise et al., 2019). The diverse experiences of those oppressed are rooted in the unique contextual situatedness of individuals. This leads to the third tenet related to power and domination. Hankivsky et al. (2019) has stated that, "social locations are inseparable and shaped by interacting and mutually constituting social process and structures, which, in turn, are shaped by power and influenced by both time and place" (p. 135). The fourth principle focuses on the impact of social location on oppressed individuals. Finally, social justice and equity praxis are vital outcomes of using an intersectional lens. These principles of intersectionality assist in comprehending LGBTQI+ migrants' various experiences as a result of intersecting social marginalization.

Scholars of intersectionality theory pave the path for critical inquiry and praxis (Collins, 2019; Hancock, 2019; Hankivsky, 2014; Hankivsky & Cormier, 2019; Muelle & Ramírez, 2019). Yet, Hankivsky and Cormier (2019) postulated that intersectionality is neither clearly understood nor effectively utilized in Canada. The term praxis here means that research and practice are intertwined, and they inform one another; inquirers and practitioners reflexively strive to highlight areas for improvement (Cho et al., 2013; Collins et al., 2021; Rodriguez et al., 2016).

Intersectional theorizing remains in its infancy in nursing praxis despite its 40-year history, but can be found in nursing research, practice, and education. As is the case with various scholars, Collins (2019) argues that intersectionality as an analytical lens can assist practitioners in informing their praxis in relation to social problems. Pepin-Neff and Wynter (2019) and Scheadler et al. (2022) have added that oppressed individuals use intersectionality in pursuing their political agendas and in their activism.

### *Intersectional Critical Inquiry: Relevance to LGBTQI+ Migrants*

Inquirers using intersectionality highlight the study of oppressive power across various social contexts and identities (Collins & Bilge, 2016). In my research, I aim to understand the experiences of LGBTQI+ migrants with nurses in Canada. Based on a review of the current literature, I have found that LGBTQI+ migrants' experiences are shaped by various systems of oppression and discrimination based on the identities of race, SOGIE, ethnicity, religion, migration, class, language, dis/ability, and mental health (Brennan et al., 2013; Cisneros, 2018; Collins et al., 2021; Khanlou, Bohr, et al., 2020; Khanlou et al., 2021; Lee & Brotman, 2013; Semlyen & Rohleder, 2021). Collins and Bilge (2016) have emphasized the importance of critical praxis, arguing that, "[critical praxis] explicitly challenge[s] the status quo and aim[s] to transform power relations" (p. 33). Critical inquiry researchers are engaged in understanding intersecting domains-of-power. In her discussion of the domains-of-power, Collins (2019) highlighted that power is neither neutral nor static, and several factors are interwoven in causing oppressions. She has noted "structural, disciplinary, cultural, and interpersonal dimensions of power operate singularly and in combination in shaping the social organization of power" (Collins, 2019, p. 170).

To achieve a deeper understanding of the experiences of LGBTQI+ migrants with nurses in Canada, I will use intersectionality as an analytical lens to challenge the dominant hetero-homo-cis-normative and privileged ideologies (Casey, 2019). In chapter two, which includes the methodology manuscript, I discuss the areas of confluences and tensions between intersectionality and Gadamerian hermeneutics. For instance, I underscore that intersectionality and Gadamerian hermeneutics share a common set of principles; both attend to reflexivity, historical context, and critical inquiry as a means to understand new ways to relate socially (Bright, 2015; Lopez & Willis, 2004). The dissonances between intersectionality and Gadamerian hermeneutics are the founders' historical backgrounds and views on building equitable communities of inquiry (Davidson, 2016). In what follows, I situate myself within my topic.

**Situating Self in Path to Understanding**

Similar to scholars of Gadamerian hermeneutics, intersectional scholars emphasize the importance of self-reflections and self-positioning. The academic, inquirer, and activist using intersectionality as a lens needs to recognize their own privileges and the forces that may have led to blame and oppression of another person or group (Collins & Bilge, 2016; Hancock, 2019). Positioning myself critically within the broader discourse, I acknowledge the oppressions and privileges that have formed my past and will continue to shape my prejudices in understanding the experiences of LGBTQI+ migrants in their encounters with nurses (Hankivsky & Jordan-Zachery, 2019b). In my discussion above, I shared how the self-exploration of my lack of knowledge created a path to enhance my understanding. In a position of privilege, I interpreted the informants' experiences and I strive to bring the experiences of LGBTQI+ migrants to the reader in an effort to engage in dialogue for more affirming health care practices.

My present experiences are shaped by continuous learning about philosophical Gadamerian hermeneutics and intersectionality through reading and presenting, as well as conversing with scholars, activists, my doctoral study committee members, and LGBTQI+ migrants. Journaling as a formal self-reflection during the research process enabled me to refer to thoughts and understandings that may influence gaining understanding, conversing with the transcriptions, and disseminating the transpired understandings (de Witt & Ploeg, 2006; Fleming et al., 2003; Moules et al., 2015; Steeves, 2000). This form of reflection is incorporated as part of interpretations and dissemination (Humphries & McDonald, 2012). In each stage of the research, I acknowledged the history and complexity of intersecting identities in understanding the experiences of LGBTQI+ migrants with nurses (Hankivsky & Jordan-Zachery, 2019a; Humphries & McDonald, 2012; Jardine, 1992).

I had planned to become an expert in my substantive field of study and methodology. However, Gadamer (1976) maintained that mastering a methodology does not guarantee application of knowledge to practice. Gadamer elucidated that mastering a methodology would close the option of the hermeneutical circle, and it is only by means of thorough imagination and questioning that one is successful in science. Gadamer was not anti-science; rather, he highlighted that in every "science" there will be things unsaid and undiscovered. Gadamer (1976) confirmed, "The real power of hermeneutical consciousness is our ability to see what is questionable" (p.13). Following the discussion here, in the next sections, I share how I conducted my research, beginning with ethical considerations.

**Ethical Considerations**

In this section, various ethical considerations are addressed. These areas where ethical concerns could arise are positions of power, psychological harm to informants, and incentives.

### *Positions of Power*

LGBTQI+ migrants may be fearful of discrimination, stigma, or being denied permanent immigration status if they voice their concerns about their experiences with NHCPs while accessing health care services (Salami et al., 2019; Spence & Smythe, 2008). Given my position of privilege and experiences as a migrant nurse, I aimed to create a safe environment during interviews to gain understanding of their experiences. As a faculty member, none of the nursing students from my place of employment could participate in the study because I am in a position of power. In the consent form and prior to the interviews, I notified informants that I am not able to impact their immigration process. As an inquirer, I ensured confidentiality by removing informants' identifiable information and by using pseudonyms and pronouns that informants selected. The option of giving verbal consent was provided to the informants. Some informants provided written consent and others provided verbal consent. I conducted and transcribed the interviews to avoid third-party involvement.

### *Harm to Participants: Low*

Per the results of the ethics application, the risk to those participating in the interviews was low. Due to the COVID-19 pandemic, interviews were held via Zoom while informants were at their safe space. Zoom is a video conferencing platform that enabled informants to use either their phone or a website to meet with me. Also, the informants had the option to turn their camera on or off. At the start of each interview, I inquired whether the informant had privacy and felt safe to discuss their experiences with nurses or if they would prefer for us to reschedule. All informants felt they had privacy in starting the interviews. On one hand, the informants could have experienced psychological risks and discomfort in sharing their experiences. For this reason, contact information for distress centres in the informants' provinces were provided in the

consent forms. On the other hand, sharing their stories may have given them a sense of liberation and empowerment. In terms of potential benefits to informants, there was no guarantee that they would directly benefit from participating in the study. The informants could choose to add their participation in the study to their professional resume.

The informants were made aware before, during, and after the interview process that they could withdraw from the study at any time. In addition, their names and identities would be anonymized, and the information they shared remained anonymous. None of the informants withdrew from the study. I advised informants at the start of the interviews that they may decline to answer questions or stop participating at any time. Sensitive information came up during the individual interviews; however, I am familiar with facilitating interviews dealing with sensitive topics, and this helped to mitigate the risk of any negative psychological stress. I addressed these concerns based on my expertise in a respectful and thoughtful manner. Periodically during the interview and at the end of the interview, I asked informants how they were feeling.

***Incentives***

In regard to time and any travel demands, individual interviews lasted 1 to 1.5 hours. The travel demands were kept to a minimum by arranging phone or virtual interviews. The minimum wage in Ontario is $14/hour. The informants were offered a $25 Tim Horton's or Amazon gift card or a money transfer of $25 to their preferred email. This amount was provided for approximately 1.5 hours of interview time and in recognition of the informants' contribution of time and expertise. Their emails were used for the purpose of transferring money, for arranging interview dates and times, and for providing Zoom information.

**Gathering Informants: Recruitment**

Gathering informants for individual interviews in an effort to understand the experiences of LGBTQI+ migrants with NHCPs in Canada is a challenging process. The first step was to ensure adherence to research ethics guidelines. Ethics approval for this study was received (Approval number 19-0591) from the University of Victoria' Human Research Ethics Board (HREB). Please see Appendix A.

Following human ethics board approval, various sampling approaches were utilized to gather the experiences of LGBTQI+ migrants with NHCPs. Three stage sampling was integrated into this study. Calling on informants to share their experiences was one method of elucidating new understandings of LGBTQI+ migrants' experiences with NHCPs. In discussion of research methodologies, the phrase participant recruitment is often used instead of calling upon informants. Moules et al. (2015) incorporated the phrase "Gathering Participants" (p. 90) instead of recruitment. Gadamerian hermeneutics and intersectionality has influenced how I gathered participants as informants. The first method used was purposive sampling, where potential participants must have had experience with the topic of interest, and be ready and willing to disclose their experiences. The second sampling approach used was convenience sampling. To reach a larger population, I extended invitation to the study by using various method of recruitment. This kind of sampling allowed the sharing of the call for research participants with potential informants (Singh et al., 2017). Third, the snowballing approach was used, where informants were asked to share the call to the research study with other LGBTQI+ migrants and potential informants. This approach is particularly useful when working with groups that have experienced mistrust and distrust of the research process (Lee & Brotman, 2013; Massaquoi, 2020).

Following ethics review board approval from relevant institutions and organizations, informants were recruited through word of mouth, social media (Facebook, Twitter, and Instagram), and connections with migrant, LGBTQI+, and migrant LGBTQI+ organizations, clubs, and groups within Canada. Just to name a few, the call for informants was shared with the following organizations: RNAO, RNIG, the International Railroad for Queer Refugees (IRQR), Sigma Theta Tau International (STTI) Honor Society of Nursing, Rainbow Health Ontario (RHO), Rainbow Health Network, the Neighbourhood Group – St. Stephen's community house, Access Alliance, Ontario Council of Agencies Serving Immigrants (OCASI), Children's Aids Society, Rainbow Resource Centre Winnipeg, and PFLAG across Canada. I also connected with refugee, LGBTQI+, and migrant agencies nationwide.

Prior to COVID-19, as I was preparing my research proposal, I had planned to visit agencies and organizations in Ontario and Quebec to personally invite informants. Indeed, I had planned to conduct the interviews in person at a location convenient for informants. However, due to COVID-19, I had to change my approach to calling upon the informants by utilizing the internet and social media. For this reason, interviews were held using the University of Victoria's secure Zoom and two separate audio-recorders were used in case of malfunctions.

Two groups of informants were selected for individual interviews. Two recruitment letters (Appendix B), two recruitment posters (Appendix C), two consent forms (Appendix D), and two sets of interview questions were prepared (Appendix E).

***Inclusion Criteria***

- First group: Migrant (refugee, new arrival immigrants, immigrants, Canadians who were immigrants, asylum seekers, or visitor/education/work visa status)

LGBTQI+ people who received care from nurses and other health care professionals in Canada

- Second group: Nurses (practicing, retired, or student nurses in Canada [diploma, degree, or graduate degree education]) who provided or witnessed nursing care provided to LGBTQI+ migrants

All informants were:

- Over the age of 19
- Comfortable communicating in English
- Comfortable being audio recorded for the purpose of research

***Exclusion Criteria***

- Migrant LGBTQI+ people who had not received nursing care in Canada
- Nurses who had not witnessed or experienced care provided to LGBTQI+ migrants

Two groups of informants were called upon to participate in this research. The first group of informants were LGBTQI+ migrants, because they could share personal experiences of receiving care from NHCPs in Canada. The informants met all the inclusion criteria. The second group of informants were nurses, because they added to my understanding of the nursing care provided to LGBTQI+ migrants. This included nurses or nursing students who may have observed, heard about, or witnessed the provision of nursing care to LGBTQI+ migrants or provided nursing care to LGBTQI+ migrants; they could identify as LGBTQI+ people, or heterosexual and cisgender; they could be Canadians or migrants themselves. Nurses and nursing students could also be family members or friends of LGBTQI+ migrants. Exclusion criteria included of nurses or nursing students who had no experience or knowledge of nursing care

provided to LGBTQI+ migrants. The nurses were "informants" as they contributed to the understanding of LGBTQI+ migrants' experiences. For example, nurse-informants helped with understanding the processes LGBTQI+ migrants go through and services that are available.

***Gaining Understanding: Data Collection***

Please see appendix E for the semi-structured individual interview questions. The questions were topic-focused but "[could not] be determined in advance as in a survey" (Moules et al., 2015, p. 45); however, a few questions were developed to guide the conversation. Not all the questions were asked since the nature of conversation unfolded uniquely with each informant. During interviews, I listened thoroughly to how various factors shaped the experiences of LGBTQI+ migrants with nurses and other health care professionals. Knowing my position of privilege as a cisgender, heterosexual, Canadian citizen and academic created feelings of uneasiness as I started my first interview. I was worried about how interviews would unfold with the informants. Upon transcribing the first interview, I heard my rigidity and nervousness in the audio recording; subsequently, I heard how I was able to slowly lose myself in the interview with the informant. I shared this first transcription with my doctoral studies supervisor and received guidance and feedback on how to be comfortable delving more deeply in future conversations. This feedback allowed me to have a more relaxed approach in future interviews; however, I always remained self-conscious about my positionality. Prior to each interview, I reviewed the aim of my study, but I stayed open to how the interview unfolded and the direction the informants would take me in speaking about their migration trajectory and diverse LGBTQI+ experiences as they encountered nurses and health care professionals in Canada.

### *Conversing with the Interviews: Data Analysis*

I carried Gadamerian hermeneutics and intersectionality into the interpretation of the interviews. Conversing with the interviews occurred with an acknowledgement that some things always remained unsaid and undiscovered. The perfect interpretation was not expected, but an understanding emerged through detailed, dedicated, and careful interpretation of various factors shaped by the historicity of each converser (Jardine, 1992). The phrase "data saturation," which is used in other methodologies, is not employed in Gadamerian hermeneutics, as philosophically there is an understanding that what is already known is disposed to be challenged and questioned. I do not claim that data saturation is reached; rather, I have gained a deepened understanding of informants' experiences, and in interpretations, highlighted what stands out meaningfully (O'Reilly & Parker, 2013; Saunders et al., 2018; Thorne, 2020). Dialogue was not static, rather in process, and consisted of many possibilities for understanding.

The purpose of Gadamerian hermeneutics was not to only concentrate on the informant but to investigate the subject matter with the informant and have a hermeneutic conversation that would lead into the hermeneutic circle. The hermeneutic circle in Gadamerian hermeneutics is a process of looking at the whole and the parts of a topic in a spiral and continuous format (Moules et al., 2015). The aim of conversing with the interviews was not to quantify the experiences of LGBTQI+ migrants, but rather to have a meaningful understanding of their unique experiences. I used the principles of intersectionality as an analytic lens for the interpretation of interviews and searched beyond the present categories by looking at how normative ideologies and structural policies in systems have created the conditions in which some people are dominated and others are privileged based on intertwined and interlocking identities (Hankivsky & Cormier, 2019). I conversed with the informants during the interviews in relation to the topic and then the specific

experiences by reading and re-reading the interview transcripts iteratively and searching for similarities, differences, what stood out, what was provoking, and even what called current understanding into question (Moules et al., 2015). I opened myself up and listened to what was being said and not said — even confronting viewpoints, which may have been hard to hear and observe. For example, some informants brought forth the notion of ally theatre, and I had a vague understanding of this concept. Delving into the interviews and transcriptions, my horizon started to change, and I further recognize that I may have been guilty of ally theatre and performative allyship. It was through engagement with others, or the fusion of horizons, that I became aware of my assumptions.

Simultaneous interpretation of conversations during interviews facilitated additional questions, and deeper understanding resulted from systemic processes on social categories of SOGIE, race, ethnicity, migration status, religion, dis/ability, and mental health (Gamble et al., 2015; Humphries & McDonald, 2012; MacDonnell, Dastjerdi, Bokore, et al., 2017). Gaining understanding in Gadamerian hermeneutics and intersectionality is a play between individuals' historicity and contextuality (Bradbury-Jones et al., 2011). Scholars in the field of intersectionality provide a framework that social inequities are based on context and are the products of many oppressive social and institutional structures and policies (Collins, 1993, 2019; Collins & Bilge, 2016; Crenshaw, 1991; Hankivsky, 2014; Heise et al., 2019). For example, LGBTQI+ people may have migrated to Canada from countries with zealous religious beliefs and a lack of political will to recognize and address violence against LGBTQI+ people (Muelle & Ramírez, 2019).

Conversing with interviews occurred at several points in time. First, as I was completing the transcriptions verbatim, I made notes about keywords and phrases that underscored the

informants' experiences. For example, during Zoom interviews when an informant's facial expressions, gestures, or changes in voice occurred in response to a question about their experiences with nurses and health care professionals, I included these details as part of my interpretation of findings (Cayir et al., 2021). Questions that arose after transcription of one interview were taken to the next interview. In keeping with intersectionality and Gadamerian hermeneutics, I made every effort to ensure that the informants' voices were amplified, and that their unique experiences were the focus of interpretations.

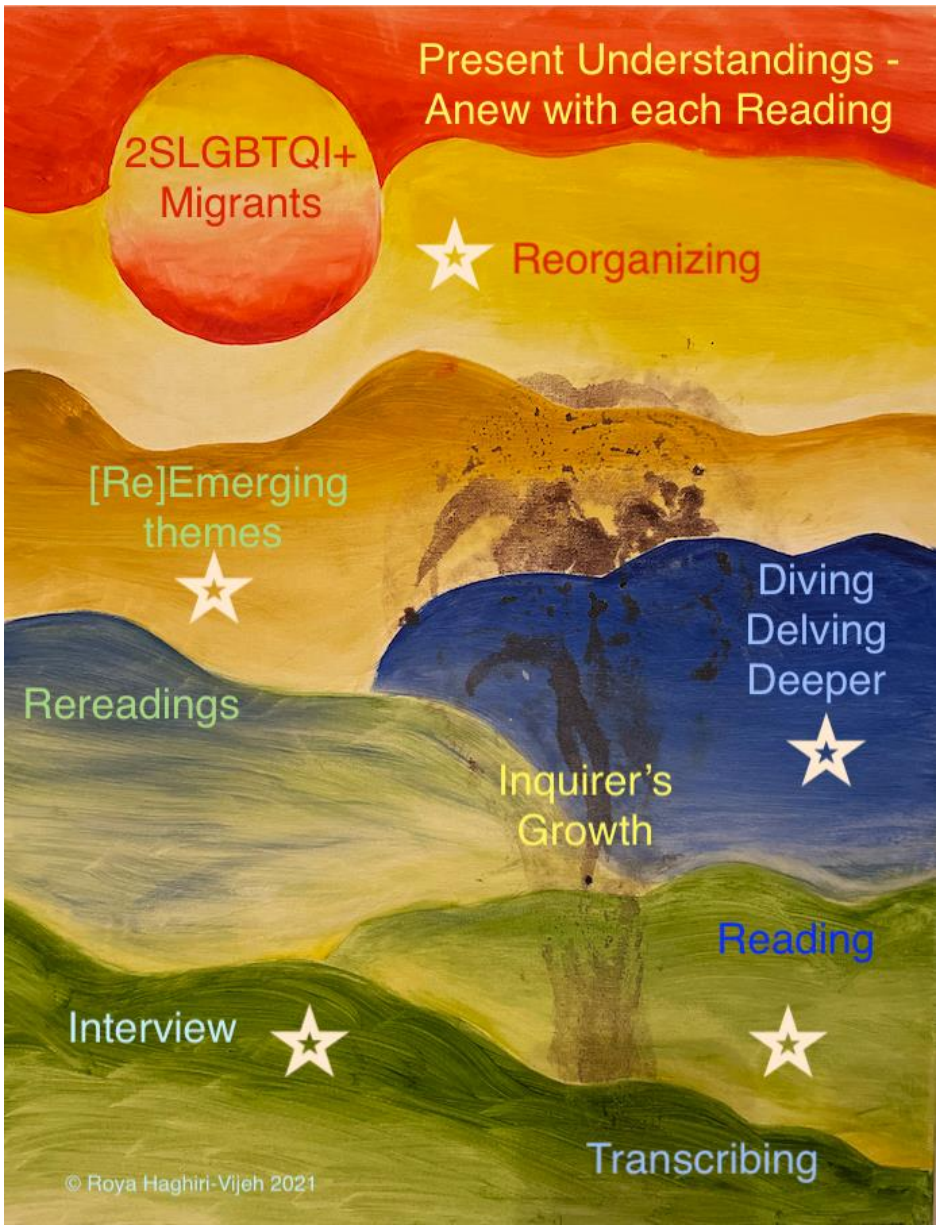
Then, I read, highlighted, and made notes on each interview individually, keeping in mind that the informants were the experts in their narratives (Moules & Taylor, 2021). I then reread each interview after completing the transcriptions, noting additional thoughts. I journaled my thoughts after interviews and in some instances after transcriptions. I started using coloured papers and sticky notes on my wall in addition to the notes made on the transcriptions. I reread all the transcriptions together, delving more deeply and noting keywords, phrases, and experiences that arose for informants, and how systems of power contextualized their positionality. To organize various experiences that informants shared with me, I pragmatically created an Excel spreadsheet with keywords, phrases, and experiences in the first left-hand column and the informants' pseudonyms in the top row. Initially, about 500 keywords, phrases, and experiences were elucidated. The visual representation of my interpretations created an opportunity to further clarify themes by going back to the interviews to ensure staying true to informants' experiences. This approach was useful as I stepped into a more conceptual level of conversation with transcripts. The emerging understandings of the experiences of LGBTQI+ migrants were presented to my doctoral studies supervisor and committee members on several occasions where further clarity and movement of themes occurred.

During analysis, I needed to allocate time to reflect and ponder upon the experiences that were shared with me. I attended conferences on anti-racism, LGBTQI+ people, and Indigenous ways of being, and read blogs, peer-reviewed journals, and books to enhance my understanding. I attended conferences where questions from the audience assisted me in further clarifying my understanding. I needed to take a few days of reflection between interpretations because re-readings of transcriptions took an emotional toll on me. Because I completed the transcriptions myself, I continuously reexperienced hearing every word, phrase, silence, tear, cry, and difficult experience. Some of the informants' experiences of bullying, discrimination, harassment, and migration journeys in transition countries brought back traumatic experiences that I had buried deep within me and had attempted to forget. I realized that I am not a blank slate, and my past traumatic experiences were informing my interpretations of the interviews. A few days between re-reading allowed me to perform self-care.

These past experiences and physical time away from transcriptions led to a fusion of horizons. I state, "physical time away," because I constantly, even to this date, think about the stories and how my understanding has emerged. I have a notebook at my bedside for when I am awakened, in the middle of the night, so that I can journal my thoughts. During one of these times of reflection, I painted an oil on canvas as a representation of my intersectional hermeneutical process of interpretation (Figure 1).

**Figure 1: Journey in Understanding**

*With this aesthetic piece, which is an oil on canvas, I illustrate my journey in this dissertation.*




On the top left of the canvas, I painted an image of an irregular circle to represent the sun. I feel privileged that the LGBTQI+ migrants agreed to participate and share their experiences and, as a metaphor for the sun, I see them as the source of enlightenment and energy in this dissertation. Without their bravery in sharing their experiences with me, writing this dissertation

would not have been possible. The different layers represent my journey in articulating the transpired understandings. The multi-layers in the painting seem linear in nature, but there was a continuous and spiral front and back movement from the start of thinking about the research to the formation of understandings. The multi-layers are the indication of the intertwined and intersecting positionality of informants in relation to encountering nurses.

The sun rises approximately in the same location; however, everyday experiences with this contextual world may differ. Using this analogy, I acknowledge that with each reading a new understanding may emerge. The stars represent the time needed to pause, reflect, journal, regroup thoughts, and delve deeper with the transcriptions. On the right side of the image is an imprint of what seems to be a *tree*. I stamped my daughter's placenta and umbilical cord on the painted image in the shape of a tree. This is meaningful for me because this tree represents how we are interconnected. This representation of a tree is not meant to be an erect, ordinary tree. The heavy trunk represents grounding myself in my position of privilege and previous experiences of oppression. The upper branches and leaves represent my growth, and the higher leaves are an attempt to reach the sun, the LGBTQI+ migrants, and cultivate an understanding of their experiences. The prominent print in the branches of the tree is a reminder of a Persian idiom "درخت هر چه پربارتر،افتاده تر" (Translation: the more a tree has fruits, the lower its trunks). The interpretation is that as an individual gains more knowledge, they should be humble in relation to other people's experiences and strive to learn more. I saw myself as a tree that did assume the researcher role, but I was open to peeling the layers back in the interpretation of the interviews. With this aesthetic piece, I hope to show my approach in conversing with the interviews.

**Rigour in Gadamerian Hermeneutics**

To ensure the rigour of the interpretations, De Witt and Ploeg (2006) proposed that Gadamerian hermeneutic research is enhanced thorough balanced integration, openness, concreteness, resonance, and actualization. First, balanced integration was weaving in philosophical themes and concepts that fit with the inquirer, research topic, and conversing during the interview transcriptions. This was accomplished by including Gadamer's discussion of play with ally theatre that was brought forward by some informants. However, philosophical terms and concepts were not taken over and there was a need for a "balance between the voice of study [informants] and the philosophical explanation" (p. 224). Second, openness required me to be in sync with the phenomenon of understanding informants' experiences, to create an audit trail throughout the entire research process, and to consistently document the multiple decisions made throughout the process. For example, the rationale for selecting a certain quotation is clearly written in the interpretation of the interviews. Third, concreteness creates an opportunity for the reader to place themselves in the study. This refers to the applicability of the findings for the reader in practice and is called "lived thoroughness" (p. 225). Fourth, resonance follows concreteness and leaves an aftermath effect for the reader that impacts the experience and feelings of the audience. I have a long-standing academic and social familiarity with the topic of the research. Concreteness and resonance were present in early readings of this work. Finally, actualizations highlight that "interpretation does not end when the study is finished" (p. 226). In other words, interpretations of the interviews are likely to evolve with the passage of time and changes in the contextual realities affecting the reader and society. De Witt and Ploeg (2006)'s approach for maintaining rigour is utilized in this research study.

At the beginning of the doctoral dissertation, my purpose was understanding the experiences of LGBTQI+ migrants' encounters with nurses; however, in addition to their experiences with nurses, informants shared their experiences with other healthcare professionals in Canada. As a gatekeeper in a position of power, I could not dismiss these experiences shared with me during interviews. For this reason, where relevant, interpretations included other members of healthcare teams. Following the above literature review and methodological framing of this dissertation to understand the experiences of LGBTQI+ migrants' encounters with nurses and other healthcare professionals, I will identify what is included in this publication-based dissertation. After presentation of the four manuscripts, in the afterward chapter, I provide a synthesis of the findings as well as implications for nursing education, practice, policy, and research.

## Four Manuscripts for Publication

In discussion with my doctoral studies committee, I have selected a publication-based dissertation. One principle of intersectionality underscores the need for change in praxis. A change in praxis starts with knowledge translation. Publication of findings, as a form of knowledge translation about the experiences of LGBTQI+ migrants with NHCPs in Canada, may create the possibility of informing practitioners about the limited knowledge in practice, education, and research, as well as provide applicable recommendations for change. Throughout the interviews, informants intentionally requested that I take their narratives beyond my dissertation and share their experiences to improve the care provided to LGBTQI+ migrants. For this reason, I am obligated to start the dialogue. I have prepared four manuscripts for publications in chapters two, three, four, and five:

- Chapter two: “Critical Perspectives on Gadamerian Hermeneutics Methodology with Intersectionality”
- Chapter three: “Experiences of LGBTQI+ Migrants with Nurses and Other Healthcare Professionals in Canada”
- Chapter four: “‘If You Can Just Break the Stigma Around It’: LGBTQI+ Migrants’ Experiences of Stigma and Mental Health”
- Chapter five: “‘Ally Theatre Is a Problem’: Exploration of LGBTQI+ Migrants’ Experiences with Nurses in Canada”

## Chapter Two: Methodology Manuscript

Haghiri-Vijeh, R., & McDonald, C. (2022). Gadamerian hermeneutics with intersectionality as an analytical lens. *Journal of Applied Hermeneutics*.

https://doi.org/10.11575/jah.v2022i2022.74902

### Abstract

For decades, hermeneutics has been used as a qualitative research approach to enhance understanding of the experiences of individuals within a particular context. However, after reviewing the literature, it became evident that only a few published articles use intersectionality as an analytical lens along with Gadamerian hermeneutics. This article draws on examples from a 2021 study that explored experiences of LGBTQI+ migrants with healthcare providers. Utilizing the philosophical underpinnings of Gadamerian hermeneutics and the theoretical foundations of intersectionality, the confluences and the tensions between these two approaches is explored. Moreover, suggestions are provided for how intersectionality as an analytical lens can expand understandings and interpretations of research findings using Gadamerian hermeneutics.

*Keywords*: Gadamer hermeneutics, intersectionality, complexity, LGBTQI+ migrants, underserved population, healthcare professionals

Although historically, hermeneutics originated as an approach to interpret sacred religious texts (Abram, 1996; Polit & Beck, 2017; West, 2010), present day Gadamerian hermeneutics focuses on developing a deep understanding of human experiences in particular contexts (Annells, 1996; de Witt et al., 2010; Dowling & Cooney, 2012; Gadamer, 2007a). In this article, we discuss Gadamerian hermeneutics, in combination with intersectionality, as an approach to understanding the experiences of underserved people whose experiences are poorly understood through many traditional research methodologies (Collins & Bilge, 2016; Kwok, 2021; Semlyen et al., 2018). Here, key examples are shared from a research study conducted in 2021 which explored the experiences of LGBTQI+ migrants with healthcare professionals in Canada. LGBTQI+ refers to lesbian, gay, bisexual, trans, Two-Spirit, queer, questioning, and intersex, and "+" is inclusive of diverse sexual orientations (e.g., pansexual) and gender identities and expressions (e.g., nonbinary) that are not named in the initialism. Migrants, broadly, refers to individuals who have relocated from one place to another (Canadian Council for Refugees, 2010).

Exploring conceptual ties between intersectionality and Gadamerian hermeneutics can potentially yield new insights into how these theories have utility for gaining understanding of human experiences with a view of social and systemic contexts. It is argued that both theoretical perspectives can be used for anti-oppressive and social justice aims. In what follows, we start with a background, afterwards examine the philosophical underpinnings of intersectional theory, and then provide an overview of Gadamerian hermeneutics. Thereafter, we discuss how this methodological approach may be used in the context of LGBTQI+ migrants' experiences with healthcare professionals.

**Background**

Increasingly, theorists and researchers acknowledge that research with underserved people benefits from anti-oppressive theoretical perspectives which aim to produce systemic change by understanding intersecting positions of power and privilege using a social justice praxis (Davidson, 2016; Lopez & Willis, 2004). The term praxis here means that research and practice are intertwined, that they inform one another, and that inquirers and practitioners reflexively strive to highlight areas for improvement (Cho et al., 2013; Collins et al., 2021; Rodriguez et al., 2016). The integration of intersectionality as an analytical lens with Gadamerian hermeneutics sets a path for critical and nuanced understandings of the realities of diverse underserved populations in health research.

> Underserved people are defined as individuals who:
>
> may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by healthcare providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with healthcare services than the general population. (Health Canada & Bowen, 2001, p.7)

Past and continuing traumatic experiences may lead LGBTQI+ migrants to experience mental and physical health challenges (Hall & Sajnani, 2015; Lee, 2021). Intersectional researchers do not assume the vulnerability or the homogeneity of groups but categorize underserved people because it allows the recognition of needs and differences within groups while attending to the structural contexts which shape disadvantages (Collins et al., 2021; McCall, 2005). The term "strategic essentialism" was coined by Gayatri Chakravorty Spivak, a post-colonial South Asian theorist and activist, and refers to a political position that is adopted to advocate for minority groups (Spivak, 1996). In this article, the term LGBTQI+ migrant is used to underscore the

common experience of being underserved while acknowledging the diversity of the experiences of migration trajectories within LGBTQI+ communities. In other words, it is strategically crucial and advantageous to temporarily "essentialize" LGBTQI+ migrants as a group to understand their experiences with healthcare professionals in an effort to inform practice, education, and policy.

In my (Roya Haghiri-Vijeh [RHV]) nursing practice as a bedside nurse and as an educator, I was struck by the limited knowledge of some nurses in caring for patients who identified at the intersections of LGBTQI+, migration, race, and religion, just to name a few. I have an understanding of the experiences of LGBTQI+ migrants with nurses through hearing nurses' LGBTQI+-phobic and racist comments. Both stigma and discrimination, including a lack of knowledge of and a sense of comfort in providing care to LGBTQI+ migrants manifested itself in my encounters with some nurses, nursing students, faculty, and administrators. I heard comments such as, "They are in Canada now. It is safe here!... So, they are trans – what is a big deal!" For this reason, to have a deeper understanding of LGBTQI+ migrants' encounters with nurses and other healthcare professionals in Canada, I pursued my doctoral research in situating these experiences through Gadamerian hermeneutics with intersectionality as an analytical lens.

The University of Victoria's human research ethics review board approved this research study (Approval number 19-0591). In this article, we draw on key examples from the first author's doctoral dissertation in which she conducted 18 semi-structured interviews on Zoom with LGBTQI+ migrants (13), non-migrant nurses (2), and migrant LGBTQI+ nurses (3). Rather than focusing on a singular "theme," the interpretations of interviews strengthened our understanding of informants' experiences. The in-depth interpretations will be published elsewhere (Haghiri-Vijeh, 2022), and here, the methodological grounding is provided. Given that

some readers of the *Journal of Applied Hermeneutics* may not be familiar with intersectionality, the next section begins with a discussion of intersectionality, follows with a discussion of Gadamerian hermeneutics, and then examines the ways in which intersectionality and Gadamerian hermeneutics share a common set of principles. Both approaches attend to reflexivity, historical context, and critical inquiry, and in the case of my study, do so in an effort to understand the experiences of LGBTQI+ migrants with healthcare professionals (Bright, 2015; Davidson, 2016; Lopez & Willis, 2004).

**Situating Intersectionality Within a Critical Theoretical Paradigm**

Intersectionality is situated within an emerging critical theoretical paradigm with roots in Black, Latinx, post-colonial, queer, and Indigenous scholarly work which reveals the complex factors that shape human lives (Collins, 2019). The earliest cited iteration of intersectionality came from the Combahee River Collective (Collins & Bilge, 2016). In 1977, the Combahee River Collective, a Black lesbian organization, challenged homophobia and heterosexism, and argued that the experiences of Black non-heterosexual women were different from those of white women (Collins & Bilge, 2016). Following this, in the 1980s, scholars continued to provide a voice for the intersecting experiences of underserved people. In 1989, legal studies scholar Kimberlé Crenshaw coined the term intersectionality as a metaphor for complexity (Crenshaw, 1989), and in 1990, sociologist Patricia Hill Collins initiated the integration of intersectionality as a critical social theory (Collins & Bilge, 2016; Hancock, 2019; Potter et al., 2019).

Intersectionality as an analytical lens is used to address complexity, and is underpinned by such concepts as relationality, power, social inequality, social context, and social justice (Collins, 2019). However, not all inquirers are guided by the same assumptions when using intersectionality (Collins et al., 2021). The core argument of intersectionality is that dominant

structures of power are embedded in policy and practices which systematically exclude individuals or groups from privileges based on their identities and social contexts (Collins, 1993; Crenshaw, 1989). Hancock (2019) identified critical race theory as an avenue to critique American structural and institutional hierarchies that produce injustices, inequities, and marginalization. Intersectional scholars note, however, that race alone cannot be understood as a distinct category of analysis apart from class or sexual orientation, gender identity and expression (SOGIE) (Collins, 2019b; Hankivsky et al., 2019); instead, these social categories intersect to shape people's experiences within systems of power (Crenshaw, 1991; Hankivsky et al., 2019).

In intersectional analysis, categories and locations are socially constructed and fluid, and are not limited to race, ethnicity, class, SOGIE, dis/ability, mental health or religion (Collins et al., 2021; Hankivsky & De Leeuw, 2011). Categories are dynamic, diverse, intertwined and in continuous interaction with one another, and understanding them should not follow normative binarizations (Hankivsky et al., 2019; Hay et al., 2019; Heise et al., 2019). The diversity of experiences of those oppressed is perpetuated by the unique contextual situatedness of individuals. In this way, intersectionality can be used as an analytic lens to uncover influences of power (Collins & Bilge, 2016; Hankivsky et al., 2019). Consequently, intersectional scholars call for transformation, collaboration, social justice, and equity praxis.

The core arguments of intersectionality assist in seeing that LGBTQI+ migrants may well experience oppression as a result of intersecting marginalization in society and in the healthcare system. For example, a trans informant who came to Canada on a student visa shared their experience of being placed in a mental health facility. Prior to migration, they ("they" is the pronoun used by many people who identify outside of a constructed gender binary) had

experienced discrimination, trauma, and violence due to their sexual orientation and gender expression. After migration to Canada, as they started their gender transition, the realities of their multiple identities resulted in a complex experience of being poorly understood and supported. Although they identified as trans, they felt that non-migrant trans people did not understand the unique challenges of identifying as trans *and* migrant *as well as* having temporary precarious migration status. At the same time, they felt excluded from their own cultural community due to their transgender identity. Additionally, with limited financial resources, they were afraid of deportation. In desperation, they experienced suicidal ideation and were brought to a mental health facility by police officers. They felt uncomfortable with being placed "in the same sack" with other patients, and felt that their intersecting experiences of migration, trans identity, mental health challenges, along with financial and language barriers were not acknowledged or understood by healthcare professionals. When they tried to communicate their fear of deportation most healthcare professionals and nurses, who were in positions of privilege, dismissed their concerns without making a meaningful attempt to understand their fears as well as their past and current experiences.

### *Intersectionality and Structural Systems of Power*

A particular strength of intersectionality is the focus it brings to structural influences such as language barriers, poverty, citizenship status, and human rights laws that shape the social lives of some groups versus others (Clark & Vissandjée, 2019; Crenshaw, 1991; Manuel, 2019). When the needs of underserved individuals are not named as a priority in policies, resources are not allocated to meet their needs; and at times even when needs are named, services are not distributed (Alessi et al., 2020; Crenshaw, 1991; Fox et al., 2020; Gupta & Raj et al., 2019; Hankivsky et al., 2019; Kahn et al., 2018). Public policies and laws can magnify the voices of

underserved individuals or silence them further. It is particularly relevant to this work that structural systems of power limit the inclusion of individuals who do not conform to normative identities and orientations (Lee, 2019; Lee & Brotman, 2013). Hankivsky and Jordan-Zachery (2019) added that those in dominant positions may use policies, unconsciously or consciously, as an apparatus to direct and regulate the experiences of marginalized individuals. For example, "normative" sexuality, or what constitutes accepted sexuality, is regulated by policies and overemphasized in institutional arenas (Cisneros, 2018; Hankivsky & Jordan-Zachery, 2019a; Lee, 2018; McDonald et al., 2011). In addition to public policy, it also becomes apparent that educational and institutional policies that directly influence the practice of healthcare professional are put in place through structural systems of power (Dickman & Chicas, 2021). Intersectionality provides the lens to view and to account for complex and marginalized lives in the policy arena. Finally, Manuel (2019) and Collins et al. (2021) asserted that qualitative intersectional approaches provide an avenue to gain a deeper understanding of individuals' lives, as they are shaped by health and public policies. In this case, Gadamerian hermeneutics is guided by intersectionality in understanding the experiences of LGBTQI+ migrants.

**Gadamerian Hermeneutics**

Hans-Georg Gadamer (1900 - 2002) was a German philosopher in a significant line of male European philosophers of phenomenology, whose works both informed and departed from Gadamer's (Gadamer, 1975b; West, 2010). In particular Gadamer expanded the philosophical position of his teacher Martin Heidegger in a number of ways that have become relevant to research approaches drawing on Gadamerian hermeneutics. Heidegger is well known for his movement away from the reductionistic and objective view of knowledge acquisition relying solely on the "scientific method" towards an ontological understanding of the world (Gadamer,

1976). Gadamer located his own philosophy in a decidedly ontological, rather than epistemological position, with implications for how those following him philosophically engage in the process of inquiry (Koch, 1995; Shaw & DeForge, 2014). Or perhaps more accurately, Gadamer moves beyond focusing on the epistemological meaning of individual experiences; he is also concerned with the formation of understanding by drawing ontologically on the present and past experiences of individuals and the inquirer (Gadamer, 2007a).

### *Ontological Presence in Dialogue*

For Gadamer, it is not only about the epistemology of one's language, but also having an ontological presence in dialogue (Gadamer, 1976, 2007c; Gadamer & Ricoeur, 1991). The ontology of Gadamerian hermeneutics is concerned with being and understanding through experiences (Ho et al., 2017). This ontological underpinning of Gadamerian hermeneutics is expressed in the hermeneutic circle, central to the process of interpretation and understanding (Gadamer, 1981b, 1986, 1998). Additionally, Gadamer's ontological hermeneutics is informed through his use of the concepts of historicity and prejudices. These concepts, which we explore shortly, contribute to an ontology in Gadamerian hermeneutics that illuminates multiple, evolving, and changing realities; therefore, understandings themselves become varied and transient (Cohen et al., 2000a; Fleming et al., 2003; Gadamer, 1976).

Following the early work of Schleiermacher and later expanded by Heidegger, Gadamer viewed the movement of the hermeneutic circle as an ontological element of understanding (Crotty, 1998). The movement between the parts and whole, sometimes viewed as a "spiral" (Moules et al., 2015, p. 44), can be seen as an account of the way in which understanding is achieved. Gadamer maintains "the circular movement is necessary because nothing that needs interpretation can be understood at once" (1998a, p. 192). The hermeneutic circle is set in motion

as the interpreter begins to reflect on the prejudices that accompany them to the work; the movement is perpetual, visiting and re-visiting understandings throughout the hermeneutic project.

### *Historicity Shaping Understanding*

According to Annells (1996), Gadamer noted that the hermeneutic circle is present when what has occurred in the past, when rediscovered, becomes new again. In addition to being ontological in nature, hermeneutics is shaped by the historicity, universality, and fluidity of each interpreter. Historicity, in the hermeneutic sense, means people are "not merely in history; their past including their social past, figures in their conception of themselves and their future possibilities" (Audi, 1999, p. 673). As historically located, we cannot act or understand without the influence of the history in which we are imbued. In this way, the hermeneutic project of "understanding is, essentially, a historically affected event" (Gadamer, 1998b, p. 300). It is this situatedness, historical and in a sense unknowable position that forms the horizons from which the interpreter and the topic begin. This approach, assuming an ontological nature, places *understanding* within the historicity, the tradition, and the context of both informants and inquirer (Cohen, 2000).

As an inquirer (RHV), my historicity is informed by the experience of a traumatic escape from my country of birth as well as experiences of navigating social, cultural, and religious communities as a first-generation settler. Additionally, this hermeneutic project is informed by my location as a nurse, an educator, and a resident in a country that legally supports LGBTQI+ people. All of this context, past and current, comes into play in the process of interpretation, beginning with my interest in the topic. Similarly, each informant brings to the interview process, their unique historical location. For a number of informants, their ontological reality

included living in a birth country where being LGBTQI+ is forbidden and punishable by death. Their lives before migration to Canada included living with trauma and daily fears of having their identity discovered. For one trans Muslim woman, their religious tradition included wearing a chādor (a long head and body covering) when reciting obligatory Islamic prayers. While this tradition was not available to them to enact prior to their gender transition, they also were stigmatized and ridiculed by their cultural and religious community after migration to Canada and beginning gender transition. Hence, in this situation it is the inaccessibility of tradition, the inability to participate in cultural and religious gatherings that shape their ontological experience.

Gadamer (1976) emphasized that the hermeneutical situations of individuals have historically been rooted in their prejudices. Rather than elevating an ideal of autonomous objectivity, Gadamer embraces the prejudices and foreknowledge of the interpreter as productive in mediating understanding (Gadamer, 1976). The idea of prejudices as a ground on which to begin understanding extends not only to the interpreter but also to the subject/objects of interpretation. While Gadamer notes that the influences of our prejudices are unknowable in advance in their completeness, he nonetheless suggests that we should endeavour to make our prejudices conscious and available to critique. He notes that active reflection on a particular prejudice "brings before me something that otherwise happens behind my back" (1976, p. 38). Additionally, he rightly noted that once something is known to us, it is impossible to "unknow" it. Gadamer (1976) insisted that prejudices can play a critical role in moving toward new understandings, and that rather than "bracket" understandings or knowledge of a topic, as in the case with other approaches to phenomenology, prejudices should be questioned and revisited.

Exploring my (RHV) prejudices were crucial as Gadamer (1976) asserted, "It is not really we ourselves who understand: it is always a past that allows us to say, 'I have understood'" (p.

58). My knowledge and understandings garnered from my experience as a migrant, a refugee, and a woman of colour, as well as through my close relationships with people who identify as LGBTQI+ migrants, furthered my understandings in hermeneutic conversations with participants. My prejudices propelled the process of engaging in questioning in a particular direction, just as the prejudices of the informants are embedded in their dialogue. LGBTQI+ migrant informers, may carry with them from their past, fear of discrimination, stigma, or of being denied residency status if they disclose their gender identity or sexual orientation, even in the context of the interviews. Similarly, based on norms and personal history in their country of birth they may be reluctant to criticize their experiences with healthcare providers (Etengoff & Rodriguez, 2021; Massaquoi, 2020; Semlyen et al., 2018). These are tacit examples of ways in which the influence of history and prejudices can directly play out in the hermeneutics research process. Prejudice is rooted in the inquirer's and informants' historical-spiritual being, their past, their culture, all of which influence their being in the world. For this reason, an absence of bracketing is evident during in-depth interviews, in conversing with the transcriptions, and in the dissemination of the findings, as understanding will arise from the movement of the hermeneutical circle, mediated by past and present experiences (Annells, 1996; McCaffrey et al., 2012).

**Confluences of Gadamerian Hermeneutics and Intersectionality**

As approaches to research, Gadamerian hermeneutics and intersectionality arise from considerably different contexts and influences. Nonetheless they do hold areas of confluence; ways in which intersectionality aligns with hermeneutics and expands the project of interpretation. These confluences are discussed as reflexivity, experience located in time and context, and critical questioning.

### *The Practice of Reflexivity*

Reflexivity finds common ground in Gadamerian hermeneutics and intersectionality; it influences gaining understanding through the continuous revisiting, reviewing, and questioning of interviews as well as acknowledging the inquirer's and informants' experiences of privilege, strength, and oppression. Qualitative researchers, Sandelowski and Barroso (2002), explain the introspective process of reflexivity: "Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share" (p. 222). Clearly this understanding of reflexivity aligns with Gadamer's discussion of the process of bringing to consciousness the prejudices and previous understandings of the inquirer that influence the hermeneutic process. Reflexivity in conversing with the data starts from the beginning when conceptualizing the research and continues throughout every stage (Moules et al., 2015; Ryan, 2005). Similarly, intersectional scholars consider their own social position, role, and power when applying an intersectional interpretation to interviews. In fact, this reflexivity starts before setting priorities and directions in research, policy, and activism (Collins, 2019).

Reflexivity was at play in creating a safe environment for the LGBTQI+ migrant informants by choosing to share some of my (RHV) experiences during interviews. I experienced discrimination as a woman and a Baha'i in my country of birth, as a non-status refugee in a transition country, as a new migrant to Canada, and as a racial minority working in the nursing profession. Cautiously allowing myself to be vulnerable led the informants to develop trust on the basis of some of our shared experiences, and this allowed me to delve more deeply into their experiences with healthcare professionals in Canada. Thus, the inquirer can reflexively engender

a safe environment during the interview to encourage a flow of conversation about the informant's unique experiences.

Using intersectionality as an analytical lens, the inquirer reflexively looks specifically for the individual oppressive experiences with healthcare during the interpretive process (Hankivsky & Jordan-Zachery, 2019b; Moules et al., 2015). The inquirer also searches beyond individual experiences and considers how dominant normative ideologies and structural policies shape those experiences (Collins et al., 2021; Lee, 2019, 2021). Hankivsky and Cormier (2019) state that there is a scarcity of research methodologies that examine the operations of power on individual experiences. Utilizing Gadamerian hermeneutics with intersectionality as an analytical lens address some of these challenges by attending to social contexts as well as institutional and interpersonal power dynamics that surround and shape experiences.

### *Experience Located in Time and Context*

Intersectional and Gadamerian hermeneutics approaches share the view that experiences are shaped by context and time (Bradbury-Jones et al., 2011). As discussed at length earlier in the paper, from a hermeneutic perspective, the lives of the inquirer and informants are understood as constituted within historicity, that is, within particular temporal and contextual realities. These realities deeply influence our understanding of experience. Scholars of intersectionality maintain that social inequities are based on context and are the result of particular oppressive social and institutional structures and policies (Collins, 1993, 2019b; Collins & Bilge, 2016; Crenshaw, 1991; Hankivsky, 2014; Heise et al., 2019). Engaging with the lens of intersectionality to understand the experiences of LGBTQI+ migrants, the inquirer converses with informants about their experiences and the contextual influences in their lives as well as interprets these conversations with a view to the temporal and historical context of the

social and institutional structures at play (Burnett, 2019; Collins & Bilge, 2016). In highlighting the impact of time and context in the positioning of LGBTQI+ migrants, both intersectionality and Gadamerian hermeneutics pave the way for critical questioning and are integral to conversing with informants.

### *Critical Questioning*

While both hermeneutics and intersectionality engage the language of critical questioning, the meaning of the term is somewhat different for each. The approaches are however compatible, and the lens of intersectionality can again be seen to extend the hermeneutic interpretation. In hermeneutics, critical questioning has been referred to as asking difficult questions and being open to questions that challenge pre-existing assumptions (de Witt & Ploeg, 2006). The hermeneutic conversation in which critical questioning takes place focuses not only on questions of the informants' experiences but investigates the subject matter *along* with the informants. Such a hermeneutic conversation leads to a hermeneutic circle in which the whole and the parts of the topic spiral in an iterative and continuous format (Moules et al., 2015). As discussed earlier, the inquirer continues to converse with the interview transcriptions during analysis, in relation to the topic, and then the specific informant's experiences by reading and re-reading the interviews iteratively while searching for similarities, differences, what stands out, what is provoking, and even what calls current understandings into question (Moules et al., 2015). The inquirer opens themself up and listens to what is being said and unsaid — even confronting viewpoints which may be hard to hear and observe (Moules et al., 2015). It is through engagement with others that individuals may become aware of their own assumptions. In meaningful readings of texts, the inquirer questions and is questioned by the text itself. Imagination needs to be rooted in the art of questioning, to see beyond what is presented during

interviews and when conversing with the transcriptions. A perfect analysis is not expected (Gadamer, 2007d), but an understanding occurs through detailed, dedicated, and careful interpretation of various factors shaped by the history of each individual (Jardine, 1992) and brought into being through a process of critical questioning.

Engaging intersectionality as an analytic focus deepens the Gadamerian understanding of the experiences of LGBTQI+ migrants by being critically attentive to the intersections of various systems of power illuminated during in-depth individual interviews and when conversing with the transcriptions (Bright, 2015; Davidson, 2016). For example, it is evident in the literature that LGBTQI+ migrants' experiences are situated in various intersecting systems of oppression and discrimination based on the identities of race, ethnicity, SOGIE, religion, migration, class, language, dis/ability, and mental health diagnosis (Altay et al., 2021; Brennan et al., 2013; Cisneros, 2018; Collins et al., 2021; Etengoff & Rodriguez, 2021; Lee & Brotman, 2013; Semlyen et al., 2018). Collins and Bilge (2016) noted that critical questioning is an integral skill that scholars using an intersectional lens require and asserted, "[critical questioning] is a way of critically analyzing the world by asking tough questions, problem solving, and critical thinking" (p. 162). Critical questioning as an approach within intersectionality and Gadamerian hermeneutics elucidates that the scientific method cannot answer all the questions (Gadamer, 2000). In a discussion of "natural situations" in science, Gadamer (1976) pointed to the reality that what is socially contextualized as natural, normal, and we add "straight" for a community now may readily differ in another time or context. Following the explanation of the confluences of Gadamerian hermeneutics and intersectionality, potential tensions between the two are explored.

**Theoretical Tensions of Gadamerian Hermeneutics and Intersectionality**

Intersectionality and Gadamerian hermeneutics' areas of potential tensions are their historical origins and aims to address the struggle of marginalized people. First, hermeneutics was developed by privileged white European men. Conversely, early intersectional writing and activism focused on Black women's vulnerabilities, oppressions, and experiences of violence (Crenshaw, 1989, 1991). Hankivsky and Jordan-Zachery (2019a) stated that oppressive and dominant policies have been created and enforced by well-educated white men's worldviews and values. However, the production of knowledge through research is not static (Gadamer & Moore, 2020), and intersectionality has advanced thinking by bringing SOGIE and other inequities to the forefront (Clark & Saleh, 2019; Kassam et al., 2020). Scholars of intersectionality do not dismiss white European men's theoretical work based on their gender, race, or ethnicity (Cho et al., 2013); rather, the inquirer learns from past epistemology to step towards praxis. In addition to historical origins, another area of tension between Gadamerian hermeneutics and intersectionality is the intention of the work regarding disenfranchised or marginalized people.

Intersectionality as an analytical lens has two aims that, in a perfunctory sense, may seem to be in tension with Gadamerian hermeneutics. These two aims, according to Collins and Bilge, (2016) are the following: "(1) an approach to understanding human life and behavior rooted in the experiences and struggles of disenfranchised people; and (2) an important lens linking theory with practice that can aid in [the] empowerment of communities and individuals" (p. 36). These are points of contention because neither the "disenfranchised" nor "empowerment" are usually addressed in Gadamerian hermeneutics. However, although not explicitly stated, Gadamerian hermeneutics is seen by some to hold space for the inclusion of these aims and renders to the issues of "large power structures" (Gadamer & Moore, 2020, p. 4). First, Gadamer underscored

the importance of looking for the unsaid in each conversation and raising the voices of those who have been silenced. Second, Gadamerian hermeneutics is focused on experiences through the continuous practice of reading between the lines and examining how context and time have shaped peoples' understanding (Gadamer, 2007b; Jardine, 1992). In particular, in the discussion of phronesis as practical knowledge in relation to sensus communis (common sense), Gadamer (1975a) asserted, "the philosophy of sound understanding, of good sense … contains the basis of a moral philosophy that really does justice to the life of society" (p. 39). Gadamer's later publications articulated concerns with global social issues and used dialogue as a praxis to engage in understanding one another rather than *othering* (Gadamer, 2007a; Johnson, 2000; Padgett, 2017). Had Gadamer been thinking or writing in the present-day historical context, he might have embraced a more explicit critique of power, race, SOGIE, and privilege (Gadamer & Moore, 2020).

**Conclusion: The End Game**

In line with Gadamer's (2007b) discussion of philosophical ethics and Collins et al.'s (2021) discourse on intersectionality, understanding moves the research endeavour towards practice and policy revision. In a document titled "Intersectionality 101," Hankivsky (2014) provided practical suggestions for inquirers, policymakers, activists, and educators to integrate intersectional theory to address oppressive taken-for-granted discourses. Manuel (2019) emphasized that employing intersectional theory is not only about what is "good to know" (p. 32) but more importantly requires integration into public policies. Manuel argued that policy makers have been slow to integrate intersectional theory into healthcare practices. Intersectional theory is not only about the oppressed, when the oppressed can also be the oppressor (Collins, 2019a, 2019b). Inquirers using intersectionality also need to highlight the resistance, resilience,

and strength in marginalized communities (Hankivsky, 2014; Jordan-Zachery, 2019). Intersectionality is an avenue for the inquirer to be reflective about their own biases and prejudices, and strive to understand the informants' experiences of oppression, privilege, and strength (Massaquoi, 2020).

While Gadamerian hermeneutics is not always associated with praxis, Gadamer, drawing on Aristotle's philosophy of practical wisdom, does discuss the place for phronesis and the application of knowledge (Gadamer, 1981, 1996; Moules et al., 2015). Practical wisdom can be understood, for example, as the first-hand knowledge LGBTQI+ migrants gather from their experiences with healthcare professionals. As we come to understand these experiences, we have the opportunity to apply practical wisdom; to use understanding in a way that betters health policy and the education of healthcare professionals. According to Moules et al. (2015), Gadamerian hermeneutics calls for "achievement of some moral good. There is an ethical obligation in healthcare, in education, and in other practice disciplines that its practitioners be guided by an ethic of care" (p. 58). Adopted from Gadamer (2007b) and Hankivsky (2014), intersectionality extends understanding of the experiences of LGBTQI+ migrants beyond a singular focus on identity. This approach to research initiates a conversation about understanding unique experiences and delves into what healthcare professionals can do and learn, thereby helping to strengthen education, practice, and policy (Moules et al., 2015). The inquirer, applying intersectionality as an analytical lens, searches for macro, meso, and micro systems of power at play in relation to experiences of LGBTQI+ migrants. That is to say, the inquirer moves beyond understanding LGBTQI+ migrants' experiences to an end game that looks for issues of domination, exploitation, resistance, and agency including how these can inform education, practice, research, and policy.

Using intersectionality as an analytical lens with Gadamerian hermeneutics may enable an inquirer to understand that, for example, LGBTQI+ migrants' health is shaped by migration, mental health, dis/ability, SOGIE, and healthcare as well as structural systems, and these have positioned LGBTQI+ migrants in situations of perpetual institutional surveillance. Engaging with intersectionality as an analytical lens provides an opportunity to delve into untapped and taken-for-granted dominant policies and practices that have marginalized and oppressed individuals (Hankivsky & Jordan-Zachery, 2019a) and underserved populations. In this article, drawing on the philosophical underpinnings of Gadamerian hermeneutics and scholars in the field of intersectionality, the confluences between these two approaches was explored demonstrating the ways in which the hermeneutics project can benefit from an intersectional lens to further research focused on marginalized populations.

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## Chapter Three: Substantive Area of Research Manuscript

Haghiri-Vijeh, R. (under journal review). Experiences of LGBTQI+ migrants with nurses and other healthcare professionals.

### Abstract

Background: LGBTQI+ migrants may have experienced discrimination and victimization related to ethnicity, culture, and race over the course of their migration journey, as well as in relation to their sexual orientation, gender identity and expression. Despite the work of some nurses in education, practice, policy, and research, there is a scarcity of literature investigating the experiences of LGBTQI+ migrants with nurses and healthcare professionals in Canada.

Methods: By utilizing Gadamerian hermeneutics with intersectional analysis, this study draws on sixteen semi-structured individual interviews with LGBTQI+ migrants who received nursing care in Canada.

Results: Two overarching areas of intersecting experience were identified: (a) challenges and (b) supports. Four interwoven interpretations emerged from experiences of challenges: (a) unwanted visibility, (b) hearing a dead name and being misgendered, (c) cultural stigma, and (d) being asked intrusive hetero-cis-normative questions.

Conclusions: Nursing interactions should not be traumatic for LGBTQI+ migrants, but rather should be encounters where care providers ask relevant non-hetero-cis-normative questions, offer inclusive safe sex education for people's diverse identities, avoid dead naming and misgendering, and provide supportive and affirming care. To support the provision of safe care and mitigate trauma, systemic changes in nursing practice must include the experiences of LGBTQI+ migrants.

**Introduction**

In Canada, the freedom to openly express one's sexual orientation, gender identity, and gender expression (SOGIE) is a privilege protected by existing human rights laws that prohibit discrimination against individuals based on gender, sex, and sexuality. There are, however, countries such as Iran that have severe penalties, ranging from imprisonment to the death penalty, for those who do not conform to norms of SOGIE.[1] Due to years of persecution, discrimination, and stigma, the voices of LGBTQI+ people (lesbian, gay, bisexual, trans-gender/transsexual, Two-Spirit, queer, questioning, intersex, and "+" for SOGIE that are not named in the initialism) may have been silenced before and after migration to Canada.[2,3] In addition to race, ethnicity, culture, religion, and migration status, the trauma LGBTQI+ migrants encountered related to SOGIE may have shaped their lives and placed these groups at risk for mental and physical health challenges.[4,5]

Over the past two decades, some nurses, with social and mental healthcare providers and in collaboration with migrants, LGBTQI+ people, or LGBTQI+ migrants, have sought to advance safe and affirming spaces for people at the intersection of identities.[6–9] Affirming care for LGBTQI+ migrants was provided when their SOGIE and migration status were recognized and accepted by nurses and other healthcare professionals (NHCPs). Despite the work of nurses in education, practice, and policy in the Canadian context, there has been evidence of hetero-cis-normativity and non-affirming care in healthcare practices with LGBTQI+ migrants.[10]

In addition to hetero-cis-normativity, LGBTQI+ migrants may have experienced additional discrimination from NHCPs based on their race, ethnicity, culture, or religion.[11] Understanding the needs of clients who are at the intersection of socially positioned identities is a key tenet when providing affirming care for LGBTQI+ migrants.[12] However, there is limited

literature investigating experiences of LGBTQI+ migrants in their encounters with NHCPs.[10] Therefore, the purpose of this study was to use Gadamerian hermeneutics research methodology with intersectionality as an analytical lens to understand the experiences of LGBTQI+ migrants with NHCPs in Canada.

## Methods

Hermeneutics and intersectionality oblige researchers to situate themselves in relation to the research and participants from the beginning of the research process. I acknowledge my position of privilege as someone holding academic positions at a college in Canada. Additional status of privilege encompasses being a nurse, a first-generation settler, heterosexual, and cisgender. However, other personal markers including gender, race, culture, migration journey, and religion reflect my minority status. This situatedness informed the research process and the interpretation of the interviews.

### *Recruitment*

Following ethics review board approval from [XXX], participants were recruited through word of mouth, social media (Facebook, Twitter, and Instagram), and connections with migrant, LGBTQI+, and migrant LGBTQI+ organizations, clubs, and groups within Canada. Two-Spirit individuals were included in all the recruitment material; however, none of the participants who came forward identified as Two-Spirit. The participants were given a $25 gift card or money transfer in recognition of their time. Although nurses were interviewed in this study, this article focuses on the inclusion criteria of LGBTQI+ migrants who have had personal experiences of receiving care from NHCPs in Canada, were over the age of 19, and comfortable in communicating in English.

***Data Collection and Analysis***

In line with a hermeneutic methodology, gaining understanding occurred through audio-recorded semi-structured individual interviews via Zoom with LGBTQI+ migrants, nurses, and nursing students in Canada. Drawing on existing studies on this topic, the questions were developed by the author and reviewed by the PhD committee members to ensure congruence with a hermeneutic and intersectional approach.[13] An LGBTQI+ migrant, who was not a participant in this research, reviewed the questions as well. The questions were topic focused but evolved with each interview. For example, participants were asked: "What has been your experience of receiving care from nurses in Canada?" Following this question, each interview unfolded through an open dialogue to allow for conversing and understanding to occur. The transpired understandings were discussed and evolved in conversation with the PhD committee members.

Interviews were transcribed verbatim by the author and participants' emotions and silences during conversations were noted. The pseudonyms and pronouns were selected by the participants themselves. In this research, intersectionality is utilized as an analytical lens in the interpretation of the interviews by searching beyond the social categories and looking at how normative ideologies and structural systems have created the conditions in which some people are dominated, and others are privileged based on intertwined and interlocking identities.[14] I engaged with intersectionality by being critically attentive, during interviews and interpretation, to the intersections of broader systemic processes of exclusion and harm as well as how systems of power may operate to mitigate oppression.[14,15]

Analysis involved conversing with the interviews in relation to the topic and then in relation to the specific experiences by reading and re-reading the transcriptions iteratively and

searching for similarities, differences, what stood out, what provoked, and even what was said and unsaid.[16–19] Aligning with hermeneutics, the "perfect" interpretation was not expected, but rather I intended to reach an understanding through detailed, dedicated, and careful interpretation shaped by each converser's context. As philosophically there is an understanding that what is already known is ontological and is disposed to be challenged and questioned,[20] I cannot claim that a data saturation was reached. Rather, I deepened my understanding of the participants' experiences. Drawing on De Witt and Ploeg[21] rigor was achieved through balanced integration, openness, concreteness, resonance, and actualization.

**Results**

Between October 2020 and June 2021, 16 participants were interviewed. Specific demographic questions were not posed, and categories and labels were avoided. Instead, participants were asked how they self-identified. Three of the 16 LGBTQI+ migrants identified as nurses who were, at various times, both recipients and providers of nursing care in formal roles. The sexual orientation of LGBTQI+ migrants in this study included those who self-identified as bisexual (1), pansexual (1), genderqueer (2), gays (8), lesbians (2); two participants did not disclose their orientation. The gender identity and expressions of LGBTQI+ migrants in this study included those who self-identified as nonbinary (1), transgender (5), and cisgender (10). The age of participants ranged from early twenties to late forties. All participants resided in Canada and were from the provinces of Quebec, Ontario, Manitoba, Alberta, and British Columbia. Two participants did not name their country nor region of birth. The self-identified regions of birth were Africa (2), China (1), Europe (1), Korea (2), Mexico (1), South America (1), Taiwan (1), the Middle East (3), the Philippines (1), and the United States of America (1). The participants migrated for various reasons, which included migration as a skilled worker,

conventional refugee, humanitarian refugee, LGBTQI+ refugee claimant, political refugee, international student, or for marriage. Other reasons included the desire to enhance economic opportunities for themselves or their families or to achieve greater safety and security. The time since migration to Canada ranged from one to 22 years ago.

The interview questions were framed around LGBTQI+ migrants' experiences with nurses in Canada; however, the participants also highlighted their experiences with other members of the healthcare system. For this reason, the interpretation of interviews lends itself more broadly to include NHCPs, rather than a limited focus on experiences with nurses. The LGBTQI+ migrants' experiences with NHCPs in Canada varied as they navigated their encounters with the healthcare system. Two distinct types of experiences emerged from the hermeneutical and intersectional interpretation of the interviews: (a) difficult experiences with NHCPs, and (b) "someone there listening to me," or support and acceptance from NHCPs.

**Difficult Experiences with Nurses and Healthcare Professionals**

Four themes were identified within the intersectional challenging experiences: (a) unwanted visibility, (b) being dead named (having their previous gendered name used) and misgendered (having their birth gender pronoun used), (c) experiencing invasive questions, and (d) experiencing cultural stigma and hetero-cis-normative assumptions in encounters with NHCPs.

***LGBTQI+ Migrants' Experiences of Unwanted Visibility***

Many participants felt uncomfortably visible in their interactions with NHCP, related to their intersecting identities based on SOGIE, race, culture, religion, language, and different health insurance. To avoid unwanted visibility, some LGBTQI+ migrants tried to appear heterosexual and cisgender. However, some characteristics, such as a language ability, race, and

migration status, could not be rendered invisible. A gay migrant, who is also a community social worker, shared his trans migrant client's unwanted visibility and experience of discrimination with a translator who should be neutral in the healthcare setting: "The translator told her (in relation to gender altering surgery), 'This is the way God created you. Why do you have to change it? Do you want to be like us? Do you want a vagina?'" In 2020, this trans migrant also experienced discriminatory comments from a pharmacist in Canada:

> "Why do you need this medication? You are a man. You look like a man… So why are you taking this hormone? This is haram!" … It was very painful… I don't think I live in Canada. I still live in the Middle East."

In this context, the trans migrant experienced vulnerability and marginalization in relation to the translator who could speak English fluently and the pharmacist who had the power to dispense medication. The migrant trans person felt inferior and unaccepted based on their SOGIE.

Some participants felt traumatized when NHCPs did not have the sensitivity to provide affirming care. One participant, who came from a country where sexual education is not provided and being LGBTQI+ is criminalized, told of his experience with sex education in Canada. He described feeling traumatized when NHCPs did not provide safe sex education in a supportive environment and instead ordered more unnecessary tests because he identified as a LGBTQI+ migrant. The participant shared, "The doctor make you do all these tests… They're going to give you more tests if you're gay." Other participants also felt they were subjected to more tests and vaccines because they were visibly identified as a migrant and LGBTQI+. Lady G, who had a work visa and had to pay for appointments, tests, and vaccinations out of pocket, felt like a "visible wallet" that NHCPs took advantage of: "Vaccines are not covered so I have to pay for them… I pay a lot of money for these vaccines. I have to come back every three or six

months and pay." The NHCPs' insistence on subjecting participants to more tests and vaccinations due to the social context of identifying as a LGBTQI+ migrant created barriers to receiving affirming care.

Some participants felt that their visibility as a racialized migrant led NHCPs to believe that they may not have a clear understanding of their health concerns. The participants felt uncomfortable when NHCPs raised their voices in communicating with them because they thought participants could not speak or comprehend English. Jamie shared his frustration with being ignored when he informed the surgeon about his concerns after top surgery. Jamie said the surgeon dismissed his concerns on the phone, but a few weeks later during his follow-up appointment the surgeon confirmed that Jamie's concerns were valid. Jamie told me, "If we treated this hematoma, I didn't have to go once or twice a week during COVID to drain this out!" Many participants felt that NHCPs thought they are health illiterate because they were migrants, and they ignored the participants' health concerns.

The interpretations showed that intertwined social contexts placed some NHCPs in a position of privilege, while participants felt disregarded or that they were treated as if they were "a number in a manufacturing line." Even prior to COVID-19, the participants spoke of feeling that their healthcare was rushed and that conversations with NHCPs were limited in time and scope. Others felt their mistreatment and high visibility was related to their accent, being a frequent client, being racialized, and/or using a different health insurance. The structural challenge of accessing services in a timely manner with a different health insurance was felt by refugee claimants and participants on work and student visas. Additionally, numerous participants reported challenges to their mental health arising from interactions with NHCPs, in

some cases, related to a history of trauma. These specific experiences are discussed in more detail in a separate publication (XXX).

***Hearing a Dead Name and Being Misgendered***

A common challenge for the migrant trans and nonbinary people interviewed for this study was hearing their dead name and being misgendered, while they were having their documents changed to accurately reflect their gender. According to the interviews, this is particularly problematic as altering documents in this way has not been an option for all of the trans and nonbinary migrants. Participants reported experiences of being dead named and misgendered by a wide variety of NHCPs including nurses, doctors, pharmacists, and chiropractors, as well as ultrasound and x-ray technicians. For participants, it seemed that some of these NHCPs intentionally refused to use the correct name and gender pronouns, and these brought back memories of trauma. For example, even after correcting the care provider, Ali, a trans migrant participant, was outed in the waiting room. Ali's health concerns, which were not related to his SOGIE, caused him to seek healthcare services, where he was placed under scrutiny and experienced unwanted visibility.

There were three challenges for participants who started their gender transition in Canada. First, their name and gender on legal documents did not match their transition identity; second, they may not have been able to change their name and gender on documents; and third, they accessed healthcare services where they were vulnerable to being misgendered and dead named. Elham, a trans migrant healthcare professional, shared her multiple and complex intersecting experiences of what she called a *migration within a migration* in Canada:

> "I immigrated from [x] to Canada, so total change of language, culture, clothes, atmosphere, weather, work, and everything, and I'm immigrating from man to woman.

> So, again changing… everything… When words come out of my mouth it is obvious that I am looking different with a deep voice and short skirt."

Elham explained her experiences of being misgendered by her patients and a few of her colleagues and went on to express that changing one's name and gender on legal documents is not an easy task for all LGBTQI+ migrants. Contrary to my understanding of other participants' experiences, she was not referring to the challenges of a language barrier in completing the documents. Instead, Elham discussed her country of birth's non-acceptance of her current gender identity and expression that prevented her from changing the name and gender on legal documents and created the context in which she could be misgendered. For Elham, and some other participants, trans people must complete all surgeries prior to having a sex marker (versus gender option) and name on documents legally changed in their country of birth. This means that in their country of birth sex can only be a binary choice of male or female, leaving no space for people who identify on a spectrum of trans and nonbinary identities. Some other participants highlighted the inability to return to their country of birth because of their gender transition. The difference between countries' laws for LGBTQI+ people delayed or made changes to legal documents in Canada challenging. Meanwhile, participants encountered NHCPs when seeking help with their routine healthcare concerns, and for those who started their gender transition process in Canada, it meant additional visits and potential risks for being dead named or misgendered.

### *Invasive Questions*

Situations where NHCPs oppressively asked irrelevant questions about a participant's gender transition, seemingly driven by curiosity rather than healthcare services, were discussed in numerous interviews. In these contexts, participants noted that identifying as a migrant

positioned them as vulnerable. They felt that some NHCPs spoke from a position of superiority and asked invasive and unnecessary questions. One such example was shared by a trans migrant participant who told me that he visited a walk-in clinic for high blood pressure. He said the doctor asked irrelevant questions that were not linked to his blood pressure out of personal curiosity: "He asked if I shave my beard; if things grow down there, if my muscle or chest changed. It was all very, um, I would say sexual harassment basically!" The participant stated this was not the first time that NHCPs in Canada asked him invasive and irrelevant questions.

Similar to these invasive questions, other participants found hetero-cis-normative questions were offensive and made their encounters with NHCPs uncomfortable and challenging. These past and recurring experiences led participants to avoid follow up care. The hetero-cis-normative assumptions made participants feel ashamed for not fitting within the healthcare system and caused them to feel unsafe disclosing their SOGIE when accessing services. Amanda, for example, visited the emergency department in a city for palpitations and immediately encountered hetero-cis-normative questions from nurses:

> "They drew a conclusion that I am in a heterosexual relationship, by saying "Is your husband here? How many kids do you have?" – Meaning you already have a husband, after all, you're Black!… They knew from my accent that I'm African… You get discouraged with questions like that. Now, you don't know if you're being shamed again for being a lesbian or for being Black."

Amanda shared that hetero-cis-normative questions are intrusive and intertwined with NHCPs' binarized normative understandings of SOGIE. Amanda suggested that intentional inclusion of LGBTQI+ migrants as NHCPs may mitigate these normative views and provide comfort to racialized LGBTQI+ migrants accessing healthcare services.

***Cultural Stigma and Heteronormative Assumptions***

Racialized and migrant participants wondered if NHCPs did not ask them specific questions about their SOGIE because they assumed LGBTQI+ identity is a "white thing." By the "white thing," participants meant that racialized migrants are perceived to be conservative, and they would not deviate from the gender binary. The participants' previous intersectional experiences of cultural stigma and discrimination, intertwined with their encounters with NHCPs, may have closed opportunities for LGBTQI+ migrants to share their SOGIE when accessing care. This was noted by Aadam, who was shocked when he spoke to a gay migrant friend about safe sex:

> "My friend is in Canada for 20 years and he has no idea about HIV. I asked him, "Don't you have this conversation with your family doctor?" He said "No, no, no! My doctor is from my hometown country, and he knows my cousin… I cannot tell him I'm gay. He thinks I'm straight."

In this context, cultural stigma and NHCPs' heteronormative assumptions prevented the LGBTQI+ migrants from disclosing their sexual orientation. Similar to this case, other participants also shared concerns about seeking care from NHCPs who were from their own culture or country of origin.

Many participants suggested that safe sex education in primary healthcare should be done with everyone regardless of SOGIE. Some participants shared that religion may impact how nurses provide affirming care to LGBTQI+ people. A participant stated, "I think sometimes religion can affect [nurses] – maybe they are following the rules because the place they are working at forces them to follow some rules, but I don't feel that they understand." Alternatively, institutions may have policies related to affirming care, but this may not translate to practice. The

interpretation of interviews revealed that difficult experiences with NHCPs led LGBTQI+ migrants to avoid follow up care.

**"Someone There Listening to Me": Support, Acceptance, and Advocacy**

In addition to what were clearly challenging and discriminatory experiences with NHCPs, participants also talked about NHCPs who *supported* them in navigating the healthcare system. The participants felt *accepted* when NHCPs heard and acknowledged them; for example, when NHCPs stood up against LGBTQI+-phobic comments or when they corrected misgendering by others. Violet, a trans nonbinary migrant person stated: "Being able to see or hear that someone is supportive would really allow me to relax and focus on getting through the procedure and it would definitely reduce my anxiety level." The participants felt heard and accepted when NHCPs listened attentively, respected them, were aware of their past traumatic experiences, and provided compassionate, caring, kind, and nonjudgmental care.

Encounters with supportive NHCPs included nurses who listened and asked appropriate questions, nurses who wrote letters for refugee claimants' court hearings, and nurses who followed up after LGBTQI+ migrants' appointments, surgeries, or discharges. Joana shared that a nurse's compassionate and kind follow up phone calls after being discharged from a mental health facility supported her: "It helped me. (sighs) It took out a lot of my pain, feelings, and fears, because every week someone was there listening to me. So, I think it was great (Smiles and pauses)." Similar to Joana, other participants found words of encouragement from NHCPs helpful, and made them feel accepted and not marginalized in the healthcare system.

Equivalently, Amanda talked about supportive experiences with her family doctor who provided words of encouragement: "I talk to my doctor about my partner… When I told her certain things that I'm doing, she said, 'I'm so proud of you, I don't know how you do it all, you

just got to Canada.'" It is particularly notable that NHCPs' affirming care allowed participants to feel comfortable and relaxed. Aaron, a gay migrant nurse, spoke about his affirming experience with nurses prior to an invasive procedure where he was taken to a separate room and a preoperative nurse explained the procedure and identified all of the people who would be involved prior, during, and after his procedure. He shared, "How you work well in context with a gay man who was raped in the past… fine line between being sensitive and just being voyeuristic… it kind of normalized it, it wasn't overindulgent, it wasn't over played." Aaron felt comfortable because invasive questions were not asked; instead, the nurse was sensitive to his past traumatic experiences and made the care seem like routine practice.

An unexpected interpretation that deepened my understanding was around participants' experiences with NHCPs at colleges and universities. Students asserted that they felt safe to disclose their SOGIE to NHCPs at their schools and they did not feel judged. The NHCPs' openness to hearing about participants' SOGIE made them feel accepted. Ron, a gay migrant student at an urban area, enthusiastically talked about his experience with NHCPs at the university: "My university doctor and nurses were just really open to listen and open to work with you." Like Ron, many of the participants felt acknowledged and supported when NHCPs took the time to know them and provided care that addressed their needs as a LGBTQI+ migrant.

**Discussion**

The participants in this study asserted that while some of their experiences have been positive, there were many areas where improvement is needed in practice, education, and health policy. In particular, participants' experiences of unwanted visibility, being misgendered and dead named, and facing cultural stigma from NHCPs and the hetero-cis-normative assumptions of NHCPs underscore the need for systemic structural changes to healthcare practice and

education. These findings support the recommendations from previous studies and build on specific suggestions to improve NHCPs' practice and education.

LGBTQI+ migrants' assumption that their lives will be safe upon arriving in Canada is erroneous.[22] While some social service providers, counsellors, nurses, doctors, and mental healthcare professionals were supportive, some have demonstrated unsupportive and discriminatory behaviour towards LGBTQI+ migrants.[3,23] Several authors have outlined the need to improve Canadian social care services when working with LGBTQI+ migrants across their life span.[5,24–26] This study adds to these previous findings, as LGBTQI+ migrants also encountered hetero-cis-normative views when in contact with nurses. In various settings, nurses' hetero-cis-normative questions at the point of care access made it challenging for participants to disclose their SOGIE. These oppressive hetero-cis-normative assumptions were perpetuated by migrant and non-migrant nurses in positions of power in Canada. These biases may be due to limited educational and systemic institutional policies that include the intersecting experiences of LGBTQI+ migrants in NHCPs' education and practice. These understandings add to the body of literature, as participants alluded to the vital need to avoid hetero-cis-normative questions in healthcare.

Intersectionality as an analytical lens enabled me to highlight migrant LGBTQI+ participants' calls to improve nursing care at micro, meso, and macro levels.[27] At the macro level, like in other studies, participants called on nursing organizations to develop institutional policies to intentionally amplify the voices of LGBTQI+ migrants in the planning and provision of healthcare services at a micro level, because their needs and past experiences of trans-biphobia, racism, Islamophobia, and xenophobia may differ compared to non-LGBTQI+ migrants or non-migrant LGBTQI+ people.[10,26,28,29] For policies at a meso level, although there may be

challenges of disclosure in the hiring process, the participants called on nursing organizations to intentionally employ migrants, LGBTQI+ people, and LGBTQI+ migrants to create a welcoming environment for clients at the intersections of marginalities. At an institutional level, recruitment for the discipline can seek applicants who meet diversity needs, as well as provide economic supports for diverse nursing students, such as scholarships and bursaries.

Previous studies have focused on safe spaces for LGBTQI+ adults in general.[9,10] This study adds that, at a structural level, institutional policy at healthcare organizations needs to include systemic education for nurses on caring for diverse populations. This work supports the recommendations of previous studies that a one-time in-service or educational session is not enough and adds that nurses need continuous education within an organizational culture that is oriented towards the inclusion of the intersectional identities of LGBTQI+ migrants.[30–32] Systematically, at a macro level, there is a need for visible advocacy and allyship from all healthcare organizations because LGBTQI+ migrants may access healthcare anywhere.

As in previous studies, this research shows that at times when LGBTQI+ people are not following up with nurses for assessment, diagnosis, and treatment, they may not receive accurate information about safe sex[33–35] and other healthcare needs. Some LGBTQI+ migrants may have experienced shock therapy or forced sex reassignment surgery pre-migration.[1] For this reason, LGBTQI+ migrants may have difficulty building a trusting relationship with nurses and avoid health visits.[35] They called on nurses to make it a habit to ask inclusive SOGIE questions with diverse racialized people and avoid assumptions that racialized communities do not identify as LGBTQI+. Some LGBTQI+ migrants acted as peer support and educated other LGBTQI+ migrants about safe sex practices and human rights laws in Canada. This aligns with previous studies that highlight that LGBTQI+ migrants should not be viewed as oppressed, passive, and

uneducated individuals in society.[4,7,8] When participants felt accepted and recognized in their healthcare encounters, nurses had the opportunity to support LGBTQI+ migrants through the provision of relevant resources as well as promoting health education about safe sex and vaccination.[10] However, the perceived imposition of discriminatory tests and vaccines due to the identities of LGBTQI+ people and their migration status creates mistrust of NHCPs.[36]

Intersections of SOGIE, language ability, and health literacy are contributing factors for accessing healthcare services and employment in countries of migration, such as Canada.[37–40] To address issues of domination and oppression created by language barriers, some participants highlighted the need to produce posters and pamphlets in different languages as well as the need for inclusion of translators. En and En[41] found that translators who have knowledge about or experience as LGBTQI+ people would be beneficial when translating content in social services settings. Giwa and Chaze[42] found that translation in settlement social service organizations needs to be inclusive of LGBTQI+ migrants. My interpretations build on previous findings by recommending that healthcare translators also be assessed for their safety and ability to affirm LGBTQI+ migrants. This is vital for LGBTQI+ migrants due to their previous experiences of trauma in their countries of birth[39,43] and in order to feel accepted and not judged when accessing healthcare services.[44]

At a micro level practice, NHCPs should also be aware of the social determinants of health, such as LGBTQI+ migrants' financial burdens, social, mental, and healthcare needs. For example, for a limited period and prior to permanent residency, refugee claimants may have free access to optometrists, chiropractors, dentists, physiotherapists, massage therapists, and certain surgeries.[45] Migrants on work visas, however, may face financial challenges and must pay out of pocket for the first six or more months of healthcare services.[46] For this reason, it is

recommended that nurses be informed of these differences and avoid unnecessary tests and procedures.

A limitation to this study was the inclusion criteria to speak English, which may have prevented some participants from joining. However, the use of translators can be problematic if they are a lay person with no training, use offensive terminology, and/or act as gate keepers in editing the dialogue.[41] When using a translator in research, the researcher must be aware that the past experience of the translator is added to how understandings are exchanged and cultivated.[47] Moreover, translators must be assessed to be affirming for LGBTQI+ migrants.

**Conclusion**

In relation to the experiences of LGBTQI+ migrants, scholars of intersectionality highlight that language barriers, poverty, citizenship status, and human rights laws dominate the social contexts of some groups versus others.[14] LGBTQI+ migrants expressed that some NHCPs lack or have a limited understanding of these intersecting past experiences and current challenges. Inadequate understandings of LGBTQI+ migrants' needs are likely to lead to negative health outcomes.[35,44] An important tenet in enhancing nursing practice in relation to LGBTQI+ migrants is institutional support.[9,33] This means that LGBTQI+ migrants and those who identify as nurses should be included as part of health policymaking.

Participants addressed the gap in accessing safe and affirming care for LGBTQI+ migrants. The participants' calls for NHCPs to use an intersectional lens to lobby for healthcare practices that are accepting and relevant to their needs were evident in this research. The participants highlighted challenging encounters with NHCPs, especially in the case of trans migrants. Unlike non-migrant trans people, the process of document change can be arduous for migrants due to language barriers or because of different countries' laws. Moreover, the

participants also shared that they valued receiving affirming nursing care. Key take away points from this research are for NHCPs to ask relevant non-hetero-cis-normative questions, offer inclusive safe sex education for diverse SOGIE people, avoid dead naming and misgendering, and provide supportive trauma- and violence-informed care that recognizes the social positions of LGBTQI+ migrants.

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## Chapter Four: Stigma and Mental Health Manuscript

Haghiri-Vijeh, R., & Clark, N. (under journal review). “If you can just break the stigma around it”: LGBTQI+ migrants’ experiences of stigma and mental health.

### Abstract

Migrants identifying as lesbian, gay, bisexual, trans, two-spirit, queer, intersex, and diverse identities and orientations (LGBTQI+) experience increased trauma and stigma when compared to heterosexual and cisgender people. A Gadamerian hermeneutics research methodology and intersectionality lens was used to understand LGBTQI+ migrants’ experiences with respect to their social and health encounters in Canada. A total of 16 semi-structured individual interviews were conducted to highlight multiple forms of stigma and discrimination affected LGBTQI+ migrant mental health. Three overlapping themes were identified: 1) “I never went back”: Stigma as an exclusionary experience, 2) “Is [your country of birth] really that bad”: Fear, safety and cultural stigma, and 3) “The circle … is not going to fix my life”: Participants’ call for affirming and trauma informed care. Affirming practice, systemic policy and practices that are culturally safe, trauma and violence informed can mitigate stigma and promote mental health and wellbeing of LGBTQI+ migrants.

**Introduction**

It is well documented that LGBTQI+ people experience poorer mental health status when compared with groups who fit within normative categories of sexual orientations, gender identities and expressions i.e., heterosexual and cisgender people (Mustanski et al., 2010; Rotondi et al., 2011). Bisexual, gay, or lesbians are two to three times more likely to report low mental health than adults who identify as heterosexual (Public Health Agency of Canada, 2018b). These higher prevalence rates could be linked to internalized stress and experiences of systemic discrimination (Meyer, 2003). According to the World Health Organization (2004) mental health is more than the absence of disease and includes intersecting determinants of health such as socioeconomic status, racism, social support, level of education and poverty. However, growing evidence suggests that stigma is a significant source of stress and social disadvantage (Berkman & Kawachi, 2000) and a significant driver of morbidity and mortality (Hatzenbuehler et al., 2013). The purpose of this manuscript is to share LGBTQI+ migrant experiences of stigma and mental health in the context of social and health care encounters.

Stigma has been identified as a key factor in mental health and psychological wellbeing and linked to institutional and internalized stigma (Government of Canada, 2019). Stigma is closely linked to discrimination and can be conceptualized as the lack of full social acceptance (Goffman, 1963). The Minority Stress Model has advanced understanding about LGBTQI+ people's experience of chronic psychological strain resulting from stigma, expectations of rejection and discrimination, decisions about disclosure of identity, and the internalization of homophobia (Meyer, 2003) and transphobia (Mustanski et al., 2010; Rotondi et al., 2011). The influence of stress may result in anxiety, depression and suicidality for many LGBTQI+ people. LGBTQI+ migrants may experience multiple forms of stigma and discrimination including but

not limited to their sexual orientation, gender identity and expression, but also due to other intersecting factors such as cultural, racism, and minority status among other social processes (Gamble et al., 2015; Salam et al., 2022). These factors compound discrimination and stigma, which are both significant to LGBTQI+ migrants' mental health (Hatzenbuehler, 2009). Sociodemographic factors such as migration, race, ethnicity, and culture may intersect with LGBTQI+ experiences of violence, and internal stigma, and lead to decreased overall health (Gamble et al., 2015).

Many LGBTQI+ migrants experience social, cultural, and institutional stigma and discriminations prior to and after relocation. Pre migration LGBTQI+ people experience high levels of violence and trauma due to their sexual orientation, gender identity and expression (Alessi et al., 2018; Lee, 2021; Nicol et al., 2017). These experiences may include physical, mental, emotional and sexual violence (Alessi et al., 2020). There are currently 30 countries where same-sex marriage is legal; however, there are 71 countries where LGBTQI+ are illegal and in some instances punishable by death (*73 Countries Where Homosexuality Is Illegal*, 2021). Some international state laws reflect homophobic and transphobic institutional violence which further stigmatize and alienate LGBTQI+ people from friends and family (Reading & Rubin, 2011). As a result, many LGBTQI+ people seek refuge in nation states which offer protection from persecution due to sexual orientations, gender identities and expressions. The legalization of same-sex marriage and enforcement of human rights laws preventing discrimination against diverse sexual orientations, gender identities and expressions have made countries like Canada a desired destination for those who identify as LGBTQI+ and who require protection. Canada has been a leader in LGBTQI+ human rights through recent implementation of Gender-Based Policy Analysis (GBPA) [masked], and federal decisions about immigration status related to LGBTQI+

rights toward a humane process of disclosure (Jordan & Morrissey, 2010, 2013; Lee, 2018, 2021).

In the context of seeking refuge and protection, many LGBTQI+ migrants experience precarious status living in Canada including refugee claimants, international students, temporary workers, sponsored family members, protected persons, and undocumented individuals (Lee, 2021). Upon arrival to Canada, individuals must claim their identity as LGBTQI+ before the Immigration and Refugee Board of Canada (IRB) who establish guiding principles for decision-makers in adjudicating cases involving sexual orientation, gender identity and expression (Immigration and Refugee Board of Canada, 2017). This process of disclosure can be retraumatizing and trigger unwanted traumatic memories (Kahn et al., 2018). Moreover, LGBTQI+ people, discussing their sexual orientation, gender identity and expression may feel increased stigma and shame due to the taboo nature of these topics in their countries of birth (Mulé et al., 2016). In addition, LGBTQI+ asylum seekers may have trouble constructing a thorough narrative regarding their fear of persecution, which in turn may affect their claim status and media portrayal of LGBTQI+ migrants as ‘non genuine’ (Lee, 2021). This may pose as a double edge sword when constant affirming of one’s identity also comes with feelings of illegitimacy and when LGBTQI+ migrants encounter hetero-cis-normative views during contact with (IRB) boards (Logie et al., 2019; Munro et al., 2013).

Despite these potentially traumatic contexts, post migration, LGBTQI+ people may not access mental health services and supports for a variety of reasons, including fear and stigma related to historical pathologizing of homosexuality and gender non-conformity (Drescher, 2015). Some LGBTQI+ migrants who access health care services continue to experience racism, discrimination and microaggressions from health care professionals in the form of rejection

(Alessi et al., 2020). Microaggressions are intentional/unintentional and verbal/nonverbal acts that target a group based on their marginality, and can be retraumatizing (Sue, 2010). LGBTQI+ migrants require accessible, supportive, trauma- and violence-informed spaces across legal, health and social service professionals in order to promote their mental health. Contextual and structural factors continue to shape LGBTQI+ migrants' experience of stigma, discrimination, and marginality post migration, which may heighten their risk of stress, and poorer mental health. Little attention has been given to LGBTQI+ people's mental health across migration contexts while accessing health and social care. We draw from a study that explored experiences of LGBTQI+ migrants' encounters with healthcare professionals, and present factors which shape their mental health in order to build inclusive spaces and access to social and health care services to support their mental health.

**Method**

We conducted a qualitative study guided by Gadamerian hermeneutics (GH) and intersectionality as an analytic lens to understand the experiences of diverse LGBTQI+ people who had health care encounters in Canada. GH enabled a deeper understanding of human experiences through interpretations, and this required knowledge of the prior, current, and future contexts of a situation (Moules et al., 2015). Intersectionality has roots in Black activists and feminists, as well as Latina, post-colonial, queer and Indigenous and legal scholars which have all produced work that reveals the complex factors and processes that shape inequitable power relations (Collins et al., 2021; Collins & Bilge, 2016). We applied intersectionality as an analytic lens to uncover structural conditions and social contexts in which power functions to privilege and/or disadvantage LGBTQI+ people based on their migration status, race, ethnicity, sexual orientations, gender identities and expressions, and how these social categories intersected to

shape their mental health. Using GH and intersectionality, we aimed to advance theorizing beyond the intersection of race, gender and class and to expose conceptual gaps as well as produce knowledge for social change. This is a dialogical way of producing knowledge which builds alliances within interpretive communities (Collins et al., 2021). Multiple forms of stigma gave meaning to understanding LGBTQI+ migrants' experiences of mental health. This research centered on the voices of LGBTQI+ people who experienced stigma across migration trajectories and in various health and social contexts.

***Setting and Recruiting Participant***

The [Masked] human research ethics review board approved this research (Approval number 19-0591). In order to capture diversity of experiences, we recruited LGBTQI + migrants across Canada during COVID-19. Participants were from the following Canadian provinces, Quebec, Ontario, Alberta, Manitoba, and British Columbia. Recruitment was done through information letters that were posted on social media sites who provide healthcare and social services for LGBTQI+ migrants. The inclusion criteria and consent were confirmed via email and included: a) 19 years of age and older, b) spoke English, c) identified as LGBTQI+ migrant, d) received healthcare in Canada, e) comfortable with being audio-recorded for the purpose of research. Consent forms were emailed to the participants prior to confirmation emails, so that they could have more time to ask questions and provide consent. An option for verbal or signed consent was provided. The participants were offered a $25 gift card or a money transfer of $25 as honoraria. Interviews were audio recorded and transcribed verbatim by the first author. To honour and protect the participants' voices, they had the option of selecting pseudonyms and/or neutral pronouns in the study.

### *Data Collection and Analysis*

Semi-structured in-depth individual interviews lasted approximately 90 minutes on a secure Zoom platform and were conducted with participants from October 2020 to June 2021. The philosophical underpinning of GH was used to explore the phenomenon of LGBTQI+ migrants' experiences of social and health care encounters (Gadamer, 2007). We engaged with GH to explore in detail how participants were making sense and meaning of their personal and social world (Tuohy et al., 2013). Based on the interviewer's understanding of the topic, interpretations and dialogical engagement started during the interview and additional questions were asked to further deepen understanding and add to the contextual experiences of LGBTQI+ migrants. In line with GH, questions that arose after transcription of one interview were taken to the next interview (Jardine, 1992; Moules et al., 2015). Interviews were re-read multiple times to 'look' for the said, not said, to deepen understanding of what gave meaning to LGBTQI+ migrants' mental health. The first author, highlighted, made notes on each interview and used a journal to reinterpret participant's experiences (Moules & Taylor, 2021). Transcriptions were then re-read to note keywords, phrases, and experiences that arose for participants and how systems of power contextualized their positionality (Crist & Tanner, 2003; Moules & Taylor, 2021). Following this, themes were reviewed with the second author to strengthen the interpretive analysis and key constructs, i.e., mental health and stigma.

### Researcher Positionality and Rigor

An integral part of using GH and intersectionality is reflexivity in terms of how the researchers' positions influenced their interpretations of the interview data (Collins et al., 2021; Moules et al., 2015). The first author is a racialized first-generation settler, who escaped their country of birth with human smugglers, communicates in English as a fourth language, is

cisgender female, heterosexual, an academic, nurse, and a PhD candidate. The second author is a first-generation migrant, of mixed biracial heritage, cisgender female, heterosexual, mental health professional, and academic. Through our own intersecting identities, we share a common experience of disadvantage based on our racialized identities, migration journey, and gender, but hold positions of power and privilege that allow us to explore encounter experiences of LGBTQI+ migrant with health care professionals (Collins et al., 2021). Thus, we are attuned to the ethical positioning of our social identities and how these might lead to a misrepresentation of the interview participants. To mitigate potential harms and promote validity of the findings, the interviewer discussed the emerging understandings with the research committee and used journaling to aid in interpretations (Moules et al., 2015). This form of validation was incorporated as part of the interpretations and the dissemination of the research.

**Results**

A total of 16 in-depth individual interviews were conducted. During the interviews, participants were asked how they self-identify as an open-ended question (Table 1). Participant's age ranged from 20-50 years. Country of origin included Korea, Europe, the United States of America, the Philippines, South America, Mexico, Tunisia, Taiwan, Lebanon, Africa, China, Syria, and Iran. Migration to Canada included less than one to 22 years. Two-Spirit individuals were included in all the recruitment material but none of the participants identified as Two-Spirit. Two-Spirit, a term coined at the third international Two-Spirit gathering in 1990 in Winnipeg, Manitoba, for some Indigenous communities is not limited to various sex and gender identities (Kia et al., 2021; Ristock et al., 2010; Trans Care BC, 2021). Beauchamp et al. (2022) assert, "being Two-Spirit frequently involved special work roles in society (e.g., weavers, healers, mediators, caretakes), sacred status, roles in ceremonies" (p. 3). At the intersections of migration

and LGBTQI+, 56% of participants were healthcare and social service providers who also were the recipient of health care services. The reasons for migration varied including, socioeconomic, seeking asylum and safety, and family reunification. They described the collective experience of stigma and mental health impacts from both professional and personal experiences.

**Table 1. Sociodemographic Characteristics of the Study Participants**

| **Characteristics** | **n (%)** | **Range** | | **n** |
|---|---|---|---|---|
| **Country/Region of birth** | | | **Profession** | |
| Africa | 2 | | Healthcare professional | 1 |
| China | 1 | | Nurse | 3 |
| The Philippines | 1 | | Resettlement worker | 2 |
| Korea | 2 | | Community social worker | 4 |
| The Middle East | 3 | | Engineer | 1 |
| Mexico | 1 | | Information Technologist | 2 |
| South America | 1 | | Not discussed | 3 |
| Taiwan | 1 | | **Reason for Migration** | |
| The United Kingdom | 1 | | Refugee based on LGBTQI+ | 8 |
| The United States of America | 1 | | Skilled worker | 2 |
| Did not name | 2 | | Studies | 3 |
| **Ages** | | 20-49 | Economic reasons | 2 |
| **Years in Canada** | | | Marital | 1 |
| 1 to 5 | 8 (40) | | **Sexual Orientation** | |
| 6 to 10 | 6 (28) | | Gender Queer | 2 |
| 11 to 15 | 1 | | Bisexual | 1 |
| 16 to 20 | 0 | | Pansexual | 1 |
| 21 to 25 | 1 | | Gay | 8 |
| **Religion** | | | Lesbian | 2 |
| Muslim | 3 | | Not identified | 2 |
| Buddhist | 1 | | **Gender Identity & Expression** | |
| Spiritual | 3 | | Nonbinary | 1 |
| Not identified | 9 | | Transgender | 5 |
| | | | Cisgender | 10 |

The most significant reason for migration was seeking refugee status based on LGBTQI+ identity 50%. This finding was expected given the fact that many countries of birth prior to coming to Canada may not reflect human rights for LGBTQI+ people and require refugee claims processing. For example, 3 of 16 participants arrived in Canada from the Middle East, self-identified as Muslim: in most parts of the Middle East, LGBTQI+ people generally have no or limited rights. Although only 13% of participants migrated for economic reasons, almost 20% of LGBTQI+ participants were nurses and 38% were social work professionals. This finding highlights how LGBTQI+ people can experience multiple and simultaneous privilege and disadvantage based on other identities, e.g., health care professional. The sexual orientations, gender identities and expressions of participants varied with 50% self-identified as gay and 32% as trans-gender. Scholars have suggested that colonialism and Western religious values, i.e., Christianity, have historically discriminated against transgender and/or Two-Spirit people who identify as masculine and feminine (McLean, 2020; Semlyen et al., 2018; Trans Care BC, 2021).

Overall, race, ethnicity, culture and migration, intersected across various social and health care encounters shaped LGBTQI+ participants' experience of stigma and gave meaning to their mental health. Importantly, power and privilege overlapped and provided nuanced understanding between providers of care and LGBTQI+ migrants who receive care. Three intersecting themes of stigma transpired from the conversations: (a) "I never went back": Stigma as an exclusionary experience, (b) "Is [your country of birth] really that bad": Fear, safety and cultural stigma, and (c) "The circle … is not going to fix my life": Participants' call for affirming care.

***"I Never Went Back": Experiences of Stigma as Exclusionary***

Some LGBTQI+ migrants shared that health providers from their own ethnic background did not understand their need for mental health support. Ahmad, a migrant Middle Eastern gay man and community worker with LGBTQI+ migrants, was silenced by a Middle Eastern doctor:

> Doctor said, 'do you pray?' I said, 'Honestly no, I don't pray, I don't really have a good connection with religion because religious people judge me a lot'. He said, 'No, see, that's why you are depressed. That is why you are feeling down. You have to go back and pray. Your name is Ahmad! So, don't ruin your name'. It was more traumatizing actually. So, I never went back to that clinic.

Ahmad added that the doctor did not prescribe medications for him, did not ask him why he was feeling down, and only made stereotypical assumptions about him. Ahmad shared that he had a recent relationship breakup, were in between jobs, moved back in with his family, who at the time were tolerant but not accepting of LGBTQI+ people. Ahmad perceived that the health care provider (HCP) did not take the time to have a conversation, consequently, Ahmad did not feel safe to disclose their experiences. These experiences may reflect cultural assumptions based on ethnicity and signifies social exclusion based on sexual orientation, gender identity and expression and ethnic background and leading to inequitable mental health support.

Settlement service providers are often the first point of contact and provide a gateway to health care for migrants resettling into a new country. In this context, a LGBTQI+ migrant settlement worker shared their experience of working with other members of their community. Aadam, also a LGBTQI+ migrant, shared one of his trans client's experiences of stigma at a college in an urban city. The trans migrant Arab student experienced bullying and transphobia from two other female heterosexual Arab students, and the teacher did not stop or addressed their

behavior. Aadam shared: “My client stopped going to school. They have to learn English to be able to be independent, but because of the trauma and what happened there, they hate school now.” In this situation, Aadam was providing mental health support for his client and experienced secondary stigma as a community health worker. Secondary stigma can also have negative mental health and emotional impacts. The students’ and instructor’s transphobia against the trans migrant Arab student illustrates how interpersonal stigma can result in systemic exclusion and marginalization. Similar to Ahmad, the result for Aadam’s client was to leave and never return to potential health promoting services. The lack of inclusive and welcoming environments led to stigmatization based on sexual orientations, gender identities and expressions and the devaluing of LGBTQI+ migrants through process of social exclusion.

Likewise, the following experiences elucidate the multidimensional cultural stigma and mental health impacts participants faced. Lady G experienced homophobia from roommates in a dormitory who were from the same country: “They were from the same country as me. I found out after I signed the contract, so it was a very bad year.” Lady G shared these experiences of discrimination in Canada that built on previous mental health challenges for him (pronoun Lady G identified with), but he had not accessed mental health services because of wanting to fit into the cultural stereotype of being a “good immigrant”. For Lady G, accessing mental health services meant being categorized as an unfit migrant which could result in deportation. Jamie, a migrant trans participant and former college student, asserted, “I previously had gay roommates, and yeh the two times that I were with the gay roommates they both turned out to be transphobic”. Jamie added, “I actually noticed that because they were White, and I am Asian, we definitely had a different cultural understanding of things.” This stigma was targeted to racial identity and gender identity. The experiences of these participants reflect exclusion based on

migration status and sexual orientations, gender identities and expressions that was perpetuated based on cultural stigma within migrant communities as well as among non-migrants. Ultimately these participants perceived that they were not included, leading to feelings of not fitting in and perpetuation of exclusionary practice.

***"Is [Your Country of Birth] Really That Bad?": Fear, Safety and Cultural Stigma***

Several LGBTQI+ migrants felt that health care professional (HCPs) were not aware of the challenges they experienced in Canada. Some LGBTQI+ migrants who were accessing health and social support, mentioned that fear of the lack of economic and social safety contributed to their mental health challenges. The participants also knew of other LGBTQI+ migrants who had not disclosed their sexual orientation, gender identity and expression to their family members who were in Canada or abroad. This was due to the fear of cultural stigma, including being disowned by their family, or losing financial support. Cultural stigma around mental health and LGBTQI+ people made participants feel not "normal" or being "wrong in the name of religion, family, and culture". These stressors compounded feelings of insecurity, vulnerability, and fear of deportation. Participants who were not dependent on their family's financial support, tended to not disclose their sexual orientation, gender identity and expression to their family in Canada or abroad because they did not want to upset or worry them. Jay, a migrant, racialized, gay nursing student added: "I want to protect my parent's sanity. They probably think homosexuality is some type of freaky thing that the Americans brought to this country. I probably would not be able to handle knowing I am the problem causing this stress." For Jay and other participants, disclosure of sexual orientation, gender identity and expression led to safety concerns for families left being in their countries of birth. Being stigmatized based on an alternative sexual orientation and gender identity is considered "freaky" within some ethno-cultural communities.

Participants who had experiences of intimate partner violence were worried about being found. Prince, who is a Canadian citizen, explained their past experiences and current fear of safety, security, and deportation, "I had a boyfriend in Mexico – whom was physically, emotionally, and mentally abusive … I have genuine fear of persecution. I feel all the time [cries] that I'm being persecuted [crying]. Seriously, I'm scared that my citizenship can be taken away." The trauma experienced by emotional and physical abuse were compounded by fears of persecution due to Prince's sexual orientation. Fears of deportation and feelings of persecution were retraumatizing and highlight the acute nature of heightened stigma that is unseen. Similarly, Joana, who self-identified as a transgender migrant on a student visa, shared their experiences of profound fear to a nurse when they were admitted to a mental health facility by police due to suicidal ideation. Joana explained:

> Not only as a transgender person, but also as an immigrant, it is so scary because I had a really bad moment with my mental health and everything. But these other patients in the facility can take you and put you in a dangerous situation or harm you, and it is real!

Joanna's fear of safety was experienced in the context of deportation and being placed with other patients who were perceived to be non-LGBTQI+.

Other participants who access health care and social support felt they were being forced to educate professionals about their "real" experiences of trauma. In one instance, Jamie, a migrant trans participant, visited an emergency department due to mental health crisis prior to their IRB hearing. The psychiatrist was dismissive and asked, "Is [your country of birth] really that bad?" Jamie shared that at a refugee clinic: "The social worker wasn't really treating me the right way. It was almost like, 'oh yeah, those things happened to you, and now you're in Canada, so, now what?!'" The statement "is [your country of birth] really that bad" captures the overall

lack of knowledge about the migration experience and the trauma and fears that result at the intersection of feeling persecuted because of one's sexual orientation, gender identity and expression. These multiple forms of stigma reflect the lack of culturally safe and trauma informed care that may retraumatize LGBTQI+ migrants.

***"The Circle … is Not Going to Fix My Life": Participants' Call for Affirming Care***

Accessible and affirming support for LGBTQI+ migrants was a common theme discussed by participants. Many participants identified across the LGBTQI+ migration status continuum, and described the need for accessible, better quality, and affirming care. Amanda shared her experience with a non-affirming mental health care professional (MHCP). The negative experience caused her to change therapists, but the therapist called Amanda, and stated: "We are very good with writing letters. I'm going to write a very good letter for your court hearing. I've done this for a lot of people of your kind". Amanda was furious by this phone call and told us that it was not about the refugee claimant letter rather she needed support for her mental health. This MHCPs did not comprehend Amanda's need for mental health services was a result of years of trauma and prosecution perpetuated by institutional and cultural stigma.

At the institutional level, some participants found that mental health care professionals (MHCPs) at colleges and universities were not familiar with nor understood migrant LGBTQI+ students' past and present intersecting experiences of stigma and discrimination and were not prepared to provide relevant resources. Deep breathing, yoga, mindfulness techniques, and general LGBTQI+ support groups were suggested by some MHCPs when participants looked for affirming care and support. Joana shared their experience with the university's MHCP:

> [The counsellor at university] was overwhelmed with my situation. It is like every problem you have is going to be fixed there [at a general trans support group]. The reality

> is not like that. I have been in some of those places… This circle of conversation is not going to fix my life.

Joana's experience suggests a need to build and develop trust and feel validated and that going to "general" groups would not necessarily "fix" their challenges. This experience indicates that there is a need for therapeutic interpersonal relationships from MHCPs who are knowledgeable and open to learning from LGBTQI+ migrants. Similarly, Lady G described his experience of going to the university's counsellor who minimized his experience of sexual abuse and trauma:

> It certainly doesn't help if you are a non-straight migrant from a country that is religious, very homophobic, and you're dealing with toxic masculinity and internalized homophobia, and that breathing technique is not going to help you … The school counsellor doesn't have a lot of resources to give. So, they have the four seconds breathing technique that they will give to everybody. Sometimes the advice is not necessarily relevant to you, because they are from a different sexuality, culture, or because they have never been an immigrant in the sense where they were born here, or they are White, straight, and or cis gender.

Feeling socially included required affirming practice that is committed to meaningful respect. Maryam, a migrant, Muslim, lesbian woman, who had escaped war and prosecution due to sexual orientation, also had a difficulty finding accessible and affirming mental health support. Maryam provided an example where she saw the MHCP pro bono but perceived a lack of affirming care:

> The counsellor was a white LGBTQI+ person, but it wasn't a good experience. They were following their own agenda. Whatever I expressed or shared – and it's not easy to open up to someone especially when you're coming from a history and society where you

> get professional at hiding – it felt like they would go back to their own agenda without trying to build on where I was, which was just not a healthy pattern for me.

Maryam went on to say, "I tried to find something for free. First bad experience, second bad experience, and decided that my mental health is worth an investment even though sometimes I can't afford it." Likewise, Ahmad, a migrant, gay man, and community worker, alluded to the need for culturally safe mental health services:

> I have a lot of newcomer-migrant service users and they are dealing with a lot. So, it means that the transition as a newcomer is adding burden and stress at their mental health. That's why I think from the time they arrive as a LGBTQI+ refugee we don't need to assume that the person needs mental health support, we just need to provide it!

Universal approaches to promoting mental health and wellbeing for LGBTQI+ migrants require affirming environments that go beyond signifiers such as a rainbow flag and may include insurance policies that support individualized patient's goals and can involve many different aspects of social, medical, and surgical care (Trans Care BC, 2021). Many participants, including health and social service providers, found it challenging to get adequate mental health services and supports. The participants also highlighted cultural stigma around mental health and shared their challenges of finding affirming MHCPs that could address their experiences of migration, language barriers, being LGBTQI+. For some, one-on-one therapeutic relationships with a counsellor were needed. For others, providing relevant peer support group meetings can promote mental health. The participants asserted support groups created an avenue to discuss similar challenges, hearing solutions, and having a sense of community in migrant LGBTQI+ groups in-person and virtually. Peer led support was viewed as affirming and validating, which was missing during many HCPs encounters.

Some LGBTQI+ migrants who were recipients of care, focused on living in the moment. They had not thought about the future because they did not think they would be alive for much longer due to past and ongoing trauma impacting their mental health. Nic, a nonbinary, heterogonous, migrant nurse, highlighted the need to dismantle institutional stigma by "expanding what caregiving looks like to include communities of people who might be involved!" They noted that affirming care for LGBTQI+ migrants would include their chosen family. Chosen family are non-biological family who offer love and security to the LGBTQI+ migrants (Hailey et al., 2020). Other participants who had children questioned whether their children would accept them and feared that cultural stigma from relatives and friends in Canada would turn their children against them. For others, inclusion of family in the resettlement context was unsafe. Elham, a trans migrant, highlighted her challenges with her abusive ex-partner's family, who attempted to take her son away in Canada, and stated, "Luckily the government is supportive, but we have the real and daily life to face these people who are giving us a hard time." The need to provide family centered mental health support required knowing about the impacts of including families in their care. Lady G stated: "Sometimes you also need to first work on your own trauma or mental health challenges before having relationships and kids because if you have trauma and you're dysfunctional, you're dysfunctional in other aspects of your life". It was important that mental health needs be addressed so that LGBTQI+ migrants would build healthy relationships and not perpetuate intergenerational trauma within their own families.

**Discussion**

Understanding experiences of LGBTQI+ migrants at the intersection of racial identities, migration, and culture need to be included in social and health care policies and practices. While

many countries have adopted human rights and humanitarian laws protecting LGBTQI+ migrants, the experience of compounded trauma and stress based on multiple forms of stigma across migration journeys affect LGBTQI+ mental health. In this study, LGBTQI+ migrants' experiences were contextualized across different dimensions of power and privilege and between LGBTQI+ migrants receiving care and those who are also providing care.

In addition, marginalization is not a one point in time event. Like other studies, we found some LGBTQI+ migrants may have mental health challenges due to traumatic experiences pre- and post-migration (Alessi et al., 2020; Fox et al., 2020). This finding is consistent with Kirmayer et al. (2011) who call for a systematic inquiry into patients' migration trajectory and subsequent follow-up on culturally appropriate indicators of social, vocational, and family functioning over time. The participants in our study questioned if non-migrant, heterosexual, and cisgender MHCPs would comprehend their intersectional experiences of interpersonal, cultural, and institutional stigma. On the other hand, our findings suggest that it should not be assumed that migrants with shared ethnicity may be able to provide culturally safe support. Our findings suggest that sexual orientations, gender identities and expressions is less understood where LGBTQI+ migrants may experience poorer mental health as a result of institutional and cultural stigma across migration trajectories. These compounded effects must be addressed to mitigate harms and adoption of culturally affirming health policies and practices. Like other studies, we found that to obtain migration status, LGBTQI+ people reexperience distress because they must narrate and disclose their traumatic stories in detail to the IRB (Kahn et al., 2017). The stress of forced disclosure (Lee, 2021) and not having a mental healthcare professional that LGBTQI+ migrants can trust, excludes them from equitable access to care. Studies suggest that when trauma- and violence-informed care models are implemented they can promote better client

experiences, satisfaction and trust, and mitigate institutional stigma (Dunbar et al., 2020; Hatzenbuehler et al., 2013; Logie, Lacombe-Duncan, et al., 2019; Whitehead et al., 2016). Hence, best practices recommend trauma- and violence-informed care and universal approaches which foster safety, trust, and inclusivity (Im et al., 2020; Kirmayer et al., 2011).

Migrants, in general, may initially refuse counselling and other social supports offered due to cultural stigma and fear of exposure (Salam et al., 2022; Salami et al., 2019; Stangl et al., 2019). Our study supports these findings as the participants felt a sense of community and strength in migrant LGBTQI+ support groups. LGBTQI+ migrant voices in this research have raised the need for continued advocacy, political coalitions, and alliances, and provide a critical analysis essential to promoting their mental health. Despite the diversity of LGBTQI+ migrant participants in this study, experiences of stigma and discrimination, fear for their safety and security was a shared experience. Peer led groups may change stigmatizing beliefs, improve coping skills, build social support, and provide an affirming space for LGBTQI+ migrants.

***Limitation***

A limitation in this study was labelling diverse sexual orientations, gender identities and expressions as LGBTQI+ people; however, this grouping was intended to deliberately draw attention to human rights and inclusion of migrants who are non-conforming to gender and sexuality norms (Lee, 2021; Salam et al., 2022). We found that despite diversity of LGBTQI+ people, there were shared experiences of discrimination and stigma across migration trajectories that influence their mental health post migration. In addition, our study sample did not include Two-Spirit people. This limitation maybe related to the colonization of Two-Spirit people within Indigenous and LGBTQ+ cultures (Trans Care BC, 2021). This may add another layer to understanding systemic stigma through a cultural lens. Our interpretations uphold previous

studies that some LGBTQI+ migrants encounter intersecting experiences of -isms and hetero-cis-normativity from others due to their religion, race, sexual orientation, gender identity and expression, or inability to communicate in English (Alessi et al., 2020; Ghabrial, 2017; Munro et al., 2013; Nakamura et al., 2013).

***Implication for Policy and Practice***

Our intersectional analysis moves beyond the mono categorical thinking of race, gender and class by analyzing how LGBTQI+ migrants require affirmative support in health and social care contexts. We recommend systemic training across health care and not-for-profit and other organizations that work with members of the LGBTQI+ migrant community. Universal approaches that are culturally safe, trauma and violence informed require conscious awareness of the connections between violence, trauma, negative health outcomes and behaviors (Public Health Agency of Canada [PHAC], 2018a). Given that the majority of LGBTQI+ migrants seek refuge and safety, it is imperative that policy and practices across health and social services mitigate potential harm and retraumatization. These approaches increase safety, control and resilience for people who are seeking services in relation to experiences of violence and/or have a history of experiencing violence (PHAC, 2018a). This approach is also consistent with PHAC (2018b) recommendations for targeting stigma pathways to better health outcomes model. This includes recognize multiple and intersecting stigmas experienced by LGBTQI+ migrants. In addition, key areas of intervention must target stigmatizing practices, and reflection on potential interpersonal, and secondary stigma in order to mitigate health care practices that potentially are retraumatizing. Most research has not focused on migration at the intersection of sexual orientation, gender identity and expression, nor the health impacts of LGBTQI+ migrants. Our findings provide an added layer of complexity related to understanding migration as a

determinant of health intensified with experiences of intersectional stigma pre, post and during relocation for many LGBTQI+ migrants (Stangl et al., 2019).

The experiences of LGBTQI+ migrants require affirming practices and social contexts to promote their mental health in Canada and other countries offering safety from persecution. In line with previous studies, we found many LGBTQI+ migrants experienced cultural stigma and microaggressions (Casey, 2019; Cerezo et al., 2014), and this caused them to avoid seeking care as well as avoidance of potential sources for social support (Ghabrial, 2017). Intersectionality and GH enabled us to understand that cultural stigma of labelling LGBTQI+ as "wrong" or "human failing" is a form of stigma, prejudice and perpetuation of hetero-cis-normative views operated by systems of power and may cause LGBTQI+ migrants to experience internalized stigma where there is a lack of cultural belonging to one's own religion and cultural community (Masked). We conclude the need for more equitable and affirming health services to support LGBTQI+ migrants. Improving gender affirming care must come with equitable and accessible care that not only recognizes the sexual orientations, gender identities and expressions of migrants, but also policies and practices that include peer, community support and that are trauma and violence informed (Public Health Agency of Canada, 2018a; Registered Nurses' Association of Ontario, 2021; Trans Care BC, 2021). Change in praxis can be operationalized with greater personal reflexivity about how one is positioned within institutional structures, while attending to intersectional dimensions of migration and LGBTQI+ people that is fitting with culturally safe, universal trauma- and violence-informed practices.

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## Chapter Five: Integration of Findings with Theory Manuscript

Haghiri-Vijeh, R. (Accepted, April 24, 2022). “Ally theatre is a problem”: LGBTQI+ migrants’ experiences with nurses in Canada. *Advances in Nursing Science*.

### Abstract

In a 2021 research study, exploring the experiences of LGBTQI+ migrants in healthcare in Canada, participants referred to the term “ally theatre” in relation to their encounters with nurses. That is, the participants asserted that some nurses publicly demonstrate performative, or superficial, allyship regarding their identities. Using participants’ experiences in healthcare as a metaphorical theatre, this paper presents a theoretical exploration of ally theatre, and raises questions about professional practice claims of inclusivity and antiracism. The participants felt like deviant performers for not abiding by institutionalized centering of white hetero-cis-normative norms and thereby positioning racialized, LGBTQI+, and migrant as Other.

What is known, or assumed to be true, about this topic:

Some white and BIPOC nursing scholars have brought attention to the experiences of people marginalized due to the relational intersection of identities at race, ethnicity, culture, religion, dis/ability, mental health, migration status, as well as sexual orientation, gender identity, and expression. Over the past two decades, nurses have been active in working with migrants, LGBTQI+, or LGBTQI+ migrants and other members of the health and social care team in addressing the needs of LGBTQI+ migrants. Yet, at the practice level, some LGBTQI+ migrants denoted to be the recipient of the performative acts of allyship from nurses.

What this article adds:

In this article, the concept of "ally theatre" is used as a metaphor to depict meaningless acts of allies' support for LGBTQI+ migrants. I underscore how the nursing profession has claimed to be affirming of diverse communities; nevertheless, nurses *can do* better, which is beyond one-dimensional, performative acts in education, practice, and policy. Drawing on normative ideologies underpinning performative allyship, a theoretical discussion with selected findings is presented on how LGBTQI+ migrants experienced cynical comments and unsacred seriousness in play with nurses in practice. In addition, nurses' genuine acts of allyship with LGBTQI+ at various practice settings are presented.

Ally theatre and performative allies refer to individuals who superficially claim to be supportive of marginalized people but do not act upon their declared solidarity in a meaningful way.[1–3] "Ally theatre" was elucidated when participants in my research pointed out that nurses' performative acts of allyship were not supportive. At that time, I claimed to be an ally, but as a nurse educator and PhD student in nursing, I had vague knowledge of "ally theatre." Here, I draw on a research study conducted in 2020 and 2021 that explored the experiences of LGBTQI+ migrants with nurses in Canada. LGBTQI+ stands for lesbian, gay, bisexual, Two-Spirit, trans, queer, intersex, and the "+" represents the diverse sexual orientations, gender identities, and expressions (SOGIE) not named in the initialism. Further, I present selected research findings with a critical discourse in understanding allies' acts resembling theatrical performances and as a mechanism for disrupting marginalization as well as potentially reinforcing it. A comprehensive discussion of the research findings is published elsewhere. Since the Gadamerian hermeneutics research methodology was used, an opportunity was presented to "peel the layers back" to uncover "performative allyship" or "ally theatre" in relation to nursing. The University of YYYY's human research ethics review board approved this research (Approval #YYYY); the pseudonyms and pronouns were selected by participants.

This paper begins with a summary of theatre and play, moves on to a conversation about performative allyship and ally theatre, and intertwines Gadamerian hermeneutics with intersectionality to present how some LGBTQI+ participants in this study experienced performative allyship and others experienced true solidarity from nurses. Specifically, I highlight that the nursing profession has claimed to be affirming of diverse communities.[1] However, nurses *can do* better, which goes beyond simplistic, performative acts in education, practice, and policy. The concept of ally theatre offers a critique of how nurses perform affirming practices

with LGBTQI+ migrants. Affirming care is defined as how healthcare systems and professionals provide supportive care for marginalized communities "while recognizing and acknowledging their [SOGIE]".[4(p141)] Next, I turn to intersectionality and Gadamer's discussion on play in theatre.

**In Play with Gadamer and Intersectionality**

Gadamerian hermeneutics with intersectionality positions the concept of play in theatre within an institutional hierarchy that influences the representation of the intersecting experiences of performers.[5,6] Gadamer referred to play as having rules and structures, but when played in a shared communal space, the performance has an open outcome based on how each player plays and how the players bring their uniqueness to this shared space.[7] Each player and the audience have a role in understanding the play because they all bring their historicity, horizons, and prejudices to understanding the shared space.[8] Utilizing the concept of play in Gadamerian hermeneutics, in this study the performers are LGBTQI+ migrants who share spaces and attempt to play their role in relation to nurses, as their co-performers, to access healthcare. As a communal place, the healthcare arena is not a neutral space for LGBTQI+ migrants and their encounters with nurses in the healthcare sector are renewed with each visit.[9] Gadamer[5] analogized that the dialogue in everyday conversation is another version of gathering in communal spaces, such as in festivities. Each players' performance impacts the experiences of the co-players. For example, nurse educators, as co-players, have a role in educational institutions to prepare students for providing affirming care for diverse populations[10,11]; however, systemically, some nursing programs have either excluded LGBTQI+ migrants in their curriculum or lack faculty who are prepared to incorporate racism, health equity, and cultural safety for these individuals in nursing education.[1,12–20]

Scholars of intersectionality highlight how individuals' social locations and identities are not politically neutral and are the result of dominant ideologies and systems of power.[21–24] In particular, race is not seen as a stand-alone category, but people are seen in the actual complexities of their lives with intersecting identities informed by race, ethnicity, culture, class, religion, dis/ability, migration status, mental health, and SOGIE. Hankivsky provided examples of such structures of power as "…laws, policies, state governments and other political and economic unions, religious institutions, media…".[25(p2)] According to Gustafson,[19,20] even organizations and institutions that attempt to demonstrate equity in services may perpetuate inequity and inequality.

Performative acts in theatre are used as metaphors to expose simple acts of allies' support for underserved people. With the proliferation of social media, issues of -phobia and -isms have been in the forefront of public scrutiny and this has led to some allies to *present* or perform their allyship over social media. However, privileged, one-dimensional, or superficial acts of allyship for diverse SOGIE, races, and cultures have been called out by people who have been marginalized due to their intersectional identities, social positions, and experiences. To this point, Collins et al.'s four principles of intersectionality are woven in this article:

> (1) race, class, gender, sexuality, nationality, ethnicity, ability, age, and similar markers of power are interdependent and mutually construct one another; (2) intersecting power relations produce complex, interdependent social inequalities; (3) the social location of individuals and groups within intersecting power relations shapes their experiences within and perspectives on the social world; and (4) solving social problems within a given local, regional, national, or global context requires intersectional analyses.[22(p694)]

These principles will be integrated as an analytical lens, with the metaphor of theatre, to understand the experiences of LGBTQI+ migrants' interactions with nurses. In the next section, I provide a summary of ally theatre, coupled with Gadamerian hermeneutics and intersectionality, and how these shaped interpretations of the interviews with participants.

**"Present" in Theatre**

Methodologically and philosophically much has been written on theatre and play.[26] Even private and public educational institutions have designed programs in performance and theatre. Most often, theatre does not require an introduction; yet it should not be assumed that everyone knows the particulars of theatre and its production. I do not claim to have a sophisticated knowledge of the complexity of organizing a play in a theatre. The online etymology dictionary defines theatre as a place to observe, watch, critique, and praise the production of a play.[27] In some theatres, the audience become part of the performance and experience.[27] Theatre may be a place where performers *present* their act for a live audience, often with elements of stagecraft, advertisement, not to mention the involvement of a playwriter, producer, director, cast member, technical production team, and existing structural venue. The performative act of a play may take many forms, such as dialogue, dance, and song.[26]

Gadamer's[5] discussion of meaning in language and communication informs my use of the word "present." In relation to theatre, the performers present their act live at the present time for the audience. The experience of performance is renewed with each repetition and audience as there may be hidden thoughts, feelings, and realities of performers that may or may not be revealed on stage. Simply put, the players present a message that they want the audience to be engaged with, which may take on a political angle and at times not aligned with the actors' politics.[26] To perform their acts well, the actors are required to lose themselves and embody their

characters' roles: they may silence some of their inner voices due to being on display for audiences' gazes and having to follow preconstructed lines of communication with co-performers. Intersectionality allowed me to attend to how contextual systems of power may privilege some voices over others on stage and how context plays out in relational healthcare encounters. In particular, the political views of the playwriter, producer, and theatrical venue may silence or amplify certain voices and experiences in performance.[26]

***Ally Theatre: Pretend Support***

The notion of how to be an ally with LGBTQI+ individuals has been rendered to in the past several decades. Instead, here I present my understanding of ally theatre by drawing from the work of mostly Black Asian and Minority Ethnic/Black, Indigenous, People of Colour (BAME/BIPOC) as well as LGBTQI+ individuals in research and activism. In 2015, Rodriguez[3] coined the phrase ally theatre when so-called allies used social media after Caitlyn Jenner's picture appeared on the cover of *Vanity* magazine. Rodriguez argued that simply reposting experiences of oppressed individuals on social media, without an in-depth engagement, is a failed attempt by allies to *show* their presence in current discourse.[3] Some authors stated this act of reposting without much effort is an attempt by allies to receive recognition and award.[1,3] McKenzie built on Rodriguez's argument and asserted, "Real solidarity doesn't require an audience to witness what a good 'ally you are' and that as an ally you shouldn't make an announcement of being an ally".[28(para10)] McKenzie and Rodriguez addressed how intersectional identities of race and SOGIE privilege some people versus others, which lead to the further marginalization of a nondominant group. As an illustration, Gustafson[19,20] , a Canadian nurse who identifies as a white woman, provides an example of white, heterosexual, and cisgender nurses' privileged positionality compared to migrant and racialized nurses and clients. Similar to

McKenzie's argument on allyship, Phillips added that 'performative allyship' on social media "refuses to acknowledge any personal responsibility for the systemic issues that provided the context for relevant tragedy".[2(para8)]

Reposting traumatic experiences on social media with a quick and simple use of hashtags is another passive act of so-called allies. Eisenbraun[29] added this is insufficient as it does not address the systemic racism and inequities that exist in the fabric of society. Instead, true allies must allocate time and effort to be supportive:

> Being a true ally requires action, whether that's in the form of donating to worthy organizations, showing up at a rally, or calling out a colleague for making racist or homophobic jokes…Do not ask people from marginalized communities to educate you. This is asking them to engage in additional emotional labor for your benefit.[29(para2)]

Similarly, Harper[30] argues that making donation without changes at systemic level is considered empty allyship. Nonmarginalized groups' meaningless acts of performative allyship with the BAME/BIPOC is harmful since it perpetuates traumas experienced by vulnerable populations.[31] Vela[32] denoted that enacting pride does not mean true solidarity:

> It takes a lot more than a single statement of support to combat the oppression that lives in all of us. We are all guilty of imposing this oppression on others… Allyship isn't all just rainbows and pride flags, and it will take a lot more work to cede the oppression faced by LGBTQ people every day.[32(para7)]

In addition to social media and marches, performative allyship has been noted as existing structurally, at a macro level, in various institutions. Morris[33] asserted structural and systemic performative allyship is evident when senior executive members jump on the band wagon of being vocal about anti-racism but take no actions to address racism within their organizations'

culture, which often leads to years of systemic barriers for racialized individuals. Case in point, some Indigenous communities highlight that it takes seven generations to witness changes aligned with decolonization.[34] Since 2002, Dr. Shaun Harper researched, published, and educated public and private organizations, companies, and institutions on the importance of avoiding anti-racist performative allyship. In a 2021 Canadian Racially Responsive Leadership Summit, he highlighted that leaders need to take meaningful steps to address racism within their organizations and concluded that exclusion, inequity, and lack of diversity is rooted in centuries of colonization, othering, and systemic discrimination.[30] Genuine allies *present* their solidarity and activism with humility, without drawing attention to themselves, by educating themselves to be informed, and take pragmatic steps when faced with people who demonstrate LGBTQI+-phobia, racism, or xenophobia.

***Opening Oneself to be Questioned – "Did I Perform Ally Theatre?"***

Researchers and nurses using methods for social justice aims, such as intersectionality, must reflexively situate themselves in the research process with the participants.[19,22] At the start of individual semi-structured interviews, I attempted to situate myself within my questions. Prior to asking participants in the research study how they identified, I disclosed that "I identify as a heterosexual, cisgender, Canadian immigrant, and as an ally to migrants, LGBTQI+, and LGBTQI+ migrants." I used the term *ally* because I thought the word ally best identified my relation to LGBTQI+ migrants, but I am now uncomfortable using it since ally implies that we are in a war, and I am waving a flag to *present* my support. Usually, allied nations during times of war do not just wave a flag: they sign contractual agreements to come to the aid of countries with which they are allied by supplying food, weapons, and military personal. Similarly, I have

aspired to go beyond attending a Pride parade by looking for meaningful ways to support LGBTQI+ migrants.

Early in my research, as I was engaged in hearing a trans, nonbinary, migrant participant's experience about affirming nursing care for LGBTQI+ migrants, zhe (a pronoun this trans person identified with) stated that "Ally Theatre is a problem! … Don't put up a rainbow flag if you're not going to actually support every member of the LGBTQI+ community! It does require that you put in some work … and make spaces safe." I thought to myself, "That doesn't apply to me! I'm a good ally!" Nevertheless, as I peeled the layers back to understand what zhe meant by this statement, I realized institutional systems of dominant power have shaped my performative act of allyship.[20] Systematically, from nursing leaders, educational institutions, and healthcare organizations, I have been disciplined to think that nursing is an inclusive profession.[1,17,19,20,35–37] However, participants in my research questioned my understanding of how to be a good ally which caused me to feel uneasy about past performative allyship. Davey[6(para11)] asserted: "A work which challenges our outlook does so because it is enigmatic by nature: it gives rise to difficulties of meaning and interpretation which cannot be explained away by a more fundamental level of understanding". The experiences of LGBTQI+ migrants with ally theatre informed my privileged position of choosing which voices to amplify or silence in the process of knowledge translation. In this process, I became a gatekeeper that occupied a position of power in which I chose to present some interpretations while holding back others. In addition to the voices of LGBTQI+ migrants, I have drawn on literature from BIPOC and white scholars to inform this manuscript.

There are theatrical influences, or structurally dominant systems of power, that may inform how nurses are prepared to provide affirming care for LGBTQI+ migrants. In the nursing

profession, an important tenet in enhancing nursing knowledge and practice about affirming care for LGBTQI+ migrants are institutional supports, such as nursing and educational organizations as well as governing and accrediting bodies.[1,19,20,38,39] While some nurses engaged in advancing health care for LGBTQI+ migrants, others have been behind. Visible LGBTQI+ flags or #BLM (hashtag of Black Lives Matter in social media) may have been presented in nursing organizations' social media and workplaces; however, the participants in this study felt that not all the nurses' act as allies when LGBTQI+ migrants accessed healthcare at the micro level.

## Systemic Normative Ideologies Underpinning Performative Allyship

For Gadamer, performers can embody their role when there is no structure, and they can lose themselves in a communal space.[6] Nevertheless, to avoid chaos and misunderstanding, these shared spaces also need to have some "sacred seriousness" between the performers.[8] Grondin and Schmidt discussed Gadamer's notion of "sacred seriousness" and added, "Only someone who does not play along is not serious about play. One who observes the play with sovereignty from outside acts as a **spoilsport**, because exactly he does not play along".[9(p44)] In the following sections, I present three themes related to nursing performative allyship that emerged from my research: nurses as "spoilsports" making "cynical" comments; nurses unsacred seriousness in play; and how nurses are engaged as allies.

### *Nurses as "Spoilsports" Making "Cynical" Comments*

The idea of LGBTQI+ migrants being recipients of "cynical comments" from nurses were verbalized by some participants. The nurses' cynical comments to LGBTQI+ migrants in Canada are akin to what Gadamer referred to as spoilsports. Some nurses were not seriously playing – or perhaps were misplaying – when providing care as co-players with participants.

The participants in this study reported that some nurses made cynical comments in response to participants' worries and concerns; for example, with LGBTQI+ migrants' fear of police and deportation. Joana, a racialized trans migrant on a student visa, experienced suicidal ideation and was brought to a mental health facility by the police. According to Joana, this facility was in an urban city in the heart of a LGBTQI+ neighbourhood and had visible ally flags. Joana tried to verbalize her fear of police and deportation to the mental health unit nurse and told me: "The nurse answered me cynically, 'yeah everyone is here because the police bring them.' What?! Please don't tell me this. God! … I was like, OK! I'm going to just shut up and take the pill!" Joana was shocked that the nurse dismissed her traumatic experience of being brought to the mental health facility by the police. Some nurses in positions of privilege did not engage in "serious" solidarity to understand their patients' contextualized fears of deportation and police resulting from previous trauma perpetuated by dominant systems of power.

Ali, a racialized trans refugee, arrived in Canada less than a year ago. He only used public transit and avoided taxis due to financial barriers. He was not aware of needing a ride home after his top chest surgery. He encountered unprofessional nursing behaviour in the post anesthesia care unit (PACU): "The nurse was punching my chest to wake me up, and I had surgery on my chest! She constantly used the wrong pronoun… And when we didn't know about using taxi she said, 'no body doesn't know how to order a taxi!" There are established 'rules' for the co-performers in a play; the established rules for nurses are to provide therapeutic and affirming care.[4] The nurses did not follow these rules to be allies, provide affirming care, and understand the contextual and intersecting experience of a new migrant who also identifies as trans. Ali told me that he was not familiar with navigating the healthcare system in Canada and was not able to defend himself because his verbal communication was restricted because of the

anesthetic. Consequently, Ali felt forcibly silenced by not being able to speak up for himself when the nurse misgendered him and punched him in his chest. He was not informed of the 'rules' to play his role, which included the requirement of transportation, such as a car or taxi after surgery. Nonetheless, he was shocked that PACU nurses after top surgery had not played their roles affirmingly. In fact, Ali thought nurses working in this facility would be allies because of the rainbow signage and the surgeries provided to trans people. Ali's migration status as a refugee, coupled with language and financial barriers, contextually positioned him as unfamiliar with the "rules" to follow in *play* with nurses, which led to misunderstandings and negative experiences.

***Nurses Unsacred Seriousness in Play***

The nursing profession sees itself as a beacon of culturally safe practice[1,19,20]; yet some participants identified that nurses were not prepared to have inclusive and affirming conversations. Some nurses' lack of "sacred seriousness" in the healthcare system made the participants feel that nurses are not affirming. According to some participants, nurses had not listened to their understanding of their illness because they had an accent, were from a racial minority, or had a different health care card. Even when health care organizations had visible LGBTQI+ flags or rainbow stickers, some nurses were not interested in speaking with LGBTQI+ migrants about their past trauma. For instance, Amanda, who identifies as a new migrant, refugee, lesbian, Black, Muslim woman, attempted to converse with a nurse about her anxiety and received a response that was not inclusive nor affirming: "She feels like I should suck it up. And I should be happy to be here… Whatever is wrong with you couldn't be worse than what you were going through". This dismissal of this person's experience is an example of unsacred seriousness in play.

Some nurses were uncomfortable once they learned that participants identified as non-heterosexual or non-cisgender and looked away or ended the conversation with an awkward silence. Aaron, a gay migrant, shared his experience when he disclosed his SOGIE to the nurse:

> The nurse asked me 'wife or girlfriend?' and I said 'well, I have a fiancé, and his name is' and that was pretty much the end of conversation, and it became this sort of very technical care… She talked less and frankly that really pissed me off … as if I said something wrong!

In other words, the play between the performers became robotic and detached; instead of losing oneself in play, Aaron felt like an unfit co-player with a nurse who he presumed to be heterosexual, cisgender, and white. In this context, I postulate that the nurse may have had knowledge with diverse SOGIE, but this did not translate to practice, in which the nurse was unable to continue therapeutic communication with Aaron. Perhaps the nurse was unexpectedly shocked that her migrant patient could also identify as LGBTQI+. This is a reminder of Gadamer's[40] discussion of losing oneself when one is faced with an unfamiliar experience:

> The play of art is not some substitute dream world in which we can forget ourselves. On the contrary, the play of art is a mirror that through the centuries constantly arises anew, and in which we catch sight of ourselves in a way that is often unexpected or unfamiliar: what we are, what we might be, and what we are about.[40(p130)]

The experience of catching the self in an unexpected and unfamiliar way was also felt by Amanda, who visited the emergency department for medical reasons and felt judged by nurses who demonstrated non-affirming care:

> They were drawing conclusion that I was probably married to a man or that I already have kids with a man… that expression of being surprised when I said I'm sexually

> active with my partner who is a woman … cruel, sarcastic, alarmed expressions that the doctor and the nurse passed between themselves. I felt like, do they think I'm blind? But I'm right here though! … Am I invisible? I'm here! … They wanted to show you in a way when you are LGBTQ, and you're Black, or that combined, you are wrong!

In this example, the nurses failed to provide affirming care as evidenced by heteronormative verbal and nonverbal forms of communication. It seems that nurses may assume migrant and racialized people may not identify as LGBTQI+: nonverbal behaviors are seen by LGBTQI+ migrants as nurses' signs of disapproval. Amanda was physically present in the healthcare arena but felt invisible when she encountered nurses who seemed uncomfortable with gender performativity that did not align with normative ideologies. Jone Martinez-Palacios, in her discussion of dominant oppressive social statuses, asserted, "The heteronorm, gender, social class, and race mark the body, reify a specific idea of marriage and family in which lesbian, gay and trans* people, single mothers, and fat, older, black women do not enter".[22(p718)]

In addition to experiences of heteronormativity, participants experienced transphobia from nurses. A nurse made a transphobic comment to a participant's ex-partner: "The nurse told my ex, that 'when I think about her, meaning me, I feel disgusted'… I was really surprised and felt very sick that she said this. How are nurses trained to be with trans people?" The interpretation of interviews elucidated that some nurses made assumptions about participants' partners, which were based on the hegemony of hetero-cis-normative views. For example, they assumed that the partner of the client was a sister or brother, and they could not advance their thinking beyond existing normative gender and sex binary discourses.[4,11,19,41] Being misgendered and hearing LGBTQI+-phobic comments led participants to feel isolated and pressured into neutralizing their SOGIE to protect their safety while receiving nursing care.

Migrant LGBTQI+ participants shared their experiences of trans-biphobia in organizations that had visible ally and LGBTQI+ flags but did not affirm the combined intersectional experiences of migrants and LGBTQI+ people. For this reason, participants underscored the importance of avoiding ally theatre. Jay, a racialized migrant gay participant, stated, "If they genuinely don't feel that way…and they are just faking it, and just because it is a recommendation, it is just going to be another thing that is paper only. It is going to be superficial." This superficial act of presenting a flag as form of allyship without providing affirming care is harmful and caused participants to further mistrust the healthcare system. Many participants shared being a recipient of the imitation of an affirming care from nurses and healthcare professionals. Amanda shared how "There was a little rainbow flag on the table. I see all these little rainbow flags in banks, offices, everywhere. Now I know better! It doesn't mean that people who are there are not homophobic." The performative act of nurses is a *representation* of what safe and affirming allies would be rather than genuinely being present with LGBTQI+ migrants. In these instances, LGBTQI+ migrants felt the need to follow normative gender identities to feel accepted while in contact with nurses. LGBTQI+ migrants performing as cisgender or heterosexual individuals resulted from the healthcare system's misunderstanding of SOGIE as immobile, static, and categorically binarized.[4,20]

***How Are Nurses Engaged?***

During the interviews, some participants asked how nurses engage in providing affirming care for diverse LGBTQI+ migrants. In 2021, the Registered Nurses Association of Ontario (RNAO)[4] published its first best practice guideline to address health equity for LGBTQI+ people and noted intersecting experiences of racialized LGBTQI+ people in the healthcare sector. In a 2003 community-based participatory action research, nurses collaborated with trans people and

presented a position paper to the Ontario Public Health Association.[42] In this document, the research team outlined the challenges that migrant and racialized trans people may face and provided recommendations for allyship and advocacy. Despite the groundwork leadership of some nurses in education, practice, and policy in the past two decades,[41–43] participants in this research noted limited visibility of nurses in solidarity with LGBTQI+ migrants. In my research, the participants who identified as LGBTQI+ migrant nurses and nursing students, in the past five years, in Canada indicated that their intersectional realities were absent from their nursing textbooks, reading materials, case studies, and lectures.

In the "Year of Nursing and Midwifery", Moorley et al.[36] urgently cautioned nurses in practice, education, policy, research, and administration roles about performative acts of allyship. They stated that "Having one BAME/BIPOC person as head of a hospital or university 'Diversity Committee' is not even close to 'tackling racism and in-equality'".[36(p2451)] They wrote that "nursing and midwifery can, just as quickly and urgently, dismantle the obstacles, blocks, and ideologies that sustain and maintain the racism and discrimination that cause such disadvantage".[36(p2452)] Some participants had similar experiences where, as a form of tokenism, they were asked to join committees when they were the only visible person of colour, migrant, LGBTQI+, or combination of these identities.[44] One participant noted experiences of systemic racism in the healthcare system's Ethics, Diversity, and Inclusion (EDI) committee. She shared that the EDI committee consisted of seven people, of which five were white or Canadian-born, one was Indigenous, and the participant was the seventh member. It seemed to her that identifying as a Black, Muslim, LGBTQI+ migrant completed the EDI's checklist of diversity in the committee. Given this narrow and problematic view on the inclusion of EDI members, the

participant turned down this position and shared with me, “how can you have an EDI team with five Caucasian, one Indigenous, and one person of colour ... this is systematically ruined.”

As an illustration, Moorley et al.[36] focused on race and culture, but in my study, participants called on nurses to include people who are marginalized due to systems of power intertwined with intersecting identities of race, culture, religion, abilities, economy, and SOGIE. Almost two decades ago, Gustafson[19,20] argued that simple integration of cultural competence and sensitivity in nursing education does not address institutionalized positioning of dominant groups. In a recent critical review of literature on racism in nursing, Bell[1] addressed the limited white nursing faculty who are prepared, willing, educated, and comfortable in having provocative conversations about anti-racism in education with future nurses. Bell questioned nursing educators’ focus on cultural diversity and inclusion; instead, she highlighted the need to explicitly attend to discourses on racism and anti-racism in nursing education. She further discussed the oppressiveness of institutions that lack an anti-racism lens that attempt to *present* inclusion and diversity as their priority, yet these acts are rendered empty repetitive performatives to validate their positions as being inclusive in practice and education.

Integration of intersectionality as an analytical lens in this study reveals that nursing allyship is more than passive engagement when caring for LGBTQI+ migrants.[42] Drawing from Gadamer, experience is a dialogue constructed in the historicity of how nurses and patients interpret their so-called *shared understanding* of each other.[8] Scholars of intersectionality add that there are systems of oppressions at macro, meso, and micro levels that have influenced how discourse is produced, repeated, and understood and why there is a need for understanding the experiences of LGBTQI+ migrants with nurses.[22,24] On this note, I return to Bell’s article, in which the author discussed limited inclusion of the concept of antiracism in nursing education:

> Nursing education is heavily criticized in the literature for its complicity in delivering politically soft curricula … that do not address racism and other oppressions … and continue to reproduce dominant norms such as whiteness, heteronormativity, middle and upper-classism and positivism.[1(p3)]

Compared to other studies, Bell included sexual orientation by naming "heteronormativity" and excluded gender identities and expressions "Author, YYYY". When trans and non-binary people are not named, nursing scholars continue to "reproduce [the] dominant" discourse on cis-normativity.[45] In this vein, exclusion has become another form of performative allyship in which nursing scholars jumped on the band wagon without giving attention to intersectionality by naming and recognizing one group while expunging the other.

For example, when I shared my recruitment letter with an agency in Canada, the Director questioned my use of language and stated, "Two-spirit individuals cannot be migrants." A common misconception is that Two-Spirit individuals, which is an umbrella term for diversity in SOGIE of Indigenous people, should not be included in relation to migration. Contrary to this limited, colonized understanding, Albert McLeod, a knowledge keeper, with ancestry from Nisichawayasihk Cree Nations and the Métis community of Norway House, informed me that Two-Spirit individuals may also identify as migrants by travelling across treaties, regions, borders, and through intra-racial marriages. When the categories of heterosexuality and cisgender were established as the norm, LGBTQI+ people were cast as a deviant derivative other. Similarly, when Canada's borders meant security for its citizens, migrants were identified as unwanted outsiders by some citizens.[19,20] In this case, LGBTQI+ migrants may resist their complex, interlocking positionality and question the power of systematic domination.

As a migrant, racialized, practicing nurse, I am cognisant of nursing scholars' strategic essentialization of a minority group.[46] Nonetheless, the exclusion of the intersections of SOGIE with race does not dismantle the issues of systematic racism and LGBTQI+-phobia that exist in nursing practice, education, research, and policy. Moorley et al.[36] enthusiastically invited nurses to engage in anti-racism work in "the Year of Nursing". At a macro level, the year of nursing and midwifery was celebrated by the World Health Organization and around the globe on Florence Nightingale's 200th birthday. Yet, Florence Nightingale, in addition to British and French sisterhoods, are accused of racism because they supported the colonization of Indigenous children and communities.[20,47]

**Nurses Ontological Presence: Genuine Allyship**

Migrant LGBTQI+ participants felt nurses' ontological presence versus performative allyship whenever the nurses demonstrated solidarity through inclusive and affirming care. The participants felt that they had received affirming care when nurses spent time listening attentively to their needs. This act was demonstrated when nurses asked relevant questions, listened to LGBTQI+ migrants' responses, and then provided applicable resources. In these contexts, there was an organic exchange of dialogue between participants and nurses as co-players. For participants who were hospitalized, listening was demonstrated when nurses were present during hospitalization, cared for them, and community health nurses followed-up with phone calls after hospitalization. Participants underscored the support of nurses who provided detailed step-by-step information about procedures to assist with language barriers. The step-by-step guidance gave LGBTQI+ migrants a sense of assurance and comfort. Participants felt comfortable and cared for when nurses had technical and therapeutic communication skills. Nurses demonstrated understanding of intersectional experiences of LGBTQI+ migrants when they used inclusive

SOGIE language and recognized traumatic migration trajectories. Elham, a racialized, migrant, trans participant, shared experiences of allyship from an emergency department nurse:

> Not only the nurse was skilled in terms of taking IV, but then he was correcting his other colleagues. For example, x-ray tech came over and used he/him pronoun and the nurse corrected him that 'it is she', so he was making sure that I'm feeling comfortable there.

In this case, the nurse was genuinely present and was not silent when misgendering occurred. Elham added that the nurse also allocated time to provide detailed explanations for tasks to ensure Elham understood all of the assessments and treatments. As a co-performer in the communal space of hospital arena, the nurse acted as a real ally by speaking up when the client was misgendered, addressed language barriers, and did not need recognition for his act of allyship. Other instances of allyship were noted when nurses were aware and provided relevant resources of participants. For example, Ali shared this supportive experience from a community health nurse:

> She talked to me for one hour. I told her my story. She was very understanding and very nice. She was really the best nurse I met here… She asked me 'where do you live, and from where do you have to go and pick up hormone therapy'.

In this case, the nurse enacted advocacy and was aware that, as a new refugee, Ali may not be familiar with navigating the healthcare system and asked if he had access as well as the ability to continue hormone therapy for gender transition. Similar to Ali's experience, many participants noted community health nurses as genuine allies who allocated time to document their past experiences of trauma, wrote supportive letters for their refugee court hearings, and provided relevant and useful resources. Other participants felt a sense of allyship when nurses provided care without judgement. Participants stated some nurses respected them by being non-judgmental

about their SOGIE, race, and ethnicity. They felt respected when nurses provided simple acts, such as smiling, maintaining eye contact, and brought water to a LGBTQI+ migrant client in the emergency department. These experiences made them feel "like a human being" or an accepted member of society. Lady G, a racialized gay participant on a work visa, shared his (Lady G's pronoun) experience of receiving nursing care from a community clinic:

> Nurses at the community clinic treat you as a person. They don't treat you as a walking container of viruses. They don't treat you as a wallet … they treat you as a person who came to see a nurse because you have questions or you're worried.

The participants felt safe and respected in the healthcare system when nurses stood up for misgendering, provided relevant resources, and were non-judgmental. Ultimately, participants found that true allyship was supportive and decreased their anxiety when receiving nursing care.

**Concluding Thoughts**

In understanding LGBTQI+ migrants' experiences, I investigated what was said and not said in conversations during interviews. The LGBTQI+ migrants in this study spoke about the performative acts of some nurses who simply were not allies. The common experiences of diverse LGBTQI+ migrants, which included people from shared positioning at the intersections of race, ethnicity, and SOGIE, underscored the need for accessible and affirming nursing care. The participants felt that they were being marked as misfit performers and deviants for not abiding by health care's institutionalized centring of middle-class, white, hetero-cis-normative rules and the othering of differences of class, race, ethnicity, SOGIE, mental health, and migration status. The normative binary ideologies understood as the truth result from centuries of colonization and oppressions and are being taken up by some white and non-white nurses while caring for LGBTQI+ migrants.

The reasons nurses may have been drawn into performing allyship are likely due to contexts that situated them in play including the systemic exclusion of the experiences of LGBTQI+ migrants in nursing education, practice, and policy.[43] Gadamer[48] discussed the notion that performing in communal gathering with people who may have some shared understanding is not neutral. The rainbow flag on the wall, going to Pride parade, or reposting a black box (to stand for #black-lives-matter) on social media should not be the only strategy for nurses to demonstrate allyship. Rather, the participants requested that nursing allies in practice and policy address mistreatment including racist and hetero-cis-normative comments and behaviors. The participants were hopeful that, with mandatory education, a new generation of nurses, and genuine allyship, nursing care to LGBTQI+ migrants will be improved.

One drawback of this study was that theatre was not taken up as an arts-based research methodology or as a form of knowledge translation. Admittedly, the theatrical visual and musical production may be a creative avenue to reach a wider audience and inform social change when non-neutral or political messages reach policymakers.[26] The participants themselves introduced the idea of performative and theatrical allyship in this research. Rather than ignoring this named experience, I stayed open and acknowledged my position of privilege in academia, and I aspired to allocate space to these unique encounters with nurses.[22] To creatively amplify LGBTQI+ migrants' voices on ally theatre, it is fitting to consider future participatory arts-based research in form of theatre. Arts-based research through use of play and theatre may cast LGBTQI+ migrants as performers and to enable their narratives and experiences to be heard and acknowledged.[26,49] Moreover, audiences can be engaged in discussions of what they observed after the play and look for opportunities for improving healthcare, nursing practices, and policies.

An important outcome of theatre is that it may spur the audience to ponder the systemic issues presented in a play and be moved by experiences, dialogues, and the exchange of expressions between the performers.[26] This exchange of experiences is relevant to Gadamerian hermeneutics in which disseminations of findings will allow the audience, meaning the reader, to interpret their understandings of experiences and critically evaluate nursing practices.[7] Whether migration is forced due to SOGIE discrimination, economic factors, or familial reunification, migration is a social determinant of health.[4,10,41] Indeed, an understanding of ally theatre emerged through a fusion of horizons as I conversed with LGBTQI+ migrants in relation to their experiences with nurses in Canada. Nursing educators, policy makers, and researchers need to continue to lobby for inclusive and affirming care because LGBTQI+ migrants may continue to experience harmful performative allyship in their encounters with nurses.[41] On the one hand, limited engagement by nurses at macro, meso, and micro levels in education, practice, and policy may have perpetuated positioning of LGBTQI+ migrants into subcategories. On the other hand, collaboration of nurses with those at the intersection of LGBTQI+ and migration has informed education, practice, and policy.[4,11,41,42,50] By using intersectionality as an analytical lens, I call on nursing allies to continue to engage in social justice and human rights praxis for LGBTQI+ migrants to inform the nursing profession.

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## Afterward: Yet A New Foreword!

In this dissertation, I explored the experiences of LGBTQI+ migrants with nurses and healthcare professionals in the Canadian context by utilizing Gadamerian hermeneutics and intersectionality as an analytical lens. In this final chapter, a synthesis of the dissertation and a discussion of the implications for nursing is provided. The overarching theme of "Nurses can do better" was prominent, as informants shared their experiences with NHCPs. On the one hand, regardless of their migration journey, informants told of countless challenges they experienced in navigating health care services in Canada, and some foresaw these challenges as likely to continue. On the other hand, the informants also identified affirming and supportive experiences with NHCPs in Canada. Nevertheless, LGBTQI+ migrants suggested approaches to improve nursing practice, policy, and education. In chapters three, four, and five, I drew on emerging understandings within this study, and here a synthesis of the work is provided. This afterward chapter is divided into three segments: (a) synthesis of research; (b) implications for nursing education, practice, policy, and research; and (c) knowledge translation.

### Synthesis of Research

In this dissertation, I have prepared four manuscripts for publication in chapters two, three, four, and five. In addition to these four chapters, an overview of the literature, rationale for the study, and methodology was provided in the foreword chapter. As noted above, the style, format, word count, and referencing of each article reflects the journal requirements; however, the heading levels are changed to ensure follow in the dissertation. One article was a methodological paper, two articles focused solely on the findings, and the last manuscript was a theoretical paper, in which I presented key findings absent from the other articles.

In chapter two, “Gadamerian hermeneutics with intersectionality as an analytical lens,” Dr. McDonald and I demonstrate that the tenets of intersectionality, which include critical inquiry, complex positionality of individuals, and reflexivity, yielded a useful analytical lens when coupled with Gadamerian hermeneutics as an innovative research approach to understanding informants’ experiences with health care providers (HCPs) in the Canadian context. LGBTQI+ migrants have experienced various forms of exclusion and trauma pre- and post-migration, intersecting with migration status, race, ethnicity, religion, and mental health, just to name a few. Throughout this article, we drew from the informants’ experiences of how intersectionality can be applied to understand systemic and structural influences on the positionality of an underserved research population. Finally, the confluences and tensions between intersectionality and Gadamerian hermeneutics were presented.

Chapter three is titled “Experiences of LGBTQI+ Migrants with Nurses and Other Healthcare Professionals in Canada.” Here, I discuss four interpretations that emerged from challenging experiences: unwanted visibility, hearing a dead name (their previous gendered name) and being misgendered (wrong pronoun used), cultural stigma, and being asked intrusive hetero-cis-normative questions. In addition, I provide examples in which informants found nurses to be supportive of their intersectional identities and provide suggestions to strengthen nursing practice, education, and policy. My interpretations show that it was crucial for nurses to acknowledge that LGBTQI+ migrants’ experiences are shaped by contextual positions in their healthcare encounters. In turn, the privileges and oppressions ingrained in hetero-cis-normative and migration discourses in practice were identified with a focus on contextual factors that impede affirming care for informants.

In the fourth chapter, Dr. Clark and I provide a more deeply intersectional analysis describing how the SOGIE of informants were shaped by migration status, religion, culture, and ethnic identity, to make tangible how LGBTQI+ migrants experienced stigma and discrimination and how it affected their mental health. Our interpretations show that many LGBTQI+ migrants were also healthcare providers but held relative positions of power and privilege because of SOGIE. In addition, LGBTQI+ migrants held multiple identities which did not fit with constructed cultural identities. In this chapter, we provide a deeper interpretation of the factors which shaped LGBTQI+ migrants' mental health and identify three intersecting themes: (a) "I never went back": Stigma as an exclusionary experience; (b) "Is [your country of birth] really that bad": Fear, safety and cultural stigma; and (c) "The circle … is not going to fix my life": Participants' call for affirming and trauma-informed care. We highlight that nurses and mental HCPs who do not identify as LGBTQI+ migrants ought to use anti-oppressive as well as trauma- and violence-informed practices to support anti-oppressive policy and practice (Alessi et al., 2018; Government of Canada, 2018; Im et al., 2020; Khanlou, Bohr, et al., 2020; Public Health Agency of Canada, 2018; Reading & Rubin, 2011; Searle et al., 2017).

In the fifth chapter, I discuss the concept of ally theatre, as a metaphor, in relation to informants' encounters with nurses. The informants asserted that some nurses presented performative acts of allyship that undermined support for LGBTQI+ migrants. Based on my interpretations, the informants felt that they were being marked as misfit performers and deviants for not abiding by health care's middle-class, white, hetero-cis-normative norms related to class, race, ethnicity, SOGIE, ability, mental health, and migration status. The word deviant was used by one of the informants to shed light on how they felt others in the society perceived them. My interpretations from conversations with other informants also underscored this feeling of being

viewed as a deviant because of both LGBTQI+ identities and orientations as well as migration status. I discuss that the normative binary ideologies understood as the truth resulted from centuries of colonization and oppressions taken up by some non-white and white nurses while caring for LGBTQI+ migrants. I drew on Gadamer, who analogized dialogue in everyday conversation to play in theatre. He referred to play as having rules and structures, but when played in a field, it has an open outcome based on how each performer plays and brings their uniqueness to the audience (as cited in Moules et al., 2015). Each co-performer has a role in understanding the play because they all bring their history, horizons, and prejudices to their shared space. In every conversation, there are words that remain unsaid as individuals and performers consider what needs to be disclosed (Jardine, 1992). I advocated for the nursing profession to continue to take up affirming practice critically by using intersectionality as an analytical lens to mitigate systemic forms of performative allyship that fall under discriminatory health care practices, which do not comprehensively address the experiences of LGBTQI+ migrants. However, it is not claimed that, for example, integration of intersectionality in the RNAO's BPG would lead individual nurses to comprehensively address the needs of LGBTQI+ migrants.

Taken together, these four chapters contain understandings of LGBTQI+ migrants' encounters that could be used to improve NHCPs' practices, and in some instances, inform health care policies. To this point, migrants' experiences suggest multiple barriers to equitable health underpinned by racism, classism, and hetero-cis-normativity. The intersectional lens required that I address broader oppressive systemic practices that unwittingly caused harm. Nursing leaders, educators, regulatory bodies, and associations must continue to advance education, practice,

policy, and research for nurses to provide safe and affirming care for racialized LGBTQI+ migrants (Casey, 2019; Registered Nurses' Association of Ontario, 2021).

## Implications for Nursing

My initial aim was not to make specific recommendations; however, while conversing with the informants and transcriptions, I remained open by reading between the lines to discover opportunities to improve nursing. Although interrelated, I have pragmatically divided and dedicated separate implication sections for nursing education, practice, policy, and research.

### Implications for Nursing Education

While some nurses in Canada may be neither aware of nor taught to comprehend the systemic and social exclusion of LGBTQI+ migrants that results from intersecting systems of power, nurses may further perpetuate those acts of dominance in practice, which could lead to poor health outcomes (Cooper Brathwaite et al., 2022; Gupta et al., 2019; Heise et al., 2019; Mikkonen & Raphael, 2010). This phenomenon was noted by the informants in this research, in which their intersecting identities were not recognized by some nurses in the psychiatric unit, walk-in clinics, doctors' offices, post-operative anesthesia care units, and emergency departments. All 18 informants noted that LGBTQI+ migrants are in contact with nurses beyond community centres and underscored that nursing encounters may occur at any level of the health care system, which ranges from primary to tertiary to home care. For this reason, nurses at all points of access need to be affirming for LGBTQI+ migrants. Here, I introduce a dialogue on the scarcity of Canadian nursing educators equipped to bring anti-oppressive, anti-racist, trauma- and violence-informed practices, including LGBTQI+ content, into the curriculum, and followed with the inclusion of counternarratives. Then, suggestions for nursing curriculum and program

evaluations are provided, before concluding with the integration of marginalized people into the education of personal support workers (PSW), also known as healthcare aides.

### *Limited Educators to Teach Affirming Care*

Although changes have been made in nursing education over the past few decades, in which most nursing programs strive to prepare nursing students to provide inclusive care for diverse populations, some other nursing programs have either included limited experiences of migrants and LGBTQI+ people in their curriculum or lack educators who are prepared to incorporate content on cultural safety and affirming practices (B. Bell, 2021; L. M. Bell et al., 2019; Browne et al., 2009; Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al., 2015; Carabez & Scott, 2016; Dinkel et al., 2007; Haghiri-Vijeh, 2013; Hardacker et al., 2014; Kellett & Fitton, 2017; Röndahl, 2011; Sirota, 2013). In a critical review of literature on racism in nursing, B. Bell (2021) addressed the systemic absence of white nursing educators who are prepared for, willing to have, and comfortable with, provocative conversations about anti-racism in education with future nurses. I argue with B. Bell that it is not a "systemic absence," and perhaps a limited number of white and non-white educators. Working in the Greater Toronto Area has created opportunities for me to work with and be educated by white and non-white educators who are scholars, researchers, and activists working with underserved people at the intersection of identities. Moreover, B. Bell questioned nursing education's focus on cultural diversity and inclusion; instead, she highlighted the need to explicitly attend to discourses around racism and anti-racism. However, as noted in the foreword chapter, in addition to other nursing organizations, in 2002, the RNAO published a position statement on addressing racism and anti-racism in nursing (Registered Nurses Associations of Ontario, 2002). B. Bell focused on racism;

however, the findings in my study foreground the need for nursing education on the intersection of SOGIE with race, ethnicity, culture, religion, and mental health.

For many nursing students, there is a scarcity of education about the needs of LGBTQI+ migrants and the use of inclusive language when providing care for diverse populations. My findings align with previous studies of nurse educators' attitudes and competencies, which indicated it was important to teach nurses and nursing students about the needs of LGBTQI+ people but the participants felt nursing educators were not prepared to do so (Lim et al., 2015; Lim & Hsu, 2016; Sirota, 2013). The lack of inclusive language in teaching materials, such as nursing textbooks, may contribute to nursing educators not being prepared to teach students (De Guzman et al., 2018; Merryfeather, 2011). One example is the textbook titled *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, which is assigned to most undergraduate and graduate nursing students (Polit & Beck, 2017). The authors of this textbook used binary and heteronormative language when discussing gender; for instance, they stated, "When categorical variables take on only two values, they are dichotomous variables. Gender, for example is dichotomous: male and female" (Polit & Beck, 2017, p. 48). As a previous diploma and current undergraduate nursing educator as well as a doctoral student, I have noticed that many nursing administrators, scholars, researchers, policymakers, and educators use this same binary language to describe diverse SOGIE. While acknowledging that personal beliefs may influence educators' views, to address structural issues, there needs to be training available for educators to equip them with resources when supporting nurses and nursing students on affirming practices with LGBTQI+ migrants.

### *Inclusion of LGBTQI+ Migrants in the Education of Nurses*

Although some work has been done by nursing scholars and educators in the past two decades in education, practice, and policy, similar to previous findings, the nurse informants in this study asserted that their intersectional contextual realities of identifying as racialized, migrants, and LGBTQI+ were not reflected in their nursing textbooks, reading materials, case studies, and lectures (Clark & Saleh, 2019; Cooper Brathwaite et al., 2022; Daley et al., 2020; Daley & MacDonnell, 2015; Gapka & Raj et al., 2003; Khanlou, Bohr, et al., 2020; Khanlou et al., 2008, 2021; MacDonnell, Dastjerdi, Bokore, et al., 2017; MacDonnell, Dastjerdi, Khanlou, et al., 2017; MacDonnell et al., 2012, 2015; Rainbow Nursing Interest Group, 2021; Registered Nurses' Association of Ontario, 2021). For example, in some health assessment courses for practical diploma and degree nurses, most educators focused on biological sex rather than including SOGIE in nursing students' understanding of clients (De Guzman et al., 2018; Haghiri-Vijeh, 2013). In fact, community nurses in my doctoral study learned about LGBTQI+ migrants after graduation when working with mentors who supported their learning; however, finding a knowledgeable mentor was not always an easy task.

Considering that racism and heterosexism are determinants of health (Canadian Nursing Association, 2021; Cooper Brathwaite et al., 2022), I propose the inclusion of content on LGBTQI+ migrants in the nursing curricular framework. The findings uncover that, at a structural level, systemic institutional policy needs to mandate the education of nursing students on caring for the intersectional experiences of diverse populations. This study supports the recommendations of previous findings that a one-time educational session is not enough (Few-Demo et al., 2016; Haghiri-Vijeh et al., 2020; Hardacker et al., 2014; Lim et al., 2014; Lim & Hsu, 2016; Maruca et al., 2018; McDowell & Bower, 2016). At a rudimentary level, content is

introduced in the first required nursing course and then threaded through each year (Lim & Hsu, 2016; R. B. Singer, 2015). This lacing of LGBTQI+ migrants' experiences in various years and courses, such as primary, acute, and community level, would reiterate the content and create opportunities for nursing students to build upon their knowledge and be informed of ways to provide affirming care to LGBTQI+ migrants. However, I do not claim that education will solely improve practice; nevertheless, as an initial step to increasing the visibility of marginalized communities and enhancing nursing students' knowledge of and comfort in communicating with underserved people, educators have encouraged nursing students to draw on their lived experiences when providing nursing care (Casey, 2019; Cooper Brathwaite et al., 2022; Haghiri-Vijeh, 2013; Haghiri-Vijeh et al., 2020; MacDonnell et al., 2015; Registered Nurses' Association of Ontario, 2021).

***Counter-narratives about LGBTQI+ Migrants in Education***

The work of intersectional scholars enabled me to add to previous discourse in which authors highlighted that public policymakers tend to assume that migrants are heterosexual and cisgender, and that LGBTQI+ people are white middle-class Canadians, and missed the opportunity to underscore that LGBTQI+ migrants have been oppressed due to dominant and intersecting systems of power (Canadian Nursing Association, 2021; Chinn et al., 2021; Gamble et al., 2015; Guruge et al., 2010; Higgins et al., 2021; Khanlou et al., 2021; Lee, 2019; MacDonnell et al., 2015). This is to say that nurses must recognize the strengths of LGBTQI+ migrants and take the standpoint that LGBTQI+ migrants are educated and/or have practical knowledge as well as have the ability to demonstrate resistance (Gamble et al., 2015; Khan & Mulé, 2021; MacDonnell, Dastjerdi, Khanlou, et al., 2017; Sachdej, 2021; Scheadler et al., 2022). For example, in this dissertation, at the intersections of migration and LGBTQI+, 56% of

participants were currently or had been working at some point as health care and social service providers who also were the recipients of health care services. Although only 13% of participants migrated for economic reasons, almost 20% of participants were nurses and 38% were social work professionals. This finding reveals how LGBTQI+ people can experience multiple and simultaneous privileges and disadvantages based on other identities, as health and social care professionals. In line with previous advocates (Clark & O'Mahony, 2021; Lam & Lepp, 2019; Lee et al., 2020; MacDonnell, 2007), this study explains the continuation of allies' leadership to dismantle oppressive structures. Similar to previous studies, informants spoke about the strength and resilience in collective actions when they were engaged in supporting one another (Hudson & Romanelli, 2019; Lam & Lepp, 2019; Lee et al., 2020; Lookingbill et al., 2021; MacDonnell, Dastjerdi, Bokore, et al., 2017; MacDonnell, Dastjerdi, Khanlou, et al., 2017; MacDonnell et al., 2015). The LGBTQI+ migrants in this research also highlighted their resilience in their transition into a new country, navigation of a new health care system, and support of the mental and physical well-being of their chosen family and friends.

### *Suggestions for the Nursing Curriculum*

At the macro level, the integration of a social justice model within broader national and local structures, as seen in most Schools/Faculties of Nursing through their policies, as well as mission and vision statements, would offer an inclusive approach to curriculum development. Below, I provide recommendations at baccalaureate, masters, and doctoral levels to inform nursing curriculum on the needs of LGBTQI+ migrants. I integrated the Canadian Association of Schools of Nursing's (CASN, 2015) National Nursing Education Framework, in table 3, titled "Proposed Nursing Curriculum Framework to Care for LGBTQI+ Migrants." In this table, under each domain, I draw from the guiding principles developed in collaboration with educators,

administrators, Deans, and Directors in Schools/Faculties of Nursing across Canada. CASN defines their guiding principles as "a generalized or objective [guidlines] for baccalaureate, master's or doctoral programs in the particular domain" (2015, p. 9). Following these guiding principles, I have written essential components, as suggestions, that outline what would be students' learning outcomes (CASN, 2015, p. 9).

**Table 3: Proposed Nursing Curriculum Framework to Care for LGBTQI+ Migrants**

| Baccalaureate | Masters | Doctoral |
|---|---|---|
| Domain 1: Knowledge | | |
| Guiding Principles:<br>1.6, 1.7, 1.8, and 1.9<br>The program provides a broad knowledge base about experiences of LGBTQI+ migrants. | Guiding Principles:<br>1.4, and 1.5<br>The program provides a comprehensive and substantive understanding and critical awareness of complex intersectional positionality of LGBTQI+ migrants in the health care with nurses. | Guiding Principles:<br>1.2, 1.4, and 1.6<br>The program provides an in-depth understanding of the foundation of nursing discipline in addressing the gap in knowledge about multiple and contextual experiences marginalized communities |
| Domain 2: Research, Methodologies, Critical Inquiry and Evidence | | |
| Guiding Principles:<br>2.2, 2.3, 2.4, and 2.5<br>The students are prepared to demonstrate ability to locate and interpret a broad range of information, knowledge, and evidence, as well as compose a written academic argument about the marginality of LGBTQI+ migrants that avoids un/intentional pathologizing of the underserved people. | Guiding Principles:<br>2.3, 2.4, 2.7, 2.8.<br>The students are prepared to demonstrate the ability to contribute to nursing knowledge through engaging in written and oral scholarly activities that include understanding of dominant power and hierarchies have socially excluded individuals based on interlocking oppressed identities and orientations that are not the same for all. | Guiding Principles:<br>2.2, and 2.3<br>The students have the knowledge to rigorously conduct research that results in creation of knowledge to be disseminated to address, when relevant, interlocking positioning of diverse people at macro, meso, and micro levels. |
| Domain 3: Nursing Practice | | |
| Guiding Principles:<br>3.2, 3.3, 3.4, 3.9, 3.12, and 3.13 | Guiding Principles:<br>3.2, 3.3, 3.4, and 3.6 | Guiding Principles:<br>3.3 and 3.4 |

| Baccalaureate | Masters | Doctoral |
|---|---|---|
| The students are prepared to demonstrate knowledge of providing affirming and trauma-informed care to diverse LGBTQI+ migrants. The program includes of practicum experiences in providing care to diverse LGBTQI+ migrants. | The students are prepared to deliver training for nurses and health care professionals about affirming spaces for underserved population, such as LGBTQI+ migrants. | The students are prepared to recognize the gap in practice and become an independent researcher to develop a program of research to be applied to practice in services provided to people at the intersection of identities, for example nonbinary refugees. |
| Domain 4: Communication and Collaboration | | |
| Guiding Principles:<br>4.2 and 4.5<br>The students are prepared to monitor their intersecting beliefs, values, and assumptions about hetero-homo-cis-normativity, migration status, disability, religion, race, and ethnicity and recognize their impact on interpersonal relationships with clients and team members. | Guiding Principles:<br>4.1, 4.2, 4.3, and 4.4<br>The students are prepared to lead diverse teams to initiate policies that improve health care access for LGBTQI+ migrants. | Guiding Principles:<br>4.3, 4.4, 4.5, 4.7, and 4.8<br>The students are prepared to share knowledge learned about experiences of underserved people, for example trans migrants, with nurses and health care professionals to diverse audiences. |
| Domains 5 and 6: Professionalism and Leadership | | |
| Guiding Principles:<br>5.1, 5.3, 5.5, 6.3, 6.4, and 6.5<br>The students are prepared to become life-long learners in understanding the differences between cultural competence, humility, and sensitivity with diverse populations and strive to address issues of social justice, equity, and other disparities affecting the health of LGBTQI+ migrants. | Guiding Principles:<br>5.3, 5.4, 5.6, 6.3, 6.4, 6.6<br>The students are prepared to coach, mentor, and teach nurses, nursing students, and other members of health care team (such as personal support workers) in provision of safe and affirming care for diverse population, such as LGBTQI+ migrants.<br>For example, the students are prepared to work with interdisciplinary teams to develop affirming and safe method of asking questions about sexual orientations, gender identities, and expressions. | Guiding Principles:<br>5.1, 5.3, 5.4, 5.5, and 6.3<br>The students are prepared to be professional scholars, teachers, and leaders in nursing and outside of nursing discipline by providing meaningfully support for systemic changes to address health disparities for marginalized communities, such as LGBTQI+ migrants. |

| Baccalaureate | Masters | Doctoral |
|---|---|---|
| | The students have the knowledge to address structural issues by lobbying for the creation of affirming spaces in organizations. | |

***Suggestions of Program Evaluation***

In addition to CASN, in some provinces, such as Ontario, registered nurse (RN) degree programs are now required to be approved by a nursing regulatory body. In keeping with RN educational programs, registered practical nurses' (RPNs) or licensed practical nurses (LPNs) diploma programs are also regulated by a nursing regulatory body in Ontario. To illustrate, I present an integration of the College of Nurses of Ontario's (CNO) competencies framework that is used as a guiding document for approving nursing programs across Ontario. I included RN and RPN nursing competencies because LGBTQI+ migrants may encounter nurses who are not degree-prepared (Daley et al., 2020; Daley & MacDonnell, 2015; MacDonnell et al., 2015; Registered Nurses' Association of Ontario, 2021). A case in point, LGBTQI+ migrants may be in contact with RPNs/LPNs who completed diploma programs that were not accredited by CASN. For this reason, in table 4, entitled "Proposed RN and RPN Program Evaluation," I applied the RN and RPN entry-to-practice competencies used by the CNO to evaluate how systemically educational institutions integrated LGBTQI+ migrants in the education of RNs and RPNs (College of Nurses of Ontario, 2018, 2019). The highlighted gaps in RPN competencies are provided in the table below.

**Table 4: Proposed RN and RPN Program Evaluation**

| **CNO RN and PRN Competencies to Practice** | **Suggestions for Evaluation: RNs and RPNs are prepared to …** |
|---|---|
| RN: #1.3 "Uses principles of trauma-informed care which places priority on trauma survivors' safety, choice, and control" (p. 5) | … take a trauma-and-violence-informed course to care for diverse populations, such as LGBTQI+ migrants. |
| RN: #2.2 "Demonstrates a professional presence, and confidence, honesty, integrity, and respect in all interactions" (p. 6)<br><br>RPN: #7 "Provides client care in a non-judgmental manner." (p. 5), and #73 "Participates in creating and maintaining a quality practice environment that is healthy, respectful and psychologically safe." (p. 7) | … respect pronouns and chosen name of diverse LGBTQI+ migrants.<br>… assess if translators are safe and affirming for intersecting experiences of LGBTQI+ migrants. |
| RN: #2.8 "Demonstrates professional judgment to ensure social media and information and communication technologies (ICTs) are used in a way that maintains public trust in the profession." (p. 6)<br><br>*RPN: Recommend for inclusion of a competency for the RPNs program.* | … provide affirming care by inclusion of diverse sexual orientations, gender identities and expressions and ensure confidentiality of this information. For example, nurses do not un/intentionally "out" a patient in a waiting room. |
| RN: #3.3 "Uses evidence-informed communication skills to build trusting, compassionate, and therapeutic relationships with clients." (p. 6)<br><br>*RPN: Recommend for inclusion of a competency for the RPNs program.* | … to looks for opportunities to build trusting, compassionate, and therapeutic relationships with LGBTQI+ migrants at various point of access. |
| RN: #6.1 "Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada."<br><br>*RPN: Recommend for inclusion of a competency for the RPNs program.* | … understand that Two-Spirit individuals may fall within the category of LGBTQI+ and migration as they relocate from one region to another, and that their experiences of migration should not be dismissed. |
| RN: #6.5 "Recognizes the impact of organizational culture and acts to enhance the quality of a professional and safe practice environment." (p.7)<br><br>RPN: #71 "Demonstrates leadership, direction and supervision to unregulated health workers and others." (p. 7) | … evaluate organizational culture is affirming for LGBTQI+ migrants across the lifespan. |

| **CNO RN and PRN Competencies to Practice** | **Suggestions for Evaluation: RNs and RPNs are prepared to …** |
|---|---|
| RN: #7.4 "Advocates for health equity for all, particularly for vulnerable and/or diverse clients and populations." And #7.8 "Supports healthy public policy and principles of social justice." (p. 7), and #7.11 "Uses knowledge of population health, determinants of health, primary health care, and health promotion to achieve health equity." (p. 8)<br><br>RPN: #26 "Advocates for equitable access, treatment and allocation of resources, particularly for vulnerable and/or diverse clients and populations." (p. 5), and 63 "Engages clients in identifying their health needs, strengths, capacities and goals." (p. 6) | … understand intersectional experiences of LGBTQI+ migrants when accessing health care services contextualized by systems of power and privilege. |
| RN: #9.3 "Engages in self-reflection to interact from a place of cultural humility and create culturally safe environment where clients perceive respect for their unique health care practices, preferences, and decisions", and #9.6 "Uses knowledge about current and emerging community and global health care issues…" (p. 8)<br><br>RPN: #21 "Takes action to minimize the impact of personal values and assumptions on interactions and decisions." (p. 5) | … engage in self-reflexivity and search for opportunities to address issues that impact health of LGBTQI+ migrants.<br>… understand that migrants' mental health is shaped by pre-, during, and post-migration contextual factors that transcend national borders (Kirmayer et al., 2011).<br><br>… take a trauma-and-violence-informed course to care for diverse populations, such as LGBTQI+ migrants. |

### *Educating Personal Support Workers*

In addition to inclusion in the nursing curriculum, content on the intersecting experiences of marginalized communities needs to be drawn into the education of personal support workers (PSWs) who may provide care to LGBTQI+ migrants at various points of entry, such as in long-term care facilities and nursing homes (Alba et al., 2021; Boamah et al., 2020; Daley et al., 2020; Daley & MacDonnell, 2015; Fasullo et al., 2021; Lyons et al., 2021; Spencer et al., 2021). The education for PSWs is of particular importance because, during COVID-19, there was a shortage

of PSWs in Ontario's long-term care facilities. This staff shortage resulted in the government of Ontario providing monetary grants for educational institutions to prepare 6,000 new PSWs in an intense six-month tuition-free program. In turn, this initiative attracted people from across Ontario to enroll in this intense PSW program. However, some of the informants who were nurses, or non-nurses who worked in long-term facilities, had concerns about how PSWs were trained. For example, a migrant LGBTQI+ informant was afraid of being judged as a patient because, in 2021, he heard LGBTQI+-phobic comments from his peers and a nurse educator in a PSW program in an urban environment in Canada. To have safe and equitable spaces, several informants recommended designating homes for older migrant LGBTQI+ adults, while some disagreed with this suggestion. The latter group asserted that it is unrealistic to have specific migrant LGBTQI+ long-term facilities due to existing differences among cultures, religions, and countries within diverse groups of LGBTQI+ migrants. Therefore, this recommendation for designated homes might not be utopian. Instead, most informants underscored the importance of continuing education for all of the staff who care for diverse SOGIE migrants.

**Implications for Nursing Practice**

In the above section, recommendations are provided for nursing program accreditation and approval bodies to include content that addresses LGBTQI+ migrants in the preparation of nurses upon entry-to-practice. Included in macro-level policies, these recommendations for educational programs require nurses, pre- and post-licensures, to learn about the experiences and needs of LGBTQI+ migrants. In the practice section, I indicate that nurses should provide safe and affirming care for LGBTQI+ migrants by avoiding superficial allyship, educating nurses post-licensure, and collaborating with migrants across the lifespan. First, in chapter five, I highlighted informants' shared experiences of LGBTQI+-phobia in organizations that had visible

ally and LGBTQI+ flags but did not affirm the combined intersectional experiences of migrants and LGBTQI+ people. The superficial act of presenting a flag as form of allyship without providing affirming care was harmful and caused informants to further mistrust the health care system. For this reason, LGBTQI+ migrants underscored the importance of avoiding ally theatre. This is supported by existing literature that provides suggestions for how organizations can become better allies (Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015; Cooper Brathwaite et al., 2022; Daley et al., 2020; Daley & MacDonnell, 2015; Flett, 2021; Gapka & Raj et al., 2003; Giwa & Chaze, 2018; Rainbow Health Ontario: Sherbourne health, 2020).

Next, the notion of the education of nurses at post-licensure emerged from interviews and in re-readings of transcriptions. Similar to previous studies, in chapters three, four, and five, I explained that, even though NHCPs attempted to demonstrate respect and professionalism, they varied in their knowledge levels and some demonstrated stereotypical attitudes on many occasions, such as using a dead name and asserting power in the context of nursing-knowledge and client's needs as well as insensitivity towards LGBTQI+ migrants (McDowell & Bower, 2016; von Vogelsang et al., 2016). In contrast, some nurses embodied humility by asking relevant questions about the specific needs of LGBTQI+ migrants, which conveyed the principles of affirming care (Casey, 2019; Doane & Varcoe, 2015).

The implication for critical praxis is highlighted by scholars who use intersectionality as a lens, and who call for a change in nursing practice (Canadian Nursing Association, 2021; Chinn et al., 2021; Cooper Brathwaite et al., 2022; MacDonnell et al., 2015; Thurman et al., 2019). Training sessions post-licensure should be specific to nurses' levels of understanding and the areas they work in to ensure the provision of affirming practices with diverse LGBTQI+ migrants (Public Health Agency of Canada, 2018; Registered Nurses' Association of Ontario,

2021; Trans Care BC, 2021). In fact, all nurses need to be educated about trauma- and violence-informed practices and provide affirming care to marginalized communities (Khanlou, Bohr, et al., 2020; Khanlou et al., 2021; Lee, 2018; MacDonnell, Dastjerdi, Bokore, et al., 2017; Semlyen et al., 2018). Although affirming care is crucial, Sansfaçon et al. (2018) found that it should not jeopardize the privacy of LGBTQI+ people, for example by placing a transmasculine man "in a service usually reserved for women – a gynecologist's office" (p. 191).

In addition to enacting the recommendations, informants in this study called on nursing agencies and organizations at the micro level to intentionally amplify the voices of LGBTQI+ migrants in the planning and delivery of health care services. This dialogue between care providers and recipients is important because the past and current experiences of LGBTQI+-phobia, Islamophobia, racism, and xenophobia differ when compared to those of non-LGBTQI+ migrants or non-migrant LGBTQI+ people (Hankivsky & de Leeuw, 2011; Hankivsky & Jordan-Zachery, 2019a). Therefore, similar to previous studies, I found that informants, across the life span, wanted to be included in the health policy decision-making process (Adam et al., 2011; Daley et al., 2020; Daley & MacDonnell, 2011; Gapka & Raj et al., 2003; MacDonnell, Dastjerdi, Bokore, et al., 2017; Spencer et al., 2021). However, when including LGBTQI+ migrants in decision-making, practitioners need to be understanding that some may want to be acknowledged, and others may want their identities to be confidential (Gamble et al., 2015; MacDonnell, 2007).

**Implications for Nursing Policy**

Nurses, along with mental health and social service providers, have initiated dialogue in health policy, and, thus far, have made gradual advances in resource allocation for LGBTQI+ migrants in those sectors. Implications for nursing policy are discussed next: support from

organization and institutional levels; increase the visibility of LGBTQI+ migrants in the nursing profession; expand visibility; and develop safe and welcoming spaces.

### *Systemic Organizational and Institutional Policies*

For change to occur in practice and education, at a systemic level, explicit policy is required from federal and provincial governments as well as nursing regulatory bodies. Similar to previous studies, I found that, in order to improve LGBTQI+ migrants' well-being, nurses can advocate for policy changes (Lee & Brotman, 2013; MacDonnell & Daley, 2015), create positive spaces for LGBTQI+ migrants by training staff (Alessi & Kahn, 2017; Guruge et al., 2010; MacDonnell et al., 2015; MacDonnell & Daley, 2015; O'Neill, 2010; Silberholz et al., 2017), and organize support groups (Logie et al., 2016; Massaquoi, 2020). Adding to previous studies, I found that nurses need continuous education within an organizational culture that is oriented towards acceptance of the intersectional identities of LGBTQI+ migrants (Burton et al., 2020; Daley & MacDonnell, 2015; Fasullo et al., 2021; MacDonnell & Daley, 2015).

For changes to occur, public policies and governmental agencies, as structural systems of power, need to collaborate with individuals who are affected by intersecting forces of oppression (Canadian Nursing Association, 2021; Chinn et al., 2021; Cooper Brathwaite et al., 2022; Daley et al., 2020; Hankivsky & Cormier, 2019; Khanlou, Bohr, et al., 2020; Lee & Brotman, 2013; MacDonnell et al., 2015; McCabe & Anhalt, 2022). When the needs of LGBTQI+ migrants are not named as a priority in health policies, resources are not allocated for them; at times, even when needs are named, services are not distributed (Alessi et al., 2020; Clark & O'Mahony, 2021; Crenshaw, 1991; Fox et al., 2020; Gupta et al., 2019; Hankivsky et al., 2019; Kahn et al., 2018; Lee, 2019; Lee et al., 2021). As discussed in chapter two, public policies can amplify the voices of LGBTQI+ migrants or silence them further.

### *Increase Visibility*

For policies at the meso level, although there may be challenges with disclosure in the hiring process, the participants called on nursing organizations to intentionally employ migrants, LGBTQI+ people, and LGBTQI+ migrants to create a welcoming environment for clients at the intersections of marginalities. There is a demand for more cultural and racialized diversity within the profession, not only for nurses in practice, but also for educators and administrators (Chinn et al., 2021; Cooper Brathwaite et al., 2022). At an institutional level, recruitment for the nursing discipline can seek applicants who meet the federal government's designated hiring targets of people who identify as visible minorities, gender minorities, Indigenous, and people with disabilities. Drawing from Ahmed's (2012a, 2012b, 2012c) discussion on commitment to diversity at an organizational level, creating flourishing experiences for LGBTQI+ migrants in the institutions must advance beyond a simple hiring process. In particular, educational institutions and health care organizations can support migrant LGBTQI+ nursing students through economic means. For example, nursing scholarship and bursary opportunities for LGBTQI+ migrants can be offered as incentives to increase the visibility of LGBTQI+ migrants in the nursing profession. To increase the visibility of LGBTQI+ migrant nurse leaders, organizations can provide opportunities for the mentorship and educational advancement of LGBTQI+ migrant nurses interested in leadership positions (Ahmed, 2012a; Iheduru-Anderson et al., 2022; Page et al., 2021).

### *Welcoming Environment*

In addition to the above, a specific systemic policy suggestion is made for health care organizations and educational institutions to create welcoming, affirming, and safe environments for educators and nursing students who identify as LGBTQI+ migrants to advance in the

profession and have a sense of belonging. This recommendation requires organizations to avoid tokenism, where one or a few LGBTQI+ migrants or BIPOC are forced to speak for entire LGBTQI+ migrant communities (Ahmed, 2012b; Cayir et al., 2021; S. R. Harper, 2020a; Massaquoi, 2020). As an illustration, in this study, a trans migrant nursing student in a first-year health assessment lab was asked by a nursing educator to share their knowledge of trans anatomy with peers. Instead of placing the only trans migrant student in a position of unwanted visibility, educational sessions must be offered for students, staff, faculty, and administrators to create safe and affirming spaces for diverse LGBTQI+ migrants (Daley et al., 2020; Daley & MacDonnell, 2015; Gapka & Raj et al., 2003; Klotzbaugh & Spencer, 2015; MacDonnell et al., 2015; Rainbow Health Ontario: Sherbourne health, 2020; Registered Nurses' Association of Ontario, 2021).

In "the First National Summit on Racism in Nursing and Health Care" held by the Canadian Nurses Association on November 24, 2021, among other speakers, the Honourable Murray Sinclair, Rani Srivastava, and Sandy Hudson highlighted their experiences of racism in nursing and health care. Similar to other authors, they added that racialized people in organizations should not have the sole responsibility of addressing racism and anti-racism in their workplaces (Ahmed, 2012a, 2012b; Canadian Nurses Association, 2021; Cooper Brathwaite et al., 2022; Felipe et al., 2020; S. Harper, 2021; S. R. Harper, 2020b; Moorley et al., 2020; Thorne, 2017). Rather, non-racialized and non-Indigenous people should enhance their knowledge and practice in relation to the social positionality of racialized people (Cooper Brathwaite et al., 2022). I extend this recommendation that non-racialized, non-Indigenous, and non-LGBTQI+ people should increase their knowledge in relation to LGBTQI+ migrants within organizations. Non-migrant and non-LGBTQI+ people need to be responsible for their learning

and attend educational sessions offered at, or outside of, their organization and read literature to create inclusive spaces for migrant LGBTQI+ educators, employees, and students. In this section, implications for nursing education, practice, and policy were provided. In what follows, I address limitations of the study and provide several suggestions for future research.

## Implications for Nursing Research

In this section, I provide three limitations of this study followed by my plan for a future program of research. Three possible areas of limitation are identified: exclusion of translators, number of informants, and lack of member checks. For each of these limitations, I provide a rationale for these shortcomings by drawing on the philosophical underpinnings of intersectionality and Gadamerian hermeneutics.

### *Exclusion of Translators*

A critique of this dissertation is that I set one of the inclusion criteria as an "ability to communicate and speak in English." On one hand, due to language barriers, some LGBTQI+ migrants were not able to participate in the study because a translator was not utilized. I acknowledge that an inability to communicate in English posed a limitation; however, employing a translator did not align with Gadamerian hermeneutics as a research methodology. This is because formation of meaning and interpretation in Gadamerian hermeneutics is not just about the signs, characters, grammatical consistency, and structure of a language, but rather, the historicity and context of the informant and interpreter (Gadamer, 2007a). On the other hand, a few informants who were settlement workers and also LGBTQI+ migrants highlighted their encounters with LGBTQI+ migrants who had negative and traumatizing experiences with NHCPs in Canada.

Following the philosophical underpinnings of Gadamerian hermeneutics, a language translator holds preunderstandings and prejudgments, and this historical past is bound to inform how communication occurs in triad translation between inquirer, translator, and informant. Gadamer (2000) asserted:

> There are not so much degrees of translatability from one language into another language as degrees of untranslatability. The despair of every translator in working on a translation is that there are not corresponding expressions for the individual expressions in the foreign language. (p. 16)

As a case in point, language is used to interpret experiences based on how people meet each experience and how events contextualize understandings. Understanding in Gadamerian hermeneutics is ontological since it is shaped by universality and fluidity. In discussing the universality of language, Gadamer (1976) highlighted that "every dialogue also has an inner infinity and no end" (p. 67), because there are finite ways to question and answer in dialogue, and this finitude may cause misunderstanding. Translation "lacks that third dimension from which the original (i.e., what is said in original) is built up in its range of meaning" (p. 68). Further, there may be concepts within a sentence that would have meaning for those who speak that language in a specific context.

As discussed in the foreword chapter, derogatory terms and phrases are used in Farsi to address LGBTQI+ people. Some Iranian nurses and translators in Canada who are not familiar with safe and affirming LGBTQI+ language may, intentionally or unintentionally, use derogatory language when referring to LGBTQI+ people. I say "intentionally" because a few of the informants shared that LGBTQI+ migrants with language barriers received discriminatory comments from their translator, whose job should have been translation — not discrimination

and judgement about the individuals' SOGIE. Finally, use of translators can be problematic if they are a lay person with no training, use offensive terminology, and/or act as gatekeepers in editing dialogue (En & En, 2019; Gamble et al., 2015; C. D. Smith et al., 2021). For future research, if a translator is hired, the inquirer must ensure that the translator is safe for LGBTQI+ migrants and be aware that the translator's past is added to how understandings are cultivated.

In the same vein, some of the informants in this study highlighted that having conversations with migrant LGBTQI+ nurses and health care professionals would influence the direction of dialogue. In particular, LGBTQI+ migrants found it retraumatizing when they had to make non-migrant and non-LGBTQI+ nurses understand their experiences of war and resettlement intertwined with identifying as LGBTQI+. However, if nurses identified as LGBTQI+ migrants or as a genuine ally, and were engaged in trauma-violence-informed practices, they may had an ability to engage in affirming practices with underserved populations. Similarly, informants expressed that because I identify as a migrant and racialized ally of LGBTQI+ people, they felt safe sharing their experiences. Many of the informants expressed that, due to the safe environment created during the interview, they disclosed their experiences of encounters with NHCPs for the first time. Hence, my prejudices, as Gadamer (1976) would call them, informed how language evolved during each research interview. In this regard, Gadamer states:

> The task of translator, therefore, must never be to copy what is said, but to place [themselves] in the direction of what is said (i.e., in its meaning) in order to carry over what is to be said into the direction of his own saying. (Brackets added, p. 68)

In this sense, during interviews I took on the role of translator, or meaning-maker, and asked relevant as well as appropriate questions to peel back the layers of understanding LGBTQI+

experiences with NHCPs. For these reasons, translators were not employed and only informants who were able to communicate in English were included.

***Number of Informants***

To understand the various experiences of LGBTQI+ migrants with nurses, I conducted 18 individual semi-structured interviews with informants until I arrived at a deep understanding of various experiences: sixteen informants were LGBTQI+ migrants and five were nurses. Out of the five nurses who had experiences or knowledge of care provided to LGBTQI+ migrants, three also identified as LGBTQI+ migrant nurses and two as non-migrant nurses. In a review of the articles that used interpretive phenomenology as a research methodology, the number of informants ranged from five to 20 individuals. Most importantly, in Gadamerian hermeneutics it is not about the quantity, but rather, it is about the quality of understandings and how these can be applied to practice (Gadamer, 2007). Interpretation of 18 informants' meaningful experiences provided rich and contextual meaning and the factors shaping LGBTQI+ migrants' experiences. Rather than a limitation, this strength allowed me to recommend opportunities to mitigate challenges at macro, meso, and micro levels for nursing education, practice, and policy.

***Member Checking Not Conducted***

Member checking, which is done in some research methodologies, such as ethnography, was not incorporated into this dissertation. The interviews were not about one individual, but informants were called upon to share their experiences with NHCPs. In the light of member checking in Gadamerian hermeneutics, Moules et al. (2015) asserted the following:

> The goal is not to describe the participants fully, nor to conserve their stories and experiences intact, but rather to listen to what participants have to say for that which will

> cast new light on the topic and expand our understanding of the phenomenon we are attending to in the conversation. (p. 123)

For this reason, member checking was not a part of the interpretation process in this study, because I did "not report on meaning but create [ed them]" (Moules et al., p. 124). In this dissertation, I did not have further contact with the informants, but I took the questions that arose for me to the next interview. In other words, the dialogue was never static, but rather in process, and consisted of in-depth interpretation. For example, a trans migrant shared that it is hard for migrants who also identify as trans when accessing health care services. After completing transcription and initial interpretations of this transcription, I noticed that I asked a few questions from the informant about experiences of trans migrants but did not delve more deeply into what that meant. I made a note to have this ongoing conversation with other informants. In follow up interviews with the informants, I observed a discussion of "migration within migration" that was unique to transgender migrants regardless of their migration trajectory. One trans migrant informant clearly stated that transgender migrants experience "immigration within an immigration." This idea of migration within a migration became one of the sub-themes that developed in my understandings of trans migrants' experiences. The process of taking questions from one interview to the next shed light on the shared experiences of LGBTQI+ migrants. In other words, the sequencing of conversations added an in depth understanding to the meaning ascribed by informants. Following the above explanation on some of the limitations of this study, the next section discusses my plan for a future program of research.

**Future Program of Research**

A few topics emerged from the interpretation of interviews that were not originally the purpose of this dissertation: (a) the experiences of college and university migrant LGBTQI+

students; (b) the experiences of racialized, Muslim, trans women as health care providers donning hijab; (c) the experiences of Two-Spirit individuals with nurses; (d) the use of theatre and arts-based research; and (e) the experiences of Iranian LGBTQI+ migrants with NHCPs in North America. The following paragraphs briefly highlight key themes for my future program of research.

First, in this study, 44% of the informants identified as current or past college and university migrant LGBTQI+ students in Canada. Through the interviews, their experiences with counsellors, educators, and other non-migrants, including non-LGBTQI+ students, were discussed. Where relevant, I highlighted some of these experiences in my chapters. For example, in chapter four, I highlighted experiences of LGBTQI+ students with precarious migration status in their encounters with counsellors at schools. However, the aim of this study was not to explore college and university migrant LGBTQI+ students' experiences. In the literature, general experiences of migrant LGBTQI+ students are discussed (Cimino-Johnson, 2021; Garvey & Dolan, 2021; Marraccini et al., 2022; Marshall, 2021; McCabe & Anhalt, 2022; Mitchell, 2018; Silver et al., 2021). Future studies can use Gadamerian hermeneutics with intersectionality to understand migrant LGBTQI+ students' experiences with counsellors, educators, and mental health service providers at the colleges and universities (Coda & Paiz, 2021; Garvey & Dolan, 2021; Joyce, 2015; Speed et al., 2020). At a systemic level, a thorough review of policy and educational documents should be done to investigate how counsellors and educators are prepared to provide affirming spaces for migrant LGBTQI+ students in their classrooms and campuses. The findings from a review of these documents could yield important knowledge, because the informants in this study felt their realities did not exist in their educational organizations and

programs of study, and that there were few educators prepared to provide safe and affirming spaces.

Second, in a recent doctoral dissertation, Saleh (2021) analyzed the counter-narrative experiences of Muslim nurses who wore hijab. Saleh used intersectionality and narrative race inquiry to highlight the overlapping experiences of identifying as a nurse and a Muslim woman donning a hijab. However, since she did not collect demographic information from her participants, there may be a gap in knowledge about SOGIE-diverse women donning hijab. Interestingly, one of the informants in my research identified as a racialized, migrant, Muslim, transwoman wearing hijab when reciting obligatory prayers. This informant, who identified as a health care professional, shared their concerns about practicing in the health care system: (a) wearing hijab and having a deep male voice; (b) fearing that speaking in the hospital's women's change room would make other women in the change room uncomfortable hearing a man's voice; and (c) patients requesting the presence of a female health care professional because they perceive her to be a man. This informant also experienced being ridiculed by people from her own culture for wearing hijab and reciting prayers, and she was mocked by some NHCPs for identifying as a Muslim and trans person. The challenges of the Muslim trans women donning hijab in the health care system added another layer of complexity that has not been addressed in the literature. Using intersectionality and Gadamerian hermeneutics in future studies brings forth new understandings of these unique experiences of the Muslim trans woman attired in a hijab in the health care system. I postulate that recommendations in a future study can be made in making spaces inclusive for trans Muslim migrant health care providers wearing a hijab.

Third, Two-Spirit individuals were included in the recruitment posters, consent forms, and interview questions; however, none of the informants identified as Two-Spirit individuals.

Two-Spirit individuals have experienced many decades of discrimination as a result of colonization (Kia et al., 2021; McLean, 2020; Trans Care BC, 2021). Culture and context shape acceptable norms for one's orientation and identity. For example, Two-Spirit is an umbrella term for Indigenous individuals in North America who identify with 2SLGBTQI+ people. However, Two-Spirit individuals should not be incorporated as a blanket term (Meyer-Cook & Labelle, 2008; Beauchamp et al., 2022). A Two-Spirit friend told me, "Being Two-Spirit is fluid and has a personal definition for everyone who identifies as such" (L. Simpson, personal communication, May 31, 2019). Two-Spirit individuals hold a spiritual role that is sacred for Indigenous communities, but colonizers identified them as unsacred, unholy, and attempted to erase their identity (Morgensen, 2010; A. Smith, 2010). This attempt of eradication may have caused disconnection of some Two-Spirit individuals from their community (Farlatte & Oliffe, 2019). Farlatte and Oliffe (2019) shed light on the experience of a Two-Spirit individual with suicidality and asserted, "He endured pain on First Nation reserve, which was invoked by other Aboriginal people, because of the erasure of Two-Spirit people's history and culture within aboriginal communities that occurred through the process of colonization" (Farlatte & Oliffe, 2019, pp. 272–273).

Indigenous identities and orientations such as osh-tisch, boté (or badé), winkte, and nadle are not named in the acronym and assimilated into the term Two-Spirit. This collation may have facilitated the exclusion of the oppressed and unnamed. Upon further reflection, a more relevant research methodology to enhance the understanding of experiences of Two-Spirit migrants with NHCPs would be community-based participatory action research (CPAR). In CPAR, the participants are co-creators of knowledge from the start of the research process until the dissemination of findings (Fine et al., 2021; Fobear, 2016; Gamble et al., 2015; Gapka & Raj et

al., 2003; Higgins et al., 2021; MacDonnell et al., 2015; Maxwel, 2013; Nunn, 2020; Trans Care BC, 2021). In this manner, Two-Spirit individuals would be included from the start of the research rather than only being involved as informants during interviews.

Fourth, to creatively amplify LGBTQI+ migrants' voices on ally theatre, it is fitting to consider future arts-based research in the form of theatre (Nunn, 2020). In chapter five, "Ally theatre is a problem," I suggested arts-based participatory action research (APAR) in the form of theatre for sharing the experiences of LGBTQI+ migrants with NHCPs. Certainly, when using APAR as a research methodology, the nuances of dissemination cannot be determined in advance. For example, the participants may choose to perform spoken words, write poetry, paint, or a combination of these arts-based approaches (Khanlou, Nunes, et al., 2020; Logie et al., 2019; Poblano Alvarez, 2020). Through use of play and theatre, arts-based research may cast LGBTQI+ migrants as performers as well as having their narratives and experiences heard and acknowledged (Lenette, 2019). According to Lenette (2019), APAR is ethical when, critically, there is attention to systems of power that aim to dismantle normative ideologies, such as hetero-cis-normativity and migration status. For example, audiences can be engaged in the discussions of what they observed after the play and look for opportunities to improve health care, nursing practices, and policies for underserved communities.

The fifth area that I plan to include in my program of research is experiences of Iranian LGBTQI+ migrants with nurses and other healthcare professionals within Iran and in North America. This future research is of particular interest to me because of my background as an Iranian-born first-generation settler in Canada. I have heard, and continue to hear, LGBTQI+-phobic comments from Iranian NHCPs and non-NHCPs in North America. To my knowledge, there are limited studies that have explored the experiences of Iranian LGBTQI+ migrants with

NHCPs within Iran and in North America. In particular, the importance of religion and family values may impact how LGBTQI+ people are viewed (Ahmady, 2018; Bucar & Shirazi, 2012; Keung, 2014; Khanlou et al., 2008; Safavifar et al., 2016; Shirpak et al., 2007; Talebi & Desjardins, 2012) and in turn how Iranian NHCPs provide affirming care to LGBTQI+ people.

Now that implications for nursing education, practice, policy, and future research have been provided, in the next section, I offer my plan for knowledge translation.

## Knowledge Translation

The Canadian Institute of Health Research (CIHR)'s discussion of Knowledge Translation (KT) requires researchers to describe how research findings would inform practice, education, policy, and future research (Barwick et al., 2014; Bowen & Graham, 2013). This requirement for knowledge translation resulted in an increased prominence of discourses around the transformation of knowledge during and after completion of research. Barwick et al. (2014) identified examples of synonyms used for knowledge translation as "knowledge transfer, knowledge mobilization, knowledge exchange, and knowledge brokering … and research utilization … and strategic communication" (pp. 2–3). Barwick et al. asserted that knowledge brokers, who are generally designated individuals at educational institutions or social and health organizations, take part in knowledge translation and strategic communications. I take on the role of knowledge broker and through the connections that I have built, and continue to build, I will strategically communicate as well as mobilize research findings. The CIHR (2010) demonstrates that knowledge translation and exchange occur in two forms: diffusion and dissemination.

### Diffusion

The diffusion of knowledge translation occurs when researchers "just let it happen." Diffusion is defined as the passive, unplanned, and uncontrolled nature of disseminations and

results from publication in peer-reviewed journals along with presentations at conferences, in which the audiences apply to practice what is presented in scholarly formats. In light of the diffusion in knowledge translation, I have prepared four manuscripts for publication in peer-reviewed, scholarly journals. In addition, I presented my research methodology at the 20th International Annual Thinking Qualitatively Conference in July 2021, and as a panel speaker I presented a section of my findings at the 2022 Rainbow Health Ontario Symposium. I plan to submit abstracts for the following conferences: National Newcomer Navigation Network Annual Conference, Canadian Immigration Summit, Canadian Association for Global Health, North American Refugee Health Conference, Canadian Community Health Nursing Conference, STTI International Nursing Research Congress, Social Justice Nursing Conference, CASN, and Canadian Association of Practical Nurses' Conference.

**Dissemination**

The CIHR describes dissemination as when knowledge mobilizers "make it happen." This distribution of knowledge occurs when understandings from a study are tailored for a particular audience. This may occur through sharing findings with organizations at a grassroots level. Following this approach, I have and will continue to take on an engaging route of knowledge translation to mobilize the findings (Bowen & Graham, 2013).

Through connections with a network of researchers, knowledge users, and organizations, I have connected with knowledge brokers in some of these organizations and plan to prepare presentations *unique to their needs*: National Newcomer Navigation Network, RNAO (Rainbow Nursing Interest Group), Canadian Nurses Association, Canada Infoway, The Neighbourhood Group (St. Stephen's Community House), Access Alliance, Ontario Council of Agencies Serving Immigrants, Centre for Addiction and Mental Health (Immigrant and Refugee Mental Health

Project), Rainbow Resources Centre Winnipeg, PFLAG across Canada, Rainbow Health Network, Children's Aid Society, The Canadian Centre for Gender & Sexual Diversity, The 519, Spectrum Community Space, Queer Health and Wellness Toronto, International Railroad for Queer Refugees, Centennial College, York University, Ryerson University, Georgian College, George Brown College, University of Calgary, University of Victoria, and University of Toronto.

**Knowledge Mobilization**

Knowledge mobilization is the actual application of the research findings to impact policy and society. This requires my ability to package and share academic research findings with non-academic community organizations and partners (Usmani & Alamgir, 2020). At a systemic macro level, I plan to write policy briefs for nursing and non-nursing organizations. As discussed above, by "making it happen" at a meso level, I have developed a plan of action to share the findings from this study with organizations at a grassroots level using visual approaches, such as through the creation of infographics. The informants, who also identified as nurses, shared the limited inclusion of their realities in nursing education in Canada.

At the micro level, I have incorporated the experiences of LGBTQI+ migrants into one of the collaborative nursing programs in Ontario. I co-authored an open access online educational resource (OER) textbook that will be used in a second-year nursing degree program at three institutions by over 500 students (St-Amant et al., 2021). Since this is an open access text, it can be used by other organizations and institutions. My role in working on this OER textbook for nursing students was to intentionally make the case studies inclusive of migrants, LGBTQI+ people, and LGBTQI+ migrants. I introduced the word cisgender in a case study to familiarize the students with the language. Moreover, in a case study that was originally about a white heterosexual cisgender youth with asthma I changed the name to Jamal Phiri, chose ze/zir/zirs

pronouns, and added intersectional experiences of LGBTQI+ migrants. Based on the experiences I heard about from the informants, I added this piece to the case study: “Ze is an only child and lives in a single parent home with zirs mother who works two jobs. Zirs father blamed the mother for their ‘daughter’s’ gender identity and sexual orientation and abandoned the family.” As this is an OER resource, I plan to engage in active mobilization and share it with other schools across Canada and abroad. Currently, I am working on the second OER textbook and I continue to thread LGBTQI+ migrant experiences into the case studies.

## The Present: Concluding Thoughts

I have titled this section “the present: concluding thoughts” because this is only the beginning of how my understanding will continue to be shaped about experience of LGBTQI+ migrants through utilization of intersectionality with Gadamerian hermeneutics. This is a reminder to be open to new experiences and acknowledge that there are always undiscovered understandings that require further interpretation (Gadamer, 2000, 2007b). As Gadamer stated, “[this statement] can never say all that there is to say” (2000, p. 16). This dissertation presented the attributes of being open, accepting new questions, being examined by the topics, and understanding the intertwined nature of oppressive powers. Intersectionality as an analytical lens created an opportunity to view and to question untapped and taken-for-granted dominant policies and practices that have marginalized and oppressed LGBTQI+ migrants in the health care system (Hankivsky & Jordan-Zachery, 2019a).

The tenets of reflexivity, context, and critical inquiry in Gadamerian hermeneutics and intersectionality led me to be open and search for the undiscovered to address the gap and build on current dialogue in nursing education, practice, policy, and research. This research approach created an opportunity for me to hear and *amplify* the voices of LGBTQI+ migrants with NHCPs.

I use the word “amplify” instead of “silenced” or “non-existent” voices because I do not assume that LGBTQI+ migrants are voiceless. I learned that their voices have always existed but may have not been heard by some nurses in positions of privilege, resulting in limited inclusion of marginalized experiences in nursing education, practice, and policy. In each phase of this dissertation, I examined the ways in which race, ethnicity, SOGIE privilege, and oppression operated within the processes of receiving care from nurses.

Audiences for this dissertation are nurses and other healthcare professionals at various settings that provide services for LGBTQI+ migrants. I embodied intersectionality and Gadamerian hermeneutics and aspired to a meaningful interpretation and representation of LGBTQI+ migrants’ experiences that would have a lasting effect on the readers. This research was not prefabricated for programmed responses; rather, my ontological presence in gaining understanding was needed for conversations to unfold with informants. I conclude by emphasizing that each reading reveals new findings and leads to a fluid fusion of horizons (Moules et al., 2015). I call on nursing allies to continue to engage in social justice and human rights praxis with LGBTQI+ migrants to inform education, practice, policy, and research (Collins et al., 2021).

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Williams, M. J., & Serpas, D. G. (2021). Minority stress in the study of LGBTQ PoC health disparities. In J. J. García (Ed.), *Heart, Brain and Mental Health Disparities for LGBTQ People of Color* (pp. 13–25). Springer International Publishing. https://doi.org/10.1007/978-3-030-70060-7_2

Worthington, E. L., Davis, D. E., & Hook, J. N. (2017). *Handbook of humility: Theory, research, and applications*. Taylor & Francis.

## Appendix A: Ethics approval

Ethics approval for this study was received (Approval number 19-0591) from the University of Victoria, the Human Research Ethics Board (HREB). This was approved in October 2020. In October 2021 a renewal was required in order to complete defense of doctoral dissertation. Centennial College's Research Ethics Board provided exemption letter for this study from additional review based on approval from the University of Victoria (REB File #2020/21 – 08).

## Appendix B: Recruitment Letters

University of Victoria

***Recruitment Letter: Migrant 2SLGBTQ+***

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**Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada**

Hello,

I am sharing this letter to communicate information regarding the study that I am conducting for my PhD dissertation, as part of my doctoral degree in the School of Nursing at the University of Victoria.

I am a migrant cisgender heterosexual nurse educator who is interested in understanding the experiences of migrant 2SLGBTQ+ communities with nurses in Canada. Research of this type is important because no research has been conducted to understand the complex experiences of migrant 2SLGBTQ+ communities with nurses using an intersectional framework.

I would like to request your assistance in bringing this study to attention of migrant (refugee, immigrant, newcomer, new-settler, citizen, asylum seeker or non-status resident) 2SLGBTQ+ by posting the study's recruitment poster in your unit. The migrant 2SLGBTQ+ people who are interested in participating in the study are to contact me directly. If you have more questions, please do not hesitate contact me via email at [redacted] or call at [redacted]. You are welcome to contact my PhD supervisor Dr. Carol McDonald [redacted] further information. Also, if at any point, you are interested in discussing the findings of the study, I would be happy to connect and would also welcome your feedback. Copies of any reports or publications from this study will be available to you upon request. Your help with this project is much appreciated. Thanks again for your interest and support.

**Purpose and Objectives**

The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

Sincerely,

Roya Haghiri-Vijeh, RN, BN, MN (Hon), PhD(c)

University of Victoria

***Recruitment Letter: Nurses***

---

**Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada**

Hello,

I am sharing this letter to communicate information regarding the study that I am conducting for my PhD dissertation, as part of my doctoral degree in the School of Nursing at the University of Victoria.

I am a migrant cisgender heterosexual nurse educator who is interested to understand experiences of migrant 2SLGBTQ+ communities with nurses in Canada. Research of this type is important because no research has been conducted to understand the complex experiences of migrant 2SLGBTQ+ communities with nurses using an intersectional framework.

I would like to request for your assistance to bring this study to attention of nurses by posting the study's recruitment poster in your unit. Nurses who are interested in participating in the study are to contact me directly. If you have more questions, please do not hesitate contact me via email at [redacted] or call at [redacted]. You are welcome to contact my PhD supervisor Dr. Carol McDonald at [redacted] for further information. Also, if at any point, you are interested in discussing the findings of the study, I would be happy to connect and would also welcome your feedback. Copies of any reports or publications from this study will be available to you upon request. Your help with this project is much appreciated. Thanks again for your interest and support.

**Purpose and Objectives**

The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

Sincerely,

Roya Haghiri-Vijeh, RN, BN, MN (Hon), PhD(c)

## Appendix C: Recruitment Posters

University of Victoria

***Recruitment Poster/Social Media Post: Migrant 2SLGBTQ+***

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**Invitation to participate in a research study "Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada"**

**Principal investigator**: Roya Haghiri-Vijeh, PhD Candidate, School of Nursing, University of Victoria and professor of nursing in the Ryerson, Centennial, George Brown Collaborative Nursing Degree program. I am conducting this research for my PhD dissertation, as part of my doctoral degree in the School of Nursing at the University of Victoria.
**Email:**
**Phone:**

**If you are a 2SLGBTQ+ migrant (refugee, immigrant, newcomer, new-settler, citizen, asylum seeker or non-status resident) and received/receiving nursing and healthcare services in Canada this study might be of interest to you!**

**Purpose and Objectives**

The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

You will have the opportunity to share your thoughts and feelings about your experiences with nurses and healthcare professionals in Canada. This will assist in identifying the factors, supports or strategies that are helpful to you and to future migrant 2SLGBTQ+.

**What is involved**

An individual interview will be conducted either virtually or by phone. Virtual interview can take place with the use of Zoom. Phone interview can take place over the phone. This interview may take 1-2 hours.

**Compensation**

If you volunteer to participate in the interview you can either request 1) a $25 e-transfer to your chosen email, **or** 2) a $25 Tim Horton's gift card mailed to your chosen address.

**Contacts**

If you have any questions about the research and would like to participate in this study please contact the principal investigator, Roya Haghiri-Vijeh at ) directly. You are welcome to contact my PhD supervisor Dr. Carol McDonald at for further information.

***If you are reading this poster online and are interested in participating in this research study, you should respond privately, and not post publicly, as this is best practice in order to maintain confidentiality.**

University of Victoria

***Recruitment Poster/Social Media Post: Nurses***

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**Invitation to participate in a research study "Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada"**

**Principal investigator**: Roya Haghiri-Vijeh, PhD Candidate, School of Nursing, University of Victoria and professor of nursing in the Ryerson, Centennial, George Brown Collaborative Nursing Degree program. I am conducting for my PhD dissertation, as part of my doctoral degree in the School of Nursing at the University of Victoria.
**Email:**
**Phone:**

**If you are a nurse (practicing, retired, student, administrator, educator, or policymaker) and have provided or have knowledge about nursing care provided to migrant 2SLGBTQ+ communities in Canada, this study might be of interest to you!**

**Purpose and Objectives**

The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

You will have the opportunity to voice your thoughts and experiences related to migrant 2SLGBTQ+ communities receiving nursing care in Canada.

**What is involved**

An individual interview will be conducted either virtually or by phone. Virtual interview can take place with the use of Zoom. Phone interview can take place over the phone. This interview may take 1-2 hours.

**Compensation**

If you volunteer to participate in the interview you can either request 1) a $25 e-transfer to your chosen email, **or** 2) a $25 Tim Horton's gift card mailed to your chosen address.

**Contacts**

If you have any questions about the research and would like to participate in this study please contact the principal investigator, Roya Haghiri-Vijeh at ext. . You are welcome to contact my PhD supervisor Dr. Carol McDonald at for further information.

***If you are reading this poster online and are interested in participating in this research study, you should respond privately, and not post publicly, as this is best practice in order to maintain confidentiality.**

## Appendix D: Consent Forms

*Depending on the provincial location of each participant, the helpline information on each consent forms were modified.*

### Participant Consent Forms: 2SLGBTQI+ Migrants

### Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada

You are invited to participate in a study entitled "Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada" that is conducted by Roya Haghiri-Vijeh.

Roya Haghiri-Vijeh is a faculty member at Centennial College and professor of nursing in the Ryerson, Centennial, George Brown Collaborative Nursing Degree program. Roya is also a PhD candidate at University of Victoria. She can be contacted at

As a graduate student, I am required to conduct research as part of the requirements for a degree in PhD of Nursing. This research is conducted under the supervision of Dr. Carol McDonald. You may contact my supervisor at

**Purpose and Objectives**
The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

**Importance of this Research**
Research of this type is important because no research has been conducted to understand the complex experiences of migrant 2SLGBTQ+ communities with nurses using an intersectional framework. You will have the opportunity to share your thoughts and feelings about your experience with nurses and healthcare professionals in Canada. This will assist in identifying the factors, supports or strategies that are helpful to you and to future migrant 2SLGBTQ+.

**Participants Selection**
You are being asked to participate in this study because of the following:

- Identify as migrant 2SLGBTQ+ and received/are receiving nursing and healthcare in Canada
- Over the age of 19
- Comfortable communicating in English
- Comfortable to be audio-recorded for the purpose of research

Before you give your consent to be a participant, it is important that you carefully read the following information about the research, ask as many questions as necessary to clarify your understanding about the purpose of the study, and the benefits and potential risks associated with

your participation. The researcher will be able to discuss the research with you, answer any questions, be available to address any concerns that may occur, and all information provided will remain confidential.

**What is involved**
Individual interview is conducted using telephone **or** virtually using Zoom. Zoom servers are located outside of Canada, and Zoom stores users' names and usage data outside of Canada. No other information is stored outside of Canada, and recordings of Zoom meetings are not stored on Zoom servers. The interview will take approximately 1 to 2 hours. Roya will conduct the interview. With your permission, the interview will be audio-taped. The audio-tape will be transcribed and then deleted. You will be asked to discuss your experience with nurses and healthcare professionals in Canada. You may refuse to answer any questions during the individual interview. Such a decision will not influence your relationship with the researchers or your status within your program, or any of your other academic courses, academic records, healthcare needs or immigration status. Your nurses or healthcare providers or employers will not be aware if you participated in this interview.

**Risks**
Given the nature of the research topic, there could be potential psychological distress after discussing your experiences. If you experience any uneasiness or if you desire additional support, please see information about counselling services available below.

Good2Talk helpline 1-866-925-5454
Distress Centres of:
Toronto: 416-408-HELP (4357)
Durham: 905-666-0483
York: 416-310-COPE (2673)

**Rights of Research Participants**
You are not waiving any legal claims, rights or responsibilities because of your participation in this research study.

**Benefits**
You will be able to build transferable skills and you may choose to add your participation in the research study to your professional resume. Your input will help inform nursing and healthcare policy, research, and education in providing care to migrant 2SLGBTQ+ communities.

**Compensation**
If you volunteer to participate in the individual interview, you can either request 1) a $25 e-transfer to your chosen email, **or** 2) a $25 Tim Horton's gift card mailed to your chosen address.

**Voluntary Participation**
Your participation in this study is voluntary. If you wish to withdraw from the study, you can do so at any time for any reason with no consequences to you. If you wish to withdraw, you may inform Roya by email or telephone. Please note, once you have completed an individual interview, it may not be possible to remove your information once the analysis is completed. If

you choose to withdraw part way during or after individual interviews, you may keep the compensation.

**Researcher's Relationship with Participants**
The researcher may have a relationship to potential participants as a teacher. If you are a Centennial student in the Ryerson, Centennial and George Brown Collaborative Nursing Degree Program you cannot participate in this study.

**Anonymity and Confidentiality**
All information collected will be anonymized and remain confidential. I will pool all data I receive so that no single individual may be identified in my report. Paper files will be kept in a locked cabinet within a locked office at Centennial College and only accessible by Roya. All electronic data collected will be stored in a password-protected computer. Your identity and participation in this study will be confidential. Your professors, immigration officers, nurses, and healthcare professionals will not know who has participated in the study.

**Dissemination of Results**
It is anticipated that the results of this study will be shared with others in the following ways. Roya will be preparing a PhD dissertation for University of Victoria, Centennial College, Collaborative BScN program, and preparing articles for publication, presenting findings at conferences, and media. The PhD dissertation will be available publicly on UVicSpace. No personal details that can identify you will be shared or published. All information will be reported in aggregate format, and in no way will be linked to any individual person.

**Disposal of Data**
Roya will keep all data for seven years, except for the audio recordings, which will be erased from the tape recorder immediately after transcription is complete. Roya will keep copies of the audio recordings from the interviews on a password-protected computer. This will be done for the purpose of analysis. Paper data will be shredded and electronic data will be destroyed.

**Contacts**
If you have any questions about the research project, please feel free to contact the principal investigator, Roya Haghiri-Vijeh at --- or Dr. Carol McDonald at ---

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (#).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

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

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

University of Victoria

**Participant Consent Forms: Nurses**

## Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada

You are invited to participate in a study entitled "Understanding experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada" that is conducted by Roya Haghiri-Vijeh.

Roya Haghiri-Vijeh is a faculty member at Centennial College and professor of nursing in the Ryerson, Centennial, George Brown Collaborative Nursing Degree program. Roya is also a PhD of Nursing student at University of Victoria. She can be contacted at

As a graduate student, I am required to conduct research as part of the requirements for a degree in PhD of Nursing. This research is conducted under the supervision of Dr. Carol McDonald. You may contact my supervisor

**Purpose and Objectives**
The purpose of this study is to understand the experiences of migrant 2SLGBTQ+ communities with nurses and healthcare professionals in Canada. The objective of this research is to inform education, practice, policy, and research and provide strategies to improve practice and policy.

**Importance of this Research**
Research of this type is important because no research has been conducted to understand the complex experiences of migrant 2SLGBTQ+ communities with nurses using an intersectional framework. You will have the opportunity to share your thoughts and feelings about your experience with nurses and healthcare professionals in Canada. This will assist in identifying the factors, supports or strategies that are helpful to you and to future migrant 2SLGBTQ+.

**Participants Selection**
You are being asked to participate in this study because of the following:

- Nurses who have knowledge or experience of nursing or healthcare provided to migrant 2SLGBTQ+ communities in Canada.
- Over the age of 19
- Comfortable communicating in English
- Comfortable to be audio-recorded for the purpose of research

Before you give your consent to be a participant, it is important that you carefully read the following information about the research, ask as many questions as necessary to clarify your understanding about the purpose of the study, and the benefits and potential risks that may occur. The researcher will be able to discuss the research with you, answer any questions, be available to address any concerns that may occur, and all information provided will remain confidential.

**What is involved**
Individual interview is conducted using telephone **or** virtually using Zoom.
Zoom servers are located outside of Canada, and Zoom stores users' names and usage data outside of Canada. No other information is stored outside of Canada, and recordings of Zoom meetings are not stored on Zoom servers.

The interview will take approximately 1 to 2 hours. Roya will conduct the interview. With your permission, the interview will be audio-taped. The audio-tape will be transcribed and then deleted.
You will be asked to discuss your experience or knowledge of nursing care provided to migrant 2SLGBTQ+ in Canada. You may refuse to answer any questions during the individual interview. Such a decision will not influence your relationship with the researchers or your status within your program, or any of your other academic courses, academic records, healthcare needs, immigration status, or your organization. Your employee or clients will not be aware if you participated in this interview.

**Risks**
Given the nature of the research topic, there could be potential psychological distress after discussing your experiences. If you experience any uneasiness or if you desire additional support, please see below information about counselling services available below.

Good2Talk helpline 1-866-925-5454
Distress Centres of:
Toronto: 416-408-HELP (4357)
Durham: 905-666-0483
York: 416-310-COPE (2673)

**Rights of Research Participants**
You are not waiving any legal claims, rights or responsibilities because of your participation in this research study.

**Benefits**
You will be able to build transferable skills and you may choose to add your participation in the research study to your professional resume. Your input will help inform nursing and healthcare policy, research, and education in providing care to migrant 2SLGBTQ+ communities.

**Compensation**
If you volunteer to participate in the individual interview, you can either request 1) a $25 e-transfer to your chosen email, **or** 2) a $25 Tim Horton's gift card mailed to your chosen address.

**Voluntary Participation**
Your participation in this study is voluntary. If you wish to withdraw from the study, you can do so at any time for any reason with no consequences to you. If you wish to withdraw, you may inform Roya by email or telephone. Please note, once you have completed an individual interview, it may not be possible to remove your information once the analysis is completed. If

you choose to withdraw part way during or after individual interviews, you may keep the compensation.

**Researcher's Relationship with Participants**
The researcher may have a relationship to potential participants as a teacher. If you are a Centennial student in the Ryerson, Centennial and George Brown Collaborative Nursing Degree Program you cannot participate in this study.

**Anonymity and Confidentiality**
All information collected will be anonymized and remain confidential. I will pool all data I receive so that no single individual may be identified in my report. Paper files will be kept in a locked cabinet within a locked office at Centennial College and only accessible by Roya. All electronic data collected will be stored in a password-protected computer. Your identity and participation in this study will be confidential. Your professors, immigration officers, nurses, and healthcare professionals will not know who has participated in the study.

**Dissemination of Results**
It is anticipated that the results of this study will be shared with others in the following ways. Roya will be preparing a PhD dissertation for University of Victoria, Centennial College, Collaborative BScN program, and preparing articles for publication, presenting findings at conferences, and media. The PhD dissertation will be available publicly on UVicSpace. No personal details that can identify you will be shared or published. All information will be reported in aggregate format, and in no way will be linked to any individual person.

**Disposal of Data**
Roya will keep all data for seven years, except for the audio recordings, which will be erased from the tape recorder immediately after transcription is complete. Roya will keep copies of the audio recordings from the interviews on a password-protected computer. This will be done for the purpose of analysis. Paper data will be shredded, and electronic data will be destroyed.

**Contacts**
If you have any questions about the research project, please feel free to contact the principal investigator, Roya Haghiri-Vijeh at ___ or Dr. Carol McDonald at ___.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (#).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

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

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

## Appendix E: Semi-structured Interview Questions

### Individual Interview Questions: With Migrants

My name is Roya Haghiri-Vijeh and my pronouns are she/her. I am a PhD nursing candidate at the University of Victoria and also in the faculty of nursing at Centennial College.

I would like to thank you for agreeing to participate in this interview for a research study titled, "Understanding Experiences of Migrant 2SLGBTQ+ with nurses and healthcare professionals in Canada". I am looking forward to hearing about:
Your experience as a migrant 2SLGBTQ+ with nurses in Canada

Before we begin, I would like to ask that you correct me at any time if you think I have used a term or phrase that is not reflective of your experiences or identities.
All disclosures and conversations today shall remain confidential (i.e. I will not share your name with anyone).
Your participation in the interview is completely voluntary.
You may refuse to answer any questions you do not wish to answer during the interview. Also, you can terminate the interview at any time.
There are no penalties for withdrawing and you may withdraw from the interview at any time.
If you are a student, your teachers will not be aware if you participated in this interview.
If you are a nurse, your employee or clients will not be aware if you participated in this interview.
If you are a migrant 2SLGBTQ+, your nurses will not be aware if you participated in this interview.
Because this interview will be audio recorded once the data are analyzed, the data cannot be extracted from the study.
I will pool all data so that no single individual may be identified in my report. Do you have any questions?
I will be audio recording our conversation for accuracy in the research process and at no time will any identifying information be disseminated in the study finding.
This interview is being recorded. Do you consent to be audio recorded? ____

1. I identify as a heterosexual, cisgender, Canadian immigrant, and an ally to migrants, 2SLGBTQ+, and migrant 2SLGBTQ+. How do you identify yourself?

2. What has been your experience of receiving nursing care outside of Canada?

3. In what areas of healthcare do/have you receive/d nursing care?

4. What has been your experience with healthcare in Canada?

5. What has been your experience with receiving nursing care in Canada?

6. What supportive care can the nurses in Canada provide for you as a migrant 2SLGBTQ+?

7. Is there anything that you would like to share with the me about experiences of migrant 2SLGBTQ+ with nurses in Canada?

Thank you for your time and participation.

**Individual Interview Questions: Nurses**

My name is Roya Haghiri-Vijeh and my pronouns are she/her. I am a PhD nursing candidate at the University of Victoria and also in the faculty of nursing at Centennial College.

I would like to thank you for agreeing to participate in this interview for a research study titled, "Understanding Experiences of Migrant Individuals of diverse gender, sex, and sexuality (or 2SLGBTQI+) with nurses or healthcare professionals in Canada". I am looking forward to hearing about your knowledge of or experience providing nursing care to migrant 2SLGBTQ+

Before we begin, I would like to ask that you correct me at any time if you think I have used a term or phrase that is not reflective of your experiences or identities.
All disclosures and conversations today shall remain confidential (i.e. I will not share your name with anyone).
Your participation in the interview is completely voluntary.
You may refuse to answer any questions you do not wish to answer during the interview. Also, you can terminate the interview at any time.
There are no penalties for withdrawing and you may withdraw from the interview at any time.
If you are a student, your teachers will not be aware if you participated in this interview.
If you are a nurse, your employee or clients will not be aware if you participated in this interview.
Because this interview will be audio recorded once the data are analyzed, the data cannot be extracted from the study.
I will pool all data so that no single individual may be identified in my report. Do you have any questions?
I will be audio recording our conversation for accuracy in the research process and at no time will any identifying information be disseminated in the study findings.

This interview is being recorded. Do you consent to be audio recorded? ____

1. I identify as a heterosexual, cisgender, Canadian immigrant, and an ally to migrants, 2SLGBTQ+, and migrant 2SLGBTQ+. How do you identify yourself?

2. What is your knowledge about or experience providing nursing care to migrant 2SLGBTQ+?

3. What can the nurses in Canada do for migrant 2SLGBTQ+ to help them flourish?

4. What can nurses learn from migrant 2SLGBTQ+ that will help strengthen nursing practice and inform policy?

5. What can nurses add to the larger conversation in nursing that might help nurses see, think about, act differently toward migrant 2SLGBTQ+?

   Probing Questions if needed:
   a. What macro systems of power are related to experiences of migrant 2SLGBTQ+ with nurses in Canada? (Global and national-level institutions and policies)

   b. What meso or intermediate systems of power are related to experiences of migrant 2SLGBTQ+ with nurses in Canada? (provincial and regional-level institutions and policies)

   c. What micro systems of power are related to experiences of migrant 2SLGBTQ+ with nurses in Canada? (community-level, grassroots institutions and policies as well as individuals or 'self')?

6. Ask nurses only: Can you think of course/s that have shaped/impacted your understanding of experiences of migrant 2SLGBTQ+?

7. Ask nurses only: Can you think of practicum/s or placement/s that have has/have shaped/impacted your understanding of experiences of migrant 2SLGBTQ+?

8. Is there anything that you would like to share with the me about experiences of migrant 2SLGBTQ+ with nurses in Canada?

Thank you for your time and participation.

## Appendix F: Table 2

**Table 2**

*Summary of the Articles*

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Adam, B. D., Betancourt, G., & Serrano-Sánchez, A. (2011). Development of an HIV prevention and life skills program for Spanish-speaking gay and bisexual newcomers to Canada. *Canadian Journal of Human Sexuality, 20*(1–2), 11–17. | Canada | Service providers | Post | | Newcomer | Research article |
| Adur, S. M. (2018). In pursuit of love: 'Safe passages', migration and queer South Asians in the US. *Current Sociology Monograph, 66*(2), 320–334. https://doi.org/10.1177/0011392117736305 | USA | | Post | | Migrants | Research article |
| Ahmady, K. (2018). Migration and gender for Iranian LGBT. *The Journal of International Relations, Peace, Studies, and Development, 4*(1). | North American and Europe | None | Both | | Asylum seekers | Discussion paper |
| Alessi, E. J., & Kahn, S. (2017). A framework for clinical practice with sexual and gender minority asylum seekers. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000244 | Canada and USA | Mental Health care | Both | | Asylum seekers | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Alessi, E. J., Kahn, S., & Chatterji, S. (2016). "The darkest times of my life": Recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity. *Child Abuse and Neglect, 51*, 93–105. https://doi.org/10.1016/j.chiabu.2015.10.030 | Canada and USA | Mental Health care | Pre | | Asylum seekers | Research article |
| Alessi, E. J., Kahn, S., & Van Der Horn, R. (2017). A qualitative exploration of the premigration victimization experiences of sexual and gender minority refugees and asylees in the United States and Canada. *Journal of Sex Research, 54*(7), 936–948. https://doi.org/10.1080/00224499.2016.1229738 | Canada and USA | Mental Health care | Pre | | Asylum seekers | Research article |
| Bourque-Bearskin, R. L. (2011). A critical lens on culture in nursing practice. *Nursing Ethics, 18*(4), 548–559. https://doi.org/10.1177/0969733011408048 | Canada | Nurses | | | Culture | Research paper |
| Bucar, E. M., & Shirazi, F. (2012). The "invention" of lesbian acts in Iran: Interpretative moves, hidden assumptions, and emerging categories of sexuality. *Journal of Lesbian Studies, 16*(4), 416–434. https://doi.org/10.1080/10894160.2012.681263 | General | None | Pre | | | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Carabez, R., & Scott, M. (2016). 'Nurses don't deal with these issues': nurses' role in advance care planning for lesbian, gay, bisexual and transgender patients. *Journal of Clinical Nursing*, *25*(23–24). https://doi.org/10.1111/jocn.13336 | USA | Nursing | | LGBTQ (in silo) | | Research article |
| Carabez, R., Eliason, M. J., & Martinson, M. (2016). Nurses' knowledge about transgender patient care. Advances in Nursing Science, 39(3). https://doi.org/10.1097/ANS.0000000000000128 | USA | Nurses | | Trans | | Research article |
| Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., & Scott, M. (2015). Does your organization use gender inclusive forms? Nurses' confusion about trans* terminology. *Journal of Clinical Nursing*, *24*(21–22). https://doi.org/10.1111/jocn.12942 | USA | Nurses and allied Health care | | LGBTQ (in silo) | | Research article |
| Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). "Never in all my years…:" Nurses' Education about LGBT Health. *Journal of Professional Nursing*, *31*(4), 323–329. https://doi.org/10.1016/j.profnurs.2015.01.003 | USA | Nurses | | LGBTQ (in silo) | | Research article |
| Carabez, R., Pellegrini, M., Mankowitz, A., Eliason, M. J., & Dariotis, W. M. (2015). Nursing students' perceptions of their knowledge of lesbian, gay, bisexual, and transgender issues: Effectiveness of a multi-purpose assignment in a public health nursing class. *Journal of Nursing Education*, *54*(1), 50–53. https://doi.org/10.3928/01484834-20141228-03 | USA | Nursing students | | LGBTQ (in silo) | | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Cerezo, A., Quintero, D., Morales, A., & Rothman, S. (2014). Trans migrations: Exploring life at the intersection of transgender identity and immigration. *Psychology of Sexual Orientation and Gender Diversity*, *1*(2), 170–180. https://doi.org/10.1037/sgd0000031 | USA | Mental Health care | Both | | Immigrant | Research article |
| Clark, N., & Vissandjée, B. (2019). Exploring intersectionality as a policy tool for gender based policy analysis: implications for language and health literacy as key determinants of integration. In O. Hankivsky & J. S. Jordan-Zackery (Eds.), *The Palgrave Handbook of Intersectionality in Public Policy* (pp. 603–623). Switzerland: Palgrave Macmillan. | Canada | Health care | Post | LGBTQ (in silo) | Immigrant (in silo) | Book chapter |
| Cooney, D. (2007). Queer newcomers land among friends. *Xtra (Toronto)*, (588), 9. Retrieved from http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=qth&AN=25146355&login.asp&site=ehost-live&scope=site | Toronto, Canada | General | Both | | Not specific | Newspaper articles |
| Dastjerdi, M. (2012). The case of Iranian immigrants in the greater Toronto area: A qualitative study. *International Journal for Equity in Health*, *11*(9), 1–8. https://doi.org/10.1186/1475-9276-11-9 | Canada | Social and Health care in general | | | Immigrant (in silo) | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Dastjerdi, M., Olson, K., & Ogilvie, L. (2012). A study of Iranian immigrants' experiences of accessing Canadian health care services: A grounded theory. International Journal for Equity in Health, 11(1), 1–15. https://doi.org/10.1186/1475-9276-11-55 | Canada | Health care | | | Immigrant (in silo) | Research article |
| De Guzman, F. L. M., Moukoulou, L. N. N., Scott, L. D., & Zerwic, J. J. (2018). LGBT inclusivity in health assessment textbooks. *Journal of Professional Nursing*, *34*, 483–487. https://doi.org/10.1016/j.profnurs.2018.03.001 | | Nursing | | LGBTQ (in silo) | | Research article (content analysis) |
| Dorsen, C., & Caceres, B. (2019). Guest editorial: We have to talk about Stonewall. *Advances in Nursing Science*, *42*(2), 87–88. https://doi.org/10.1109/mnet.1987.6434204 | | Nursing | | LGBTQ+ | Immigrant | Editorial - call to action |
| Durso, L. E., & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research and Social Policy*, *10*(1), 35–42. https://doi.org/10.1007/s13178-012-0105-2 | USA | Health care | | LGBTQ (in silo) | Immigrant (in silo) | Research article |
| Farlatte, O., & Oliffe, J. (2019). Lobbing suicide prevention policy for gay and bisexual men: An intersectionality-informed photovoice project. In O. Hankivsky & J. S. Jordan-Zachery (Eds.), *The Palgrave Handbook of Intersectionality in Public Policy* (pp. 263-284.). Switzerland: Palgrave Macmillan. | Canada | Social and Health care in general | Post | Gay and bi-sexual men | Canadians and Migrants | Book chapter |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Fensham, C. J. (2021). Considering spiritual care for religiously involved LGBTQI migrants and refugees: A tentative map. *Religions*, *12*(12), 1113. https://doi.org/10.3390/rel12121113 | Canada | None | Post | LGBTQI | Migrants | Research article |
| Fergus, K. B., Teale, B., Sivapragasam, M., Mesina, O., & Stergiopoulos, E. (2018). Medical students are not blank slates: Positionality and curriculum interact to develop professional identity. *Perspectives on Medical Education*, 17–19. https://doi.org/10.1007/s40037-017-0402-9 | USA and Canada | Medical students | | LGBTQ (in silo) | Immigrant (in silo) | Discussion paper |
| Fobear, K. (2015). "I thought we had no rights" - challenges in listening, storytelling, and representation of LGBT refugees. *Studies in Social Justice*, *9*(1), 102–117. | Canada | Activist | Both | | Refugee → Immigrant | Research article |
| Fobear, K. (2016). Nesting Bodies: Exploration of the body and embodiment in LGBT refugee oral history and participatory photography. *Social Alternatives*, *35*(3), 33–43. Retrieved from https://login.proxy.libraries.rutgers.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=121172481&site=eds-live | Canada | Activist | Both | | Refugee → Immigrant | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Gamble, K., Mulé, N. J., Nicol, N., Waugh, P., Jordan, S., & Ontario Council of Agencies Serving Immigrants. (2015). *Envision LGBT refugee rights in Canada: Is Canada a safe haven?* | Canada | Service providers and refugees (e.g., health) | Both | | Refugee | Research article |
| Ghabrial, M. A. (2017). "Trying to figure out where we belong": Narratives of racialized sexual minorities on community, identity, discrimination, and health. *Sexuality Research and Social Policy*, *14*(1), 42–55. https://doi.org/10.1007/s13178-016-0229-x | Canada | Service providers (e.g., health) | Post | | Newcomer, refugees, immigrant, and even Canadian-born with interracial parents. | Research article |
| Giwa, S., & Greensmith, C. (2012). Race relations and racism in the LGBTQ community of Toronto: Perceptions of gay and queer social service providers of color. *Journal of Homosexuality*, *59*(2), 149–185. https://doi.org/10.1080/00918369.2012.648877 | Canada | Social service workers | Post | | Asylum seekers | Research article |
| Goldberg, L., Ryan, A., & Sawchyn, J. (2009). Feminist and queer phenomenology: A framework for perinatal nursing practice, research, and education for advancing lesbian health. *Health Care for Women International*, *30*(6), 536–549. https://doi.org/10.1080/07399330902801302 | Canada | Nurses | | LGBTQ (in silo) | | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Haghiri-Vijeh, R. (2013). The importance of including the needs of the LGBTIQ community in the millennium development goals and education of healthcare professionals. *Journal of Global Citizenship & Equity Education, 3*(1). Retrieved from journals.sfu.ca/jgcee | Canada | Health care | | LGBTQ (in silo) | | Discussion paper |
| Haghiri-Vijeh, R., McCulloch, T., Atack, L., & Bedard, G. (2019). The impact of Positive Space Training on students' communication with LGBTTQ+ communities. *Nursing Education Perspectives*, 0–5. https://doi.org/10.1097/01.NEP.0000000000000474 | Canada | Social and Health care in general | | LGBTQ (in silo) | | Research article |
| Hopkinson, R. A., Keatley, E., Glaeser, E., Erickson-Schroth, L., Fattal, O., & Nicholson Sullivan, M. (2017). Persecution experiences and mental health of LGBT asylum seekers. *Journal of Homosexuality, 64*(12). https://doi.org/10.1080/00918369.2016.1253392 | USA | Mental Health care | Pre | | Asylum seekers | Research article |
| Huang, Y. (2017). *Opportunities and challenges: Identity development and lived experiences among Chinese immigrant young gay men in Toronto*. University of Toronto. | Toronto, Canada | Social worker | Post | | Immigrant | PhD Thesis |
| Islam, F., Khanlou, N., Macpherson, A., & Tamim, H. (2018). Mental health consultation among Ontario's immigrant populations. *Community Mental Health Journal*, *54*(5), 579–589. https://doi.org/10.1007/s10597-017-0210-z | Canada | Mental Health care | | | Immigrant (in silo) | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Jordan, S. R. (2009). Un/convention(al) refugees: Contextualizing the accounts of refugees facing homophobic or transphobic persecution. *Refuge*, *26*(2), 165–182. | Canada | Service providers, community organizers, and lawyers | Both | | Asylum seekers and refugees | Research article |
| Jordan, S., & Morrissey, C. (2013). "On what grounds?" LGBT asylum claims in Canada. Forced Migration Review, 42(April), 13–15. | Canada | Mental Health care and physicians | Both | | Asylum seekers | Discussion paper |
| Kahn, S., Alessi, E., Woolner, L., Kim, H., & Olivieri, C. (2017). Promoting the wellbeing of lesbian, gay, bisexual and transgender forced migrants in Canada: providers' perspectives. *Culture, Health and Sexuality*, *19*(10), 1165–1179. https://doi.org/10.1080/13691058.2017.1298843 | Canada | Legal providers, mental health providers, advocates, resettlement workers, and private sponsors | Both | | Refugee | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Kellett, P., & Fitton, C. (2017). Supporting transvisibility and gender diversity in nursing practice and education: embracing cultural safety. *Nursing Inquiry*, *24*(1), 1–7. https://doi.org/10.1111/nin.12146 | Canada | Nursing | | Trans sexual | | Discussion paper |
| Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming health care environments. *Sexual Health*. https://doi.org/10.1071/SH16145 | Canada and USA | Health care | | LGBTQ (in silo) | | Research article |
| Khanlou, N., Haque, N., Skinner, A., & Landy, K. (2017). Scoping review on maternal health among immigrants and visible minority women in Canada: Postnatal Care (in progress). *Journal of Pregnancy*, *2017*, 1–14. https://doi.org/10.1155/2017/8783294 | Canada | Health care (Maternal Nursing) | | | Migrants (in silo) | Research article |
| Lee, E. O. J. (2019). Responses to structural violence: The everyday ways in which queer and trans migrants with precarious status respond to and resist the Canadian immigration regime. *International Journal of Child, Youth and Family Studies*, *10*(1), 70–94. https://doi.org/10.18357/ijcyfs101201918807 | Canada | Social worker and community organizers | Both | | | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Lee, E. O. J., Kamgain, O., Hafford-Letchfield, T., Gleeson, H., Pullen-Sansfaçon, A., & Luu, F. (2021). Knowledge and policy about LGBTQI migrants: A scoping review of the Canadian and global context. *Journal of International Migration and Integration*, *22*(3), 831–848. https://doi.org/10.1007/s12134-020-00771-4 | Canada | | Both | | Migrants | Research article (Scoping review) |
| Lee, E. O. J., & Brotman, S. (2011). Identity, refugeeness, belonging: Experiences of sexual minority refugees in Canada. *Canadian Review of Sociology*, *48*(3), 241–274. | Toronto and Montreal, Canada | Social worker and community organizers | Post | | Refugee | Research article |
| Lee, E. O. J., & Brotman, S. (2013). Speak out! Structural intersectionality and anti-oppressive practice with LGBTQ refugees in Canada. *Canadian Social Work Review*, *30*(2), 157–183. Retrieved from http://www.jstor.org/stable/43486768 | Toronto and Montreal, Canada | Social worker and community organizers | Post | | Refugee | Research article |
| Lewis, R. A., & Naples, N. A. (2014). Introduction: Queer migration, asylum, and displacement. *Sexualities*, *17*(8), 911–918. https://doi.org/10.1177/1363460714552251 | General | None | Both | | Migrants | Discussion paper |
| Lim, F. A., & Hsu, R. (2016). Nursing Students' Attitudes Toward Lesbian, Gay, Bisexual, and Transgender Persons: An Integrative Review. *Nursing Education Perspectives*, *37*(3), 144–152. https://doi.org/10.1097/01.NEP.0000000000000004 | | Nursing | | LGBTQ (in silo) | | Research article (Integrative lit review) |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Lim, F. A., Brown, D. V, & Kim, S. M. J. (2014). Addressing Health Care Disparities in the Lesbian, Gay, Bisexual, and Transgender Population: A Review of Best Practices. *The American Journal of Nursing*, *114*(6), 24–34. https://doi.org/10.1097/01.NAJ.0000450423.89759.36 | Canada and USA | Social and Health care in general | | LGBTQ (in silo) | | Discussion paper |
| Logie, C. H., Lacombe-Duncan, A., Lee-Foon, N., Ryan, S., & Ramsay, H. (2016). "It's for us -newcomers, LGBTQ persons, and HIV-positive persons. You feel free to be": A qualitative study exploring social support group participation among African and Caribbean lesbian, gay, bisexual and transgender newcomers and refugees in Toronto. *BMC International Health and Human Rights*, *16*(1), 1–10. https://doi.org/10.1186/s12914-016-0092-0 | Canada | Social and Health care in general | Post | | Newcomer and Refugees | Research article |
| Logie, C. H., Lacombe-Duncan, A., Persad, Y., Ferguson, T. B., Yehdego, D. M., Ryan, S., … Guta, A. (2019). The TRANScending love arts-based workshop to address self-acceptance and intersectional stigma among transgender women of color in Toronto, Canada: Findings from a qualitative implementation science study. *Transgender Health*, *4*(1), 35–45. https://doi.org/10.1089/trgh.2018.0040 | Canada | Social Work | Post | Trans | Migrants | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| MacDonnell, J. A., & Daley, A. (2015). Examining the Development of Positive Space in Health and Social Service Organizations: A Canadian Exploratory Study. *Journal of Gay & Lesbian Social Services*, 27(3), 263–301. https://doi.org/10.1080/10538720.2015.1040186 | Canada | Organizations | Both | | Racialized and newcomer | Research article |
| MacDonnell, J. A., Dastjerdi, M., Bokore, N., & Khanlou, N. (2012). Becoming Resilient: Promoting the Mental Health and Well-Being of Immigrant Women in a Canadian Context. *Nursing Research and Practice*, *2012*, 1–10. https://doi.org/10.1155/2012/576586 | Canada | Health care (Nursing scholars) | Post | ** | Immigrant | Research article |
| MacDonnell, J. A., Dastjerdi, M., Bokore, N., Tharao, W., Khanlou, N., & Njoroge, W. (2017). "Finding a space for me outside the stereotypes": Community engagement in policy and research to foster Canadian racialised immigrant women's mental health and well-being. *International Journal of Mental Health and Addiction*, *15*(4), 738–752. https://doi.org/10.1007/s11469-017-9776-5 | Canada | Health care (Nursing scholars) | | | Immigrant | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| MacDonnell, J. A., Dastjerdi, M., Khanlou, N., Bokore, N., & Tharao, W. (2016). Activism as a feature of mental health and wellbeing for racialized immigrant women in a Canadian context. *Health Care for Women International*, *38*(2), 187–204. https://doi.org/10.1080/07399332.2016.1254632 | Canada | Health care | | ** | Immigrant | Research article (Scoping review) |
| Mangrio, E., & Sjögren Forss, K. (2017). Refugees' experiences of healthcare in the host country: a scoping review. *BMC Health Services Research*, *17*(1), 814. https://doi.org/10.1186/s12913-017-2731-0 | General | Social and Health care in general | Post | | Refugee → Immigrant (in silo) | Research article (Scoping review) |
| Massaquoi, N. M. (2020). *No Place Like Home: African Refugees and the Making of a New Queer Identity*. https://tspace.library.utoronto.ca/bitstream/1807/103314/3/Massaquoi_Notisha_202011_PhD_thesis.pdf | Canada | Social service workers | Post | Queer identities | Refugee → Immigrant | PhD Thesis |
| McDowell, A., & Bower, K. M. (2016). Transgender Health Care for Nurses: An Innovative Approach to Diversifying Nursing Curricula to Address Health Inequities. *Journal of Nursing Education*, *55*(8), 476–479. https://doi.org/10.3928/01484834-20160715-11 | USA | Nursing students | | Trans | | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Merryfeather, L. (2011). A personal epistemology: Towards gender diversity. *Nursing Philosophy*, *12*(2), 139–149. https://doi.org/10.1111/j.1466-769X.2010.00469.x | Canada | Nursing and allied health care | | Trans | | Discussion paper |
| Merryfeather, L., & Bruce, A. (2014). The invisibility of gender diversity: Understanding transgender and transsexuality in nursing literature. *Nursing Forum*, *49*(2), 110–123. https://doi.org/10.1111/nuf.12061 | Canada | Nurses and allied Health care | | Trans-visibility | | Discussion paper |
| Muelle, C. E., & Ramírez, J. A. B. (2019). Intersectionality and LGBTI public policies in Colombia: Uses and displacements of a critical notion. In O. Hankivsky & J. S. Jordan-Zachery (Eds.), *The Palgrave Handbook of Intersectionality in Public Policy* (pp. 489–510). Switzerland: Palgrave Macmillan. | Colombia | Policy and activists | Pre | | | Book chapter |
| Mulé, N. J., & Smith, M. (2014). Invisible populations: LGBTQ people and federal health policy in Canada. *Canadian Public Administration*, *57*(2), 234–255. https://doi.org/10.1111/capa.12066 | Canada | Health policy and federal policy makers | | LGBTQ (in silo) | | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Munro, L., Travers, R., St. John, A., Klein, K., Hunter, H., Brennan, D., & Brett, C. (2013). A bed of roses?: Exploring the experiences of LGBT newcomer youth who migrate to Toronto. *Ethnicity and Inequalities in Health and Social Care*, *6*(4), 137–150. https://doi.org/10.1108/EIHSC-09-2013-0018 | Canada | Social worker | Both | | Refugee → Immigrant | Research article |
| Murphy, T. (2009). No man's land. *Out*, *17*(10), 58-157. | Canada | | Both | | Asylum seekers and refugees | Newspaper articles |
| Murray, D. A. B. (2014). Real queer: "authentic" LGBT refugee claimants and homonationalism in the Canadian refugee system. *Anthropologica*, *56*(1), 21–32. https://doi.org/10.1353/ant.2014.0027 | Canada | Social workers and lawyers | Post | | Refugee | Research article |
| Murray, D. A. B. (2014). The Challenge of home for sexual orientation and gendered identity refugees in Toronto. *Journal of Canadian Studies*, *48*(1), 132–152. https://doi.org/10.1353/jcs.2014.0019 | Canada | Social work | Post | | Refugee | Research article |
| Mustafa, M. (2018). *Confidential publics: Digital reconciliation and queer Muslim identities*. Western Michigan University. | USA | | | | Migrants/ Muslims | Master's Theses |
| Nagington, M. G. (2016). Judith Butler's theories: reflections for nursing research and practice. *Nursing Philosophy*, *17*(4), 307–316. https://doi.org/10.1111/nup.12134 | England | Nursing | | LGBTQ (in silo) | | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Nakamura, N., Chan, E., & Fischer, B. (2013). "Hard to Crack": Experiences of Community Integration Among First-and Second-Generation Asian MSM in Canada. *Cultural Diversity and Ethnic Minority Psychology*, *19*(3), 248–256. https://doi.org/10.1037/a0032943 | Canada | Mental Health care | Post | | Immigrant | Research article |
| Nama, N., MacPherson, P., Sampson, M., & McMillan, H. J. (2017). Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: A survey study. *Medical Education Online*, *22*(1), 1–8. https://doi.org/10.1080/10872981.2017.1368850 | Canada | Medical students | | LGBTQ (in silo) | | Research article |
| O'Neill, B. (2010). Challenges faced by lesbian, gay and bisexual newcomers: implications for services. *Social Work*, *12*(1), 24–31. | Canada | Social service workers | Post | | Newcomer | Research article |
| Pollock, G., Newbold, B. K., Lafrenière, G., & Edge, S. (2012). Discrimination in the doctor's office: Immigrants and refugee experiences. *Critical Social Work*, *13*(2), 60–79. Retrieved from http://www1.uwindsor.ca/criticalsocialwork/discriminationdoctoroffice | Canada | Social and Health care in general | | | Immigrant (in silo) | Research article |
| Rinaldi, J., & Fernando, S. (2019). Queer credibility in the homonation-state: Interrogating the affective impacts of credibility assessments on racialized sexual minority refugee claimants. *Refuge: Canada's Journal on Refugees*, *35*(1), 32–42. | Canada | Legal and social work | Post | | Refugee | Discussion paper |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Rosenberg, B. J. S. (2015). "Like a Stray Dog on the Street": Trans* refugees encounter further violence in the cities where they flee. *LGBTQ Policy Journal*, *6*, 76–88. | Host countries | Service workers | Both | | Asylum seekers and refugees | Research article |
| Rousseau, C., Kuile, S. ter, Munoz, M., Nadeau, L., Ouimet, M.-J., Kirmayer, L., & Crépeau, F. (2008). Health care access for Hoosiers. *Canadian Medical Association Journal*, *99*(4), 290–292. Retrieved from https://liverpool.idm.oclc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=104493719&site=ehost-live&scope=site | Canada | Health care | | | Refugee → Immigrant (in silo) | Research article |
| Sansfaçon, A. P., Hébert, W., Lee, E. O. J., Faddoul, M., Tourki, D., & Bellot, C. (2018). Digging beneath the surface: Results from stage one of a qualitative analysis of factors influencing the well-being of trans youth in Quebec. *International Journal of Transgenderism*, *19*(2), 184–202. https://doi.org/10.1080/15532739.2018.1446066 | Canada (Montreal) | Social worker and community organizers | | Trans | Some racialized and migrants | Research article |
| Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: A scoping review. *Administration and Policy in Mental Health and Mental Health Services Research*. https://doi.org/10.1007/s10488-021-01183-x | Canada | Mental Health care | Both | | Immigrant and refugees | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. https://doi.org/10.1111/inm.12512 | Canada | Mental Health care | | | Immigrant (in silo) | Research article |
| Shirpak, K. R., Maticka-Tyndale, E., & Chinichian, M. (2007). Iranian Immigrants' perceptions of sexuality in Canada: A symbolic interactionist approach. *Canadian Journal of Human Sexuality*, *16*(3–4), 113–128. Retrieved from http://www.scopus.com/inward/record.url?eid=2-s2.0-39749184079&partnerID=tZOtx3y1 | Canada | Service providers | | | Immigrant (in silo) | Research article |
| Shishehgar, S., Gholizadeh, L., DiGiacomo, M., & Davidson, P. M. (2015). The impact of migration on the health status of Iranians: An integrative literature review. *BMC International Health and Human Rights*, *15*(1). https://doi.org/10.1186/s12914-015-0058-7 | General | Social and Health care in general | | | Immigrant (in silo) | Research article (Integrative lit review) |
| Shuman, A., & Bohmer, C. (2014). Gender and cultural silences in the political asylum process. *Sexualities*, *17*(8). https://doi.org/10.1177/1363460714552262 | USA | Activist and social workers | Post | | Asylum Seekers | Literature Review |
| Silberholz, E. A., Brodie, N., Spector, N. D., & Pattishall, A. E. (2017). Disparities in access to care in marginalized populations. *Current Opinion in Pediatrics*, *29*(6), 718–727. https://doi.org/10.1097/MOP.0000000000000549 | Canada | Health care | | LGBTQ (in silo) | Immigrant (in silo) | Literature Review |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Singer, R. B. (2015). LGBTQ focused: Can inclusion be taught? *International Journal of Childbirth Education*, *30*(2), 17–20. | | Social and Health care in general | | LGBTQ (in silo) | | Discussion paper |
| Sirota, T. (2013). Attitudes Among Nurse Educators Toward Homosexuality. *Journal of Nursing Education*, *52*(4), 219–227. https://doi.org/10.3928/01484834-20130320-01 | USA | Nursing Educator | | LGBTQ (in silo) | | Research article |
| Smith, S. K., & Turell, S. C. (2017). Perceptions of healthcare experiences: relational and communicative competencies to improve care for LGBT people. *Journal of Social Issues*, *73*(3), 637–657. https://doi.org/10.1111/josi.12235 | USA | Health care | | LGBTQ (in silo) | | Research article |
| Stewart, K., & Reilly, P. O. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Education Today*, *53*(July 2016), 67–77. https://doi.org/10.1016/j.nedt.2017.04.008 | United States, Canada, Australia, New Zealand, Scandinavia, the United Kingdom and Ireland. | Nurses and allied Health care | | LGBTQ (in silo) | | Research article |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Strong, K. L., & Folse, V. N. (2015). Assessing undergraduate nursing students' knowledge, attitudes and cultural competence in caring for lesbian, gay, bisexual, and transgender patients. *Journal of Nursing Education*, *54*(1), 45–49. https://doi.org/http://dx.doi.org/10.3928/01484834-20141224-07 | Canada | Nursing students | | LGBTQ (in silo) | | Research article |
| Talebi, M., & Desjardins, M. (2012). The Immigration Experience of Iranian Baha'is in Saskatchewan: The Reconstruction of Their Existence, Faith, and Religious Experience. *Journal of Religion and Health*, *51*(2), 293–309. https://doi.org/10.1007/s10943-010-9351-x | Canada | Service providers | | | Immigrant (in silo) | Research article |
| Tanner, A. E., Reboussin, B. A., Mann, L., Ma, A., Song, E., Alonzo, J., & Rhodes, S. D. (2014). Factors influencing health care access perceptions and care-seeking behaviors of immigrant Latino sexual minority men and transgender individuals: Baseline findings from the HOLA intervention study. *Journal of Health Care for the Poor and Underserved*, *25*(4), 1679–1697. https://doi.org/10.1353/hpu.2014.0156 | USA | Health care | Both | | Immigrant | Research article |
| Thurman, W. A., Johnson, K. E., & Sumpter, D. F. (2019). Words matter: An integrative review of institutionalized racism in nursing literature. *Advances in Nursing Science*, *42*(2), 89–108. https://doi.org/10.1097/ANS.0000000000000265 | | Nursing | | | Racism | Literature Review |

| Article | Country | Profession | LGBTQI+ Migration | LGBTQI+ (silo) | Migration status | Format |
|---|---|---|---|---|---|---|
| Vogler, S. (2016). Legally queer: The construction of sexuality in LGBQ asylum claims. *Law and Society Review, 50*(4). https://doi.org/10.1111/lasr.12239 | USA | Advocates and Law | Post | | Asylum Seekers | Research article |
| Von Vogelsang, A. C., Milton, C., Ericsson, I., & Strömberg, L. (2016). 'Wouldn't it be easier if you continued to be a guy?' – a qualitative interview study of transsexual persons' experiences of encounters with Healthcare. Journal of Clinical Nursing, 25(23–24), 3577–3588. https://doi.org/10.1111/jocn.13271 | Swedish | Health care | | Trans sexual | | Research article |

*The word silo means the selected resource discussed the topic individually. For example, immigration in silo means that the authors only focused on immigration and not on gender, sex, and sexuality.

** Some self-identified as same-sex and lesbian