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Still, We Thrive: Understanding How Gay, Bisexual, Transgender, and Other Men Who Have Sex with Men (GBTMSM) Experience Structural Barriers & Facilitators to Wellness

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By

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Abstract

Historically and concurrently, structural violence has been a significant force influencing the sexual health and broader health of gay, bisexual, transgender and other men who have sex with men (GBTMSM). Yet to date, the majority of projects exploring the health inequities facing GBTMSM have focused on intrapsychic and behavioural factors as most related to poor health outcomes. As well, these studies are sometimes deficits focused, and fail to evaluate how GBTMSM continue to thrive, and maintain positive health. As a result, the ways in which systems and policies underlie and perpetuate health inequities facing GBTMSM have been somewhat obscured. Connectedly, little is known about the relevance of 2SLGBTQIA+ affirming systems and policies for the wellbeing of GBTMSM. As such, this study seeks to expand on the scarce qualitative literature exploring how systems and policies may act as structural barriers and facilitators to wellness for GBTMSM. 30 GBTMSM with diverse ethnoracial identities, gender identities, HIV statuses and ages from across Southwestern Ontario (five per region) were purposively sampled through local AIDS service organizations (ASOs), other agencies and services who serve GBTMSM, and through social media platforms, including Instagram and Facebook. Semi-structured/narrative blended interviews were implemented to characterize how systems and policies serve as barriers and facilitators to wellness. Particular questions tended to favour a structural-level analysis, asking participants to reflect on their experiences with heteronormativity and/or cisnormativity, racism, healthcare access, sexual health education, and community cohesion. An inductive latent thematic approach following Braun & Clark's Six Phases was employed to develop a coding grid, where a final set of themes were identified. Knowledge produced through this project will be used to identify tangible points for systems change, where greater 2LGBTQ+ affirming policies and services can be introduced.

Keywords: structural violence, gay, bisexual, transgender, MSM, HIV, wellness

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GBTMSM living in SW Ontario and beyond. I can't thank you enough for your openness, vulnerability and strength demonstrated during these interviews. I promise to continue using these findings to push for meaningful changes in SW Ontario and beyond.

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Research Preface

Recognizing the limited qualitative literature exploring how systems and policies impact the sexual health and broader health of gay, bisexual, trans and other men who have sex with men (GBTMSM), the proposed research project seeks to understand the influence of structural-level factors as facilitators and barriers to wellness for GBTMSM. By use of semi-structured qualitative interviews with 30 GBTMSM from across the Southwestern (SW) Ontario region, the researcher sought to elucidate narrative accounts that detail how heteronormativity, cisnormativity, racism and/or societal policies and attitudes that challenge these forces may relate to the presence or absence of 2SLGBTQ+-affirming systems and policies, and by association, 2SLGBTQ+-specific healthcare and social services. As well, these interviews sought to understand how GBTMSM continue to thrive and maintain positive health despite the potential impact of structural violence on the wellbeing of GBTMSM. Ultimately, by considering how structural-level factors may serve as both barriers and facilitators to wellness, the researcher sought to emphasize the importance of considering not only the relevance of individual behaviours and community attitudes for wellbeing, but also the importance of systems and policies for creating overall climates where achieving positive wellbeing may be more challenging for those with intersecting marginalized identities.

Still, We Thrive: Understanding How Gay, Bisexual, Transgender, and Other Men Who Have Sex with Men (GBTMSM) Experience Structural Barriers & Facilitators to Wellness

Structural violence, those powers which seek to maintain and reproduce social inequalities and oppressions by normalizing marginalization and erasure as the status quo, placing the blame on individuals and communities for their problems (Dutta et al., 2016), is a significant force influencing the sexual health and broader health of GBTMSM. Broadly,

structural violence manifests in the lives of GBTMSM as widespread heteronormativity and/or cisnormativity, or the processes by which institutionalized and normative heterosexuality and cisgenderism regulates those kept within in its boundaries while marginalizing and sanctioning those outside of them (Munro & Travers, 2020). In particular, heteronormativity and cisnormativity serve to perpetuate historical and ongoing structural stigmatization and discrimination along the lines of sexual orientation and gender identity (Hatzenbuehler, 2014; Bauer et al., 2009; Enson, 2015), and also related to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (Lane et al., 2004; Levy et al., 2014). Moreover, recognizing intersectionality, or the ways in which multiple and overlapping identities interact to create a number of privileges or disadvantages (Collins, 2019), facilitates an analysis that better recognizes how structural violence manifests uniquely amongst GBTMSM who experience additional marginalization according to their race, for example (see Ro et al., 2013; Levy et al., 2014). In fact, the systemic racism faced by Black, Indigenous, People of Colour (BIPOC) GBTMSM both from inside and outside of the larger 2SLGBTQ+ community sustains reduced access to healthcare and social services, in part, explaining the disproportionate HIV burden facing BIPOC GBTMSM (Phillips II et al., 2021; Wilson et al., 2016).

Reviewing the ongoing HIV/AIDS epidemic facing GBTMSM is an important starting point for understanding the mechanisms through which structural violence has historically and concurrently influenced the health of this group. In the early 1980s, when the HIV/AIDS epidemic first emerged in North America, the majority of individuals presenting with AIDS-related symptomatology were GBTMSM, compelling service providers and researchers to conflate the disease with queerness, in part explaining the early labelling of HIV/AIDS as gay-related immunodeficiency (GRID) (Powell et al., 1998). As well, a largely conservative society

imposed a moral lens on the HIV epidemic, shifting the blame of acquiring HIV onto the individual (Powell et al., 1998). One can argue that this conflation of HIV/AIDS with queerness worked to justify the lack of attention and urgency directed towards HIV/AIDS research, prevention, and treatment regimes, furthering the harm experienced by GBTMSM during this era (Powell et al., 1998). Moving into the mid 90s and early 2000s, anti-retroviral therapy (ART) drastically improved the experiences and outcomes of those diagnosed with HIV (Olding et al., 2017). However, structural violence contributed to ongoing barriers to accessing and adhering to treatment regimes. In particular, research suggests that homophobia, racism, stigma, and discrimination, especially when codified by law, social mores or religious institutions may act as barriers for ART uptake and adherence, in part, explaining limited treatment initiation and adherence by Black, Indigenous and GBTMSM of a lower socioeconomic status (SES) (Christopoulos et al., 2011). From the year 2008 onward, the development of pre-exposure prophylaxis (PrEP), a daily preventative pill that reduces the likelihood of contracting HIV by upwards of 90% (Wilton et al., 2018) has provided a solution for reducing rates of HIV transmission amongst GBTMSM. However, uptake remains relatively low, especially among GBTMSM in non-metropolitan regions (Region of Waterloo Public Health & Emergency Services, 2018). Additionally, disparities to access similar to those related to ART persist, highlighting that PrEP is most accessible for GBTMSM who do not face additional discrimination according to their race, class, or gender identity (Pérez-Figueroa, et al., 2015; Poteat et al., 2016).

Alongside these structural inequities, GBTMSM in Canada have also experienced significant structural advances that have contributed to their positive sexual health and broader health. For instance, in 1969 Bill C-150 was introduced, decriminalizing homosexuality and in

turn, contributing to a climate where LGBTQ+ individuals felt safer to disclose their sexual orientation and/or gender identity (Smith, 2020). In addition, the declassification of homosexuality as a mental disorder in the Diagnostic and Statistical Manual (DSM) in 1973 sought to depathologize queerness and began to redirect psychology and psychiatry's attention toward promoting positive mental health among non-heterosexual individuals (Coleman, 1978; Cass, 1979). Further, in the 1980s and 1990s sexual orientation and gender identity have been incorporated into Ontario and Canada's Human Rights Codes, establishing a solid foundation for preserving the rights and liberties of 2SLGBTQIA+ individuals (Smith, 2020). These measures set the stage for the legalization of same-sex civil marriage across Canada in 2005 (Smith, 2020).

Since 2005, more inclusive legislation has been introduced, such as Bill C-16, which provides protections for transgender, non-binary, and gender non-conforming (GNC) people on the grounds of both gender identity and gender expression (Government of Canada, 2022). Beyond the establishment of same-sex marriage rights and specific considerations for trans people in Canada, more recently, under Bill C-4, Canada banned conversion therapy, making it illegal to use homophobia, biphobia, and/or transphobia against 2SLGBTQ+ people, reflecting a structural shift away from practices seeking to reproduce heteronormativity and cisnormativity (Government of Canada, 2021). Together, structural advances such as these contribute to the normalization of queerness and transness, reducing the stigmatization and resulting discrimination experienced by the 2SLGBTQIA+ community, inclusive of GBTMSM. Interestingly, research exploring the implications of such policy advances highlights that the implementation of same-sex marriage and anti-discrimination laws may serve to attenuate the effects of institutionalized stigma on 2SLGBTQIA+ individuals, underscoring the significance of

structural advances for contributing to the wellbeing of 2SLGBTQIA+ people, inclusive of GBTMSM (Buffie, 2011).

Rationale

Extant literature exploring the sexual health and broader health of GBTMSM often employs an intrapsychic (i.e., concerned with individual behaviours, emotions, and thoughts) and deficits-focused lens that tends to centralize individual behavioural management as most significant for reducing the HIV burden facing the GBTMSM community. As a consequence, these projects have somewhat obscured how structural factors may contribute to the health inequities facing GBTMSM. In addition, despite major structural advances for GBTMSM, the majority of projects exploring the sexual health and broader health of this community are often deficits focused, failing to examine how 2SLGBTQIA+-affirming policies may contribute to the positive health of GBTMSM. As a result, there is minimal extant literature examining how GBTMSM thrive and continue to maintain positive health and wellness. Accordingly, research recognizing how individual-level factors may contribute to health inequities that also interrogates how systems and structures continue to influence GBTMSM is needed to identify tangible points for systems change that better situate GBTMSM sexual health and broader health within heteronormative, cisnormative and racist climates.

The majority of studies characterizing the sexual health and broader health of GBTMSM are quantitative in nature, and come from large metropolitan centres, such as Toronto. As a result, in-depth, region-specific data is lacking, and local 2SLGBTQIA+ organizations and services working to serve GBTMSM are compelled to rely on data that may not be generalizable to the GBTMSM in their regions. To best inform GBTMSM service provision across the SW Ontario region, it is pertinent that qualitative data recognizing how relevant factors (e.g., rurality)

may be associated with unique health outcomes especially for those with overlapping marginalized identities is gathered.

Purpose Statement(s)

Following these outlined gaps in the extant literature, this project is guided by three overarching purpose statements: 1) to move beyond the limitations of existing projects that overemphasize an intrapsychic lens by prioritizing a structural level analysis that investigates how systems and policies might underlie health inequities facing GBTMSM above and beyond individual behaviour; 2) to understand how GBTMSM maintain positive sexual, mental and physical health despite the potential impacts of structural violence; and 3) by gathering narrative accounts, researchers can delve deeper into the lived experiences of GBTMSM, understanding intersectional complexities influencing the sexual health and broader health of GBTMSM who face additional marginalization according to overlapping marginalized identities.

Literature Review

Approach

The breadth of this project is quite extensive, and accordingly, it is essential that the researcher takes the time to elucidate existing literature and relevant analysis vantage points for studying the sexual health and broader health of GBTMSM. For this project, five primary areas of interest should be reviewed to contextualize the research goals and method most effectively: 1) The Sexual Health & Broader Health of GBTMSM in Canada; 2) Overlapping Epidemics: GBTMSM, Sexual Health, Mental Health, and Substance Use; 3) Structural and Systemic Considerations for GBTMSM; 4) Non-Metropolitan & Rural GBTMSM; and 5) HIV Incidence/Prevalence in SW Ontario.

The Sexual Health & Broader Health of GBTMSM in Canada

It has been well-established that GBTMSM experience significantly worse health than their heterosexual and/or cisgender counterparts. In particular, research from the United States has demonstrated that GBTMSM face high rates of psychosocial problems, including depression, anxiety, polysubstance use, adverse childhood events (ACEs) and intimate partner violence (IPV) (Cochran et al., 2016; Stall et al., 2003; Parsons et al., 2012; Herrick et al., 2013). Moreover, GBTMSM continue to demonstrate disproportionate rates of sexually transmitted infections and HIV in comparison to their heterosexual and/or cisgender counterparts (Wolitski & Fenton, 2011). In the Canadian context, similar health inequities have been reported. For instance, in a study comparing a number of health behaviours and outcomes amongst gay, bisexual, and heterosexual men, researchers described that gay and bisexual men reported a significantly higher prevalence of mood or anxiety disorders and were significantly more likely to report a history of lifetime suicidality (Brennan et al., 2010). In fact, gay and bisexual men were four and six times more likely to report having ever seriously considering suicide in comparison to heterosexual men (Brennan et al., 2010). Furthermore, gay men in Canada are disproportionately impacted by sexually transmitted and blood-borne infections (STBBIs), with 26.6% of gay men reporting having ever been diagnosed with an STBBI compared to only 5.4% of heterosexual men (Brennan et al., 2010). Connectedly, despite being estimated to represent only 2.1% of Canadians (Tjepkema, 2008), GBTMSM account for the highest percentage of new HIV diagnoses in Ontario at 58.8% (Wilton et al., 2016).

Contributing to these adverse health outcomes, research demonstrates that GBTMSM in Canada experience significant barriers to accessing healthcare and social services, representing challenges in accessing HIV and STBBI testing, 2SLGBTQIA+ informed care, and social

support networks more generally (Tjepkema, 2008). In particular, data from the OutLook study describes that in the Kitchener-Waterloo region of Ontario, less than half (45.5%) of GBTMSM felt that there were enough sexual health services in the region that met their needs (Region of Waterloo Public Health and Emergency Services, 2018). Specifically, inaccessible opening hours and locations and a lack of 2SLGBTQIA+ specific sexual health services and competencies in local healthcare professionals were described as barriers to accessing competent and validating care (Region of Waterloo Public Health and Emergency Services, 2018). Alarmingly, these barriers to accessing healthcare services seem to be exacerbated for GBTMSM who use substances. In fact, Souleymanov et al., (2020) describe that amongst a sample of GBTMSM who use drugs in Toronto, medical mistreatment and stigmatizing environments serve as barriers for disclosing potentially sensitive health information. Because of these stigmatizing environments, GBTMSM may avoid accessing healthcare and social services altogether, perpetuating an unnecessary burden of harm (Souleymanov et al., 2020).

Overlapping Epidemics: GBTMSM, Sexual Health, Mental Health, and Substance Use

Although it is clear that GBTMSM in Canada experience significant health inequities, the ways in which these various health disparities overlap and interact to form pathways contributing to poor health outcomes is less well understood. An important emerging research area in the GBTMSM sexual health and broader health sector is based on “syndemics”, a concept introduced by Singer (2009) to characterize the set of enmeshed and mutually enhancing health problems that synergistically, in a context of precarious social and physical conditions, influence the overall disease burden and health of a population. In the context of GBTMSM sexual health and broader health, the syndemics framework has most commonly been applied to better contextualize the disproportionate HIV incidence facing GBTMSM as coexisting amongst other

psychosocial challenges. In particular, by exploring how overlapping health inequities, or syndemic indicators, such as disproportionate rates of IPV and ACEs (Tulloch et al., 2015) might contribute to HIV risk by way of higher engagement in condomless anal intercourse (CAI) amongst GBTMSM, researchers seek to underscore the relevance of conceptualizing the physical, mental, and sexual health of GBTMSM as interrelated (Singer, 2009).

Research exploring GBTMSM-related syndemics in the Canadian context highlights that an increased number of syndemic indicators is associated with greater engagement in CAI with a serodiscordant (HIV status differs from their own) partner in the previous three months (Hart et al., 2017). Connectedly, qualitative projects seeking to better characterize the specific pathways by which these syndemic indicators influence the health of GBTMSM have elucidated the significance of the relationship between historical traumas and current health-related behaviours. In particular, Adam et al. (2017) demonstrates that, among a sample of GBTMSM in Toronto, the synergism of ACEs with later episodes of depression or substance use is a primary pathway for HIV-related risk behaviour. Moreover, it seems that migration and the transition from family to post-secondary school or work represent minor modal pathways toward heightened HIV risk (Adam et al., 2017). In the American context, Egan et al. (2011) reported similar findings, suggesting that migration from a smaller region to a larger urban centre and/or familial rejection are associated with depression or substance use, and as a result, heightened HIV risk.

Further studies have included an intersectional analysis, exploring how the syndemic affecting GBTMSM may manifest uniquely amongst BIPOC GBTMSM, GBTMSM living with HIV (LWH), and trans gay, bisexual, and other men who have sex with men (GBMSM). For syndemics research focusing on BIPOC GBTMSM, research has most commonly emphasized the importance of recognizing the role of systemic racism and race-related discrimination for

comprehensively understanding HIV risk amongst BIPOC GBTMSM. For instance, Quinn (2019) proposes an intersectional syndemic lens for Black GBTMSM, describing those experiences of sexual and race-related marginalization that create barriers to accessing HIV knowledge and care, meanwhile, rigid masculinity norms, homophobia, White-centred systems and internalized homonegativity serve to exacerbate existing disparities facing Black GBTMSM. As well, Black GBTMSM are privier to the oppression of interlocking systems, such as community violence, criminal justice involvement and unaddressed mental health needs (Quinn, 2019). Similarly, Wilson et al. (2014) posits that structural, social, and biological factors interact in the context of social marginalization to put Black and Latino GBTMSM at higher risk for HIV. In particular, researchers demonstrate that the synergism of substance abuse, trauma, incarceration, and poverty in part, explains the disproportionate HIV burden facing Black and Latino GBTMSM in New York City (Wilson et al., 2014). Importantly, Wilson et al. (2016) implicates resilience within the HIV-related syndemic facing Black GBTMSM, demonstrating that hardiness and adaptive coping may play a significant role in reducing the HIV risk facing Black GBTMSM above and beyond social support.

Although the HIV-related syndemics literature concerned with trans GBMSM is somewhat limited, research here most commonly seeks to characterize how cisnormativity might create barriers to accessing healthcare and social services. In particular, Poteat et al. (2016) demonstrates that community-level and structural-level discriminatory laws which discourage trans GBMSM from accessing sexual health services might minimize HIV testing and care. However, social gender transitioning may serve as a protective factor, reducing the influence of syndemic indicators on wellbeing (Poteat et al., 2016).

In comparison, for GBTMSM LWH, literature commonly explores how psychosocial problems may influence treatment initiation and adherence. In particular, Friedman et al. (2015) highlight the association between syndemic count and ART adherence, demonstrating that in a sample of men who have sex with men (MSM) from Los Angeles, Pittsburgh, Chicago, and Baltimore, when more syndemic indicators are present, lower adherence is reported. As well, syndemic count was highly associated with a high viral load (VL), most especially for BIPOC GBTMSM, GBTMSM of a lower SES and recently diagnosed GBTMSM living with HIV. Pantalone et al. (2016) report a similar situation amongst MSM in Northwestern United States, demonstrating that the presence of syndemic indicators serves as a barrier to ART adherence, positive health, and healthcare utilization. In particular, those reporting three or four indicators had a more than three-fold increase of being non-adherent to ART (Pantalone et al., 2016). In addition, recognizing that little is known about the effects of the HIV-related syndemic on GBTMSM LWH beyond poor ART adherence, Harkness et al. (2019) sought to explore the most common syndemic indicators and their correlations with CAI amongst GBMSM LWH in the Boston, Massachusetts region. The researchers reported that ACEs, post-traumatic stress disorder (PTSD), anxiety and polysubstance use were the most common syndemic indicators, and a substantial amount of GBTMSM LWH reported two, three, or four of these indicators (Harkness et al., 2019). As well, between 27%-43% of the sample reported serodiscordant (HIV-status differs from their own) CAI; the likelihood of CAI increased by 1.34 with each additional syndemic indicator (Harkness et al., 2019).

An additional useful lens for interpreting the overlapping health problems experienced by GBTMSM is the concept of minority stress, introduced by Meyer (1995) to characterize the chronic stress experienced by LGBTQ+ individuals facing consistent marginalization and

discrimination. Broadly, this experienced stress includes societal and community stigmatization, the internalization of this stigmatization, or internalized homophobia/transphobia, and those actual experiences of prejudice and violence (Meyer, 1995). In 2003, Meyer expanded on their initial proposition, describing that via the social stress experienced under prejudicial and hostile societal environments, LGBTQ+ individuals face a higher prevalence of mental health problems than their heterosexual/cisgender counterparts (Meyer, 2003).

For GBTMSM-related research, the minority stress framework has been implemented to understand how stigmatization, discrimination and homophobic and/or transphobic societal attitudes may impact the mental, physical, and sexual health of GBTMSM across multiple levels (Hatzenbuehler & Pachankis, 2016). For instance, Bruce et al. (2015) explored minority stress in light of positive identity growth and concealment amongst gay, bisexual, queer, and other men who have sex with men (GBQMSM) in the Chicago, Illinois area. Here, experiencing stigma was associated with internalized homophobia and major depressive symptoms, while concealment stress showed a direct effect on major depression (Bruce et al., 2015). Similarly, Gibbs & Goldbach (2015) highlight that internalized homophobia is a strong predictor of suicidal behaviour and thoughts amongst LGBTQ+ individuals across the United States, most especially for those who grew up in religious contexts. Further, Reisner et al. (2015) describe that in the United States, identifying as a member of the LGBTQ+ community represents an increased propensity to struggling with alcohol, marijuana, and other substance use.

Other studies have included an intersectional lens to examine how minority stress manifests uniquely amongst BIPOC LGBTQ+ individuals who face discrimination according to their sexual orientation and/or race and gender identity. In particular, Cyrus (2017) describes that racialized LGBTQ+ individuals are adversely affected by the cumulative impacts of

discrimination and social exclusion, including racism from the LGBTQ+ community and homophobia and heterosexism from their racial/ethnic communities. As a result, BIPOC LGBTQ+ individuals are at a heightened risk for mental illness but face significant barriers to accessing quality care (Cyrus, 2017). Moreover, amongst a sample of Black GBTMSM involved in the Ballroom community in Los Angeles, Wong et al. (2014) demonstrate a significant association between distal stress, including racism and homophobia, gay identification, and internalized homophobia. However, social support and denser social networks served to moderate these associations, reducing the effects of the experienced minority stress (Wong et al., 2014).

As well, research has also demonstrated the significance of resilience and social support as attenuators for the relationship between minority stress and poor health. In particular, Breslow et al. (2015) highlight that amongst a sample of trans people from across the United States, resilience seemed to moderate the association between minority stress and psychological distress, suggesting the importance of bolstering resilience amongst trans, non-binary and GNC GBMSM. Similarly, parental acceptance and familial support have been implicated as moderators for the relationship between minority stress and poor health. Feinstein et al. (2014) describe that amongst a sample of lesbians and gay men from across New York state, the relationship between internalized homonegativity and rejection sensitivity were positively correlated with depression only for those with less accepting family members. Further, Woodford et al. (2015) describes that amongst a sample of LGBTQ+ post-secondary students at a large Midwestern United States university, exercise and having other LGBTQ+ friends moderated the effects of minority stress on mental health problems and alcohol abuse (Woodford et al., 2015). Similarly, Toomey et al. (2018) describe that amongst a sample of lesbian, gay, bisexual (LGB) young adults in the San

Francisco area, involvement with LGBTQ+ organizations, garnering new friendships and imagining a better future were associated with enhanced psychosocial adjustment and an increased likelihood of high school completion.

In the Canadian context, work by Hart et al. (2018) neatly ties together ideas from both minority stress and syndemics, highlighting that historical traumas and concurrent experiences of marginalization and discrimination are equally relevant for explaining health inequities amongst GBTMSM. In particular, by relying on the theoretical underpinnings of minority stress theory, and emerging pathways presented by syndemics theory, the researchers demonstrated an association between childhood abuse and anti-gay bullying victimization, and adult psychological distress amongst GBTMSM in Toronto (Hart et al., 2018). Studies of this sort emphasize the importance of including multiple frameworks when studying GBTMSM sexual health and broader health, as in unison, these frameworks explain more than either could on its own.

Despite the utility of syndemics and minority stress for characterizing how individual- and community-level factors influence the sexual health and broader health of GBTMSM, it remains less clear how systems and structures may underlie these factors, perpetuating health inequities above and beyond individual behaviour and community climates. Accordingly, some important questions have been raised regarding the utility of these aforementioned frameworks for explaining how structures and systems both underlie and perpetuate health inequities facing GBTMSM with other intersecting marginalized identities (see Lane et al., 2004; Quinn, 2019, Wilson et al., 2014). As well, the syndemics framework in particular may be unnecessarily stigmatizing, labelling certain individuals and behaviours as “risky” rather than interrogating why this context of heightened risk may exist in the first place.

Structural & Systemic Considerations for GBTMSM: The Importance of Intersectionality

Implicating structural and systemic variables as relevant factors influencing the sexual health and broader health of GBTMSM is vital for better contextualizing these aforementioned overlapping health disparities amongst a climate of heteronormativity, cisnormativity and racism. By doing so, research can better capture how structural level factors, such as racism, may mediate the relationship between individual behaviour and HIV transmission. For instance, Chakrapani et al. (2007) situated the health of GBTMSM in Chennai, India as existing within a web of multiple intersecting social and institutional contexts and experiences of stigmatization, discrimination and violence across police, community, family, and healthcare systems. By doing so, the researchers more accurately describe HIV risk as not inherently associated with being male-identified and having sex with other male-identified individuals, but rather, as a shortcoming of widespread societal stigmatization, discrimination and minimal healthcare services in place supporting GBTMSM in Chennai (Chakrapani et al., 2007). Similarly, Lane et al. (2004) highlight that in the United States, individual factors alone fail to explain racial or ethnic differences in HIV prevalence rates. Rather, structural violence seems to account for more of these disparities, manifested along three ecological pathways: community rates of infection, concurrent partnerships, and increased vulnerabilities (Lane et al., 2004). In addition, the researchers describe emerging structural-level risk factors, including disproportionate rates of incarceration of Black men and constraints on access to STBBI testing services as significant predictors of HIV risk above and beyond individual behaviour (Lane et al., 2004).

Furthermore, a structural lens facilitates in an analysis that recognizes how negative social responses to HIV remain pervasive in seriously affected communities, reproducing social differences according to existing inequalities of class, race, gender, and sexuality (Parker &

Aggleton, 2003). In particular, Phillips et al. (2013) demonstrates that in the North American context, the criminalization of HIV disproportionately impacts Black and Indigenous GBTMSM by reducing the social capital attained by these men, in turn, predicting lower rates of ART access and adherence. Similarly, Doyle & Molix (2016) highlight the relevance of structural violence and its association with reduced social capital for the wellbeing of GBTMSM; amongst a sample of LGBTQ+ individuals from across the United States, for those who resided in states with greater discriminatory public policy toward sexual minorities, structural violence moderated the association between discrimination and social capital, in that a higher prevalence of structural violence predicted fewer social ties and lower social support (Doyle & Molix, 2016). However, in contrast, Irvin et al. (2014) describes that amongst a sample of Black GBTMSM from Atlanta, Boston, Los Angeles, New York City, San Francisco and Washington, DC, healthcare-specific racial discrimination was positively associated with seeing a healthcare provider, suggesting that barriers beyond racial discrimination may be driving the disproportionate HIV burden facing Black GBTMSM (Irvin et al., 2014).

In addition to racism, cisnormativity and heteronormativity seem to contribute to instances of structural violence influencing the health of GBTMSM. In a study examining the health of trans GBMSM from across Ontario, a high proportion of participants had never been tested for HIV, and only one in five had been tested in the past year (Bauer et al., 2013). This lack of HIV service uptake was attributed to limited outreach and education campaigns targeted towards trans GBMSM and prior discriminatory healthcare experiences, creating barriers for trans GBMSM to access testing and care (Bauer et al., 2013). Similarly, Knight et al. (2012) describe that amongst a sample of young men and service providers in British Columbia, heteronormative discourse conflating sexual orientation with STI/HIV risk alleviated concerns

for STI/HIV exposure by virtue of their sexual identity rather than their sexual practices, minimizing discussions about sexual health. Together, these findings describe the shortcomings of cisnormativity and heteronormativity in the healthcare sector, in that these systems create environments where the sexual health needs of GBTMSM are either overlooked (Bauer et al., 2013), or overemphasized (Knight et al., 2012).

Clearly, a structural and intersectional framework is important for implicating structural violence and characterizing the experiences of racialized GBTMSM and trans GBMSM. However, the few studies integrating such a lens are conducted in large metropolitan centres, leaving some questions remaining regarding the generalizability of these findings to GBTMSM living in small to mid-sized regions.

Non-Metropolitan & Rural GBTMSM

Although it has been well-documented that many GBTMSM migrate to large urban centers upon entering early adulthood (Egan et al., 2011) a substantial portion of GBTMSM return to or remain in less populated rural areas (Kazyak, 2011), such as the SW Ontario region. It is important to highlight the heterogeneity of these less populated regions, recognizing that non-metropolitan areas often consist of densely populated suburban and urban centres alongside more sparsely populated rural areas. For instance, Hamilton, Ontario and Kitchener-Waterloo, Ontario are within the SW Ontario region, and represent the ninth and tenth most populated city centres in Canada, respectively. However, few would categorize these centres as metropolitan in comparison to Toronto, Ontario and Montreal, Quebec, Canada's two most populous metropolitan regions. In comparison, Woodstock, Ontario, a smaller city outside of London, Ontario falls much lower on this list, representing Canada's seventieth most populated city centre. Woodstock, Ontario is included in the catchment area of Regional HIV/AIDS Connection

(RHAC), an ASO in the overarching project's sample based in London, Ontario. Although Woodstock, Ontario and London, Ontario both fall within the SW Ontario region and neighbour one another, their populations vary significantly; in comparison to Woodstock, Ontario, London, Ontario represents Canada's eleventh most populated city centre. Accordingly, although RHAC is based in London, Ontario, an urban centre, the agency is tasked with engaging with GBTMSM situated in and around Woodstock, Ontario, a much more rural region. These semi-urban/rural-mixed regions are quite typical of SW Ontario and reflect the variability in population density across the SW Ontario region.

In light of these nuances related to the heterogeneity associated with non-metropolitan and rural regions, it is important to explore how living outside of a major metropolitan centre and non-metropolitanism or rurality might be associated with unique health-related outcomes for GBTMSM. Research in this area most commonly highlights an association between higher rates of discrimination in non-metropolitan and rural areas and reduced access to health and social services. For instance, in a sample of MSM from across Oklahoma, United States, Hubach et al. (2017) describe that the stigma experienced by MSM in non-metropolitan and rural areas contributes to less LGBTQ+-related competencies amongst service providers, serving as a barrier to accessing quality care. Moreover, for LGBTQ+ Australian and Torres Strait Islander youth, Brown et al. (2015) highlight that because of the presence of less LGBTQ+ visibility in non-metropolitan regions, rural LGBT youth may experience barriers to accessing mental health care and other services. In connection, Cain et al. (2017) & Lyons et al. (2014) highlight that for GBTMSM in the United States and Australia, living in a rural area is associated with lower social support, self-esteem, life-satisfaction and higher internalized homonegativity, perhaps reflecting the consequence of the limited structures and services in place for GBTMSM in non-

metropolitan regions. As well, for GBTMSM LWH, a similar situation prevails; Hubach et al. (2015) report that amongst a sample of rural GBTMSM LWH from the south-central Indiana, United States area, HIV-related stigma experienced at the interpersonal and community level creates barriers to disclosing their status.

In contrast to these findings, Felson & Adamcyzk (2017) highlight the significance of LGBTQ+ affirming spaces, even in smaller regions. In their US-National study, researchers reported less mental health disparities between sexual minorities and others in areas highly concentrated with LGBTQ+ people. Interestingly, these findings also applied to states that are less tolerant towards LGBTQ+ people (Felson & Adamcyzk, 2017). The researchers attributed this unexpected finding to the significance of queer enclaves and the associated social support for bolstering resilience even in the face of adversity (Felson & Adamcyzk, 2017). As well, research with gay and lesbian individuals residing in Midwestern, United States by Kazyak (2011) suggests that some GBTMSM may actually return back to rural areas upon migrating to urban enclaves. This suggests the presence of important social support and community mediators that attenuate the effects of a higher prevalence of stigma and discrimination in rural areas (Kazyak, 2011). On a similar note, Giano & Hubach (2019) describe that amongst a sample of GBTMSM residing in Oklahoma, United States, ACEs, including childhood bullying and maltreatment, were only significantly linked to GBTMSM living in metropolitan areas, suggesting that GBTMSM living in more rural areas might have unique support networks that serve to mitigate the effects of ACEs and bolster resiliency.

Reflecting on the relevance of structural violence for the wellbeing of GBTMSM, it is important to consider the individual experiences of GBTMSM in non-metropolitan and rural regions, but also to understand how the systems and services in place in these areas might

influence health. Research on rural GBTMSM that includes a structural analysis highlights that in general, a lack of sexual minority-affirming policies, institutional practices and hostile cultural norms leads to reduced access to quality care (Hubach et al., 2019). Because of this reduced access to quality care, GBTMSM living in more rural areas across the United States have been demonstrated to be less likely to test for HIV as well as other STBBIs and are less privy to receive condoms or other prevention tools or counselling (McKenney et al., 2017). Further, considering the influence of these structural factors on individual service provider competencies and attitudes, Rowan et al. (2019) highlight that in a sample of providers in rural United States, the majority (75%) automatically assumed their patients were cisgender. Connectedly, about half (40%) indicated the need for more education (Rowan et al., 2019). In a similar project, Patterson et al. (2019) describe that only about half of the service providers in their sample felt competent to treat LGBTQ+ patients. Within this sample, providers recounted feeling uncomfortable with LGBTQ+ clients, and being unfamiliar about the use of proper language (Patterson et al., 2019).

Together, these studies exploring the influence of structures and policies for the health of GBTMSM in non-metropolitan and rural areas emphasize that there is much work to be done. However, these projects most commonly come from the United States. Accordingly, Canadian research in this area is needed to better understand how GBTMSM living in non-metropolitan and rural areas of Canada experience social support and healthcare and social services.

HIV Incidence/Prevalence in Southwestern Ontario

Although detailed region-specific demographic data is lacking, it seems that GBTMSM in the SW Ontario region continue to be disproportionately affected by HIV compared to their heterosexual and/or cisgender counterparts. Data from the Ontario HIV Epidemiology and Surveillance Initiative (OHESI) helps to illuminate the HIV incidence/prevalence amongst

GBMSM (inclusive of trans men) in Ontario more broadly. According to OHESI, from 2010-2019, between 62-67% of people diagnosed with HIV for the first time identified as GBMSM, depending on the year (OHESI, 2021a). Detailed data from OHESI describes that although overall rates of HIV diagnoses in Ontario decreased in 2019, this decrease was only found in White men, whereas the rate of racialized men diagnosed with HIV increased (OHESI, 2021a). In addition, male-to-male sexual contact remains the predominant HIV exposure category (59.2%). However, the number of first-time diagnoses among GBMSM decreased from 343 in 2018 to 307 in 2019, likely driven by decreased diagnoses in White GBMSM due to increased uptake of PrEP in that population (OHESI, 2021a). More recent data suggests that as of 2020, there were an estimated 12,027 GBMSM diagnosed with HIV living in Ontario, of which around 88.7% were accessing care, 86.9% were on ART, and 85.6% were virally suppressed, closely mirroring the rates of those diagnosed with HIV who are accessing care, on ART, and being virally suppressed captured amongst the general population (OHESI, 2018).

The most recent region-specific data reflecting rates of diagnoses per 100,000 people suggests that between 2013 and 2017, the average rate of new diagnoses per 100,000 people in Ontario was 6.1, and this rate was four-times higher for males (9.9) than for females (2.4) (OHESI, 2018). Drawing on proportional HIV diagnosis data described earlier, it is likely that the majority of these diagnoses for males were amongst GBMSM (OHESI, 2021). Importantly, OHESI also provides details on rate of diagnoses per each region in Ontario; Middlesex-London represented a new HIV diagnosis rate of 10.0 per 100,000, while Hamilton represented a rate of 5.9 per 100,000, and Windsor-Essex represented a rate of 5.7 per 100,000 (OHESI, 2018). As well, Middlesex-London (14.5), Windsor-Essex (9.9) and Hamilton (8.5) represent the second, fourth, and fifth highest rates of male diagnoses in Ontario, respectively (OHESI, 2018). The

other three regions in SW Ontario represented markedly lower rates of HIV diagnoses per 100,000, with Niagara representing a new HIV diagnosis rate of 2.58 per 100,000, Waterloo representing a rate of 3.50 per 100,000, and Wellington-Dufferin-Guelph representing a rate of 1.40 per 100,000 (OHESI, 2018).

Although more recent data is absent, data suggests that between 2013 and 2017 approximately 87.5% of people diagnosed with HIV in Ontario were receiving care, with 81.2% of these people being on ART, and 79.6% having a viral load that was virtually suppressed (OHESI, 2018). For SW Ontario more specifically, between 2013 and 2017, approximately 89.2% of people diagnosed with HIV were receiving care, 83.5% were on ART, and 81.7% had a viral load that was virtually suppressed, reflecting higher averages than those for Ontario more generally (OHESI, 2018). However, these rates suggest that a sizeable number of PLW are without care, or at least, without appropriate and consistent care. In particular, for the Hamilton region (inclusive of Haldimand-Norfolk & Halton), 90.8% of people diagnosed with HIV were in care, 86.2% were on ART, and 85% had a viral load that was virtually suppressed. For the Windsor-Essex region (inclusive of Chatham-Kent), 93.6% of people diagnosed with HIV were in care, 92% were on ART, and 89.4% had a viral load that was virtually suppressed. In comparison, for Middlesex-London (inclusive of Elgin-St. Thomas & Oxford), 81.3% of people diagnosed with HIV were in care, 81.3% were on ART, and 77.1 had a viral load that was virtually suppressed. For Niagara, 90.3% of people diagnosed with HIV were in care, 85.9% were on ART, and 82.4% had viral loads that were virtually suppressed. In comparison, for Wellington-Dufferin-Guelph, 86.2% of people diagnosed with HIV were in care, 79.6% were on ART, and 78.4% had a viral load that was virtually suppressed. Finally, for Waterloo, 85% of people diagnosed with HIV were in care, 78.6% were on ART, and 77.9% had viral loads that

were virtually suppressed (OHESI, 2018). These variabilities in linkage to care, access to ART, and viral load suppression emphasize that access to and efficacy of HIV treatment retainment varies quite significantly across SW Ontario, highlighting the need for more detailed research and data in these areas.

It is also important to consider how the COVID-19 pandemic has and continues to influence access to HIV testing and diagnosis in Ontario, obscuring trends and creating challenges for capturing the current state of the HIV epidemic in Ontario. Data from OHESI describes that in 2020, the number of HIV tests conducted dropped by 26%, however, people at high risk continued to access HIV testing, suggesting that testing targeted at those at elevated risk of HIV or with symptoms of HIV continued throughout the COVID-19 pandemic (OHESI, 2021b). In addition, there was a 25% drop in first-time HIV diagnoses that researchers attribute to some missed diagnoses due to inaccessible testing related to COVID-19 restrictions, a real drop in new infections due to COVID-19 restrictions contributing to less contact between GBMSM and decreases in immigration due to global lockdown measures (OHESI, 2021b). Despite the utility of this dataset for understanding how COVID-19 influenced HIV testing and diagnosis in Ontario, detailed and specific data pertaining to GBMSM in SW Ontario is warranted to best capture how COVID-19 has intersected with existing barriers to accessing HIV testing and diagnosis to influence HIV amongst GBMSM in SW Ontario.

Closing

The research area of GBTMSM sexual health and overall general health is extremely broad and requires recognizing how individual-, community-, and structural-level factors may overlap and influence one another to cumulatively contribute to health inequities. As well, recognizing how geographical location may relate to distinct experiences of service access,

discrimination and social support that differ from those experienced by metropolitan GBTMSM is essential for recognizing how rurality might intersect with queerness to collectively influence the sexual, mental, and physical health of GBTMSM. In reflecting on the overarching goals of the proposed project and the state of the existing knowledge in this sector, working from theoretical vantage points that facilitate an analysis that appreciates the relevance of individual behaviour but especially positions the researcher to explore how community- and structural-level factors may influence the wellbeing of GBTMSM is essential for moving beyond the noted shortcomings of work in this area.

Theoretical Frameworks

Approach

This project is guided by four primary theoretical frameworks that work well to explore both individual-, community- and structural-level factors that influence wellbeing. These theories include Krieger's Ecosocial Model, but more specifically, the Modified Socioecological Model (MSEM) presented by Baral et al. (2013), the Wellness as Fairness lens, provided by Prilleltensky (2012), minority stress theory, presented by Meyer (1995; 2003), and syndemics theory, introduced by Singer (1994; 2009), reflecting on work by Stall (et al., 2003) Halkitis et al. (2013) and others who have extrapolated syndemics to focus on the sexual health and broader health of GBTMSM.

The Ecosocial Framework

In reflecting on the significance of structural factors for influencing the sexual health and broader health of GBTMSM, the ecosocial model fits well to name structural violence as a significant factor contributing to health disparities experienced by GBTMSM. Under this

framework, health and health behaviours are contextualized amongst physical, social and policy environments, seeking to underscore the complex associations between social and structural factors, individual practices and the physical environment for health and wellness (Krieger, 2012). In particular, by recognizing how the broader public policy and legal context might influence an individual's access to specific community organizations and institutions, and as a result, the magnitude of their social networks and access to social support, the model seeks to demonstrate the interplay of biological and social factors for contributing to health inequities (Krieger, 2012). The model acknowledges that by solely focusing on how individual behaviour might influence an individual's health, research may be inadvertently perpetuating stigma, and as a result, obscuring the impact of structures and systems on population health (Krieger, 2012). Accordingly, the ecosocial framework recognizes that research methods must address the lived realities of marginalization as an exploitative and oppressive societal phenomenon, whereby factors operate at several levels and via multiple pathways to influence an individual's health (Krieger, 2012).

More recently, the ecosocial model (2012) has been operationalized to contextualize HIV incidence and prevalence amongst GBTMSM. Following the understanding that social and structural factors are now well accepted as determinants of HIV vulnerabilities, Baral et al. (2013) proposed the modified social ecological model (MSEM), a framework comprising of five layers of risk for HIV, including individual, network, community, policy, and stage of epidemic variables. Under this model, the boundaries between layers can be understood as porous rather than distinct, suggesting that various levels overlap and influence one another (Baral et al., 2013). Overarchingly, the model seeks to define and characterize individual level risks of poor health while underscoring the importance of recognizing how higher order social and structural

levels of risk facilitate poor health above and beyond individual behaviour (Baral et al., 2013). By doing so, the framework emphasizes that no behaviour, policy or law, community determinant, network attribute or individual characteristic alone can create infectious disease; rather, these factors only create conditions which either decrease or increase the probability of poor health (Baral et al., 2013).

At the individual level, biological or behavioural characteristics, such as condom use, are associated with vulnerability to experience poor health (Baral et al., 2013). In comparison, on a social and sexual networks plane, health risks are associated with social influence, social engagement, disease prevalence, access to information, intimate contact, and social networks (Baral et al., 2013). For GBTMSM, the density and size of an individual's network might contribute to their health; for instance, having greater close acquaintances may contribute to social support, or rather, larger sexual networks might correlate with episodic bursts of HIV transmission (Baral et al., 2013). Connectedly, the community level is useful for characterizing how an individual's environment can either promote health and wellbeing or be a source of stigma and distress. Here, considering the role of socio-cultural norms and values is central for understanding how community attitudes might increase or mitigate health behaviour (Baral et al., 2013). For instance, GBTMSM living in more rural areas might encounter greater stigma, and as a result, experience reduced access to healthcare and social services in their communities (Hubach et al., 2017; Baral et al., 2013). In addition, racial discrimination might intersect with sexual orientation-/gender identity-related discrimination here, exacerbating existing barriers to accessing healthcare and social services (Wilson et al., 2014; Baral et al., 2013). In comparison, the legal and policy plane is concerned with how policies and their financing and implementation either promote or decrease a community's ability to provide preventative or harm reduction

services to its constituents (Baral et al., 2013). For GBTMSM, the criminalization of sex work, homosexuality and substance use, or the criminalization of prevention and harm reduction practices are most relevant here (Baral et al., 2013). As a consequence of these policy stances, a high proportion of GBTMSM do not have access to HIV prevention, treatment, and care services, and GBTMSM may face discrimination from police and healthcare providers (Baral et al., 2013; Chakrapani et al., 2007; Quinn, 2019).

The ecosocial framework, but more specifically, the MSEM presented by Baral et al. (2013) provides a significant guiding framework for this project. In particular, this model facilitates for an analysis that recognizes how various systems and levels overlap and interact to influence the wellbeing of GBTMSM. Here, the MSEM will facilitate in moving beyond shortcomings related to existing GBTMSM-related research that focuses predominantly on individual behaviour, and instead, will position the researcher well to implicate systems, policies and structures as dominant forces influencing the wellbeing of GBTMSM. As well, a noteworthy strength of the MSEM is its consideration of the significance of intersectional marginalization for comprehensively understanding health inequities (Baral et al., 2013). This intersectional lens embedded within this framework will facilitate an analysis that recognizes how GBTMSM who face intersectional marginalization may be at increased risk for structural violence and as a result, poor health. Although, the MSEM most definitely recognizes the influence of structural- and policy-level factors on the sexual health and broader health of GBTMSM, the inclusion of additional frameworks that hone in more specifically on how structural violence may manifest in lived experiences of discrimination, rejection and internalized stigma are necessary for best capturing intersectional nuances associated with GBTMSM of different gender identities, ethnoracial identities and HIV statuses, for example.

Wellness as Fairness

The wellness as fairness lens proposed by Prilleltensky (2012) works well to address positive health and wellness, exploring how GBTMSM may experience structural advances and protections. Under this framework, wellbeing refers to experiences of pleasure and purpose over time that exist across four domains: personal; interpersonal; organizational; and communal (Prilleltensky, 2012). The presence of these various manifestations of wellbeing are associated with lower degrees of stress, higher degrees of resilience and more positive outlooks on life and may serve to attenuate the impacts of societal stressors (Prilleltensky, 2012). Accordingly, fostering the development and sustainment of wellbeing is vital for promoting the health and wellness of communities who may experience a substantial amount of structural violence (Prilleltensky, 2012). Equally relevant is justice, which centres around equity and inclusion, and exists across two domains: distributive and procedural (Prilleltensky, 2012). Distributive justice refers to the fair and equitable allocation of burdens and privileges, rights and responsibilities and pains and gains in society, meanwhile procedural justice refers to fair, transparent, informative, respectful, and inclusive processes (Prilleltensky, 2012). Together, Prilleltensky (2012) synthesizes wellbeing and justice, proposing the concept of wellness as fairness; here, justice can be understood as synonymous with fairness, in that justice represents the fair and equitable distribution of resources and treatment which contribute to wellbeing.

For GBTMSM, the wellness as fairness lens provided by Prilleltensky (2012) is useful for characterizing how structural factors influence wellbeing. More specifically, it can be argued that GBTMSM experience a lack of just and fair conditions which can be conceptualized as barriers to wellbeing (Tan et al., 2014). For instance, GBTMSM may experience poor intrapersonal justice as a result of internalized stigma, or internalized homophobia (Prilleltensky, 2012; Frost

& Meyer, 2009). Further, the issue of community justice is especially relevant for GBTMSM, as they experience more limited access to health and social services, and face community and societal discrimination with limited space for retributive justice (Prilleltensky, 2012; Hatzenbuehler, 2014). However, conversely, GBTMSM also experience positive community justice in the form of increased human rights protections and LGBTQ+ affirming policies (Smith, 2020). As predicted by Prilleltensky (2012), these advances toward greater equity and justice for GBTMSM are in fact, associated with greater realizations of wellbeing (Buffie, 2011). Accordingly, recognizing the harms associated with structural violence while also exploring how structural advances and the associated increase in equity might attenuate poor health outcomes is crucial for comprehensively assessing the sexual health and broader health of GBTMSM in this project.

Minority Stress

The concept of minority stress was borne out of social stress theory and introduced by Meyer (1995) to capture the social stress experienced by LGBTQ+ individuals when navigating heteronormative social structures, norms, and institutions (Meyer, 2003). In particular, LGBTQ+ individuals face both distal and proximal stressors that impact their health and wellness (Meyer, 2003). Distal stressors operate on the macro level, and largely involve societal and structural attitudes toward LGBTQ+ individuals, namely those grounded in cisnormativity and heteronormativity (Meyer, 2003). As well, in recognizing cisnormative and heteronormative societal attitudes, LGBTQ+ individuals may come to expect rejection because of their sexual orientation and/or gender identity, compelling these individuals to conceal their orientations or identities (Meyer, 2003). In connection, this instinct to conceal LGBTQ+ status in fear of discrimination may lead to self-loathing and shame related to orientation, or rather, internalized

homophobia (see Frost & Meyer, 2009). In comparison, proximal stressors are the individual experiences of prejudice or discrimination that are encountered by LGBTQ+ individuals (Meyer, 2003). Through these proximal experiences of discrimination, distal stressors are reified and weaponized against the LGBTQ+ community through enacted discrimination against LGBTQ+ individuals (Meyer, 2003).

In general, the minority stress model is most commonly applied to LGBTQ+ individuals broadly. As a result, minimal studies have introduced a minority stress framework to characterize the sexual health and broader health of GBTMSM, making it difficult to discern how minority stress may be experienced uniquely by GBTMSM. However, from the few projects which have explicitly focused on GBTMSM, the minority stress model has been extrapolated to demonstrate the association between experienced stigma, internalized homophobia, and major depression (see Bruce et al., 2015). Dunn et al., (2014) report similar findings, highlighting an association between internalized homophobia and depressive symptoms. Further, other projects have demonstrated that amongst GBTMSM, familial rejection is associated with experiencing homelessness and facing substance use problems (See Bruce et al., 2014). As well, projects integrating an intersectional lens have demonstrated that BIPOC GBTMSM may face exacerbated forms of minority stress due to the dual stigmatization experienced on the counts of sexual orientation/gender identity and race (see Cyrus, 2017; McConnell et al., 2018).

For the purposes of this project, minority stress shows utility for recognizing how structural violence, such as cisnormativity and heteronormativity, might manifest in the lives of GBTMSM as significant intrapsychic problems. In particular, the theory facilitates for the examination of how an LGBTQ+ individual experiences societal- and community-level discrimination and stigmatization, recognizing how these marginalization’s may be internalized,

in turn, contributing to poor health (Meyer, 2003). Whereas the MSEM presented by Baral et al. (2013) describes these community and societal contexts where health inequities, stigmatization and discrimination may occur, the minority stress model facilitates in an analysis that characterizes the tangible impacts of these climates on the mental, sexual, and physical health of 2SLGBTQ+ folks. As such, the framework presented by minority stress theory is invaluable for better understanding how the attitudes and behaviours of communities and societies translate to health outcomes and inequities for GBTMSM.

In addition, as mentioned, a primary focus of this project is to understand how GBTMSM maintain positive mental, sexual, and physical health despite facing significant structural barriers to wellness, such as systems of heteronormativity and cisnormativity. Adaptations of the minority stress framework that include resilience and social support in their models work well to expand the scope of this project and may serve as guidelines for examining how positive psychosocial factors might attenuate the potential impacts of the structural violence facing GBTMSM (see Feinstein et al., 2014; Breslow et al., 2015; Woodford et al., 2015). Regardless, the limited extrapolation of minority stress theory specifically to the subpopulation of GBTMSM within the larger 2SLGBTQ+ community in extant literature warrants the inclusion of an additional framework that best captures the disproportionate HIV burden facing GBTMSM as well as the unique and interconnected health inequities experienced by GBTMSM that differ from lesbian women, for example.

Syndemics Theory

The concept of a syndemic stems from critical medical anthropology and was introduced in the mid-1990s by Merill Singer to describe the tendency for multiple epidemics to co-occur, in that multiple psychosocial problems and health inequities may overlap and interact with one

another, together producing worse health outcomes than each epidemic alone (Singer, 1994; Singer, 2009). Ultimately, the framework aims to emphasize the fact many diseases and social problems do not exist in isolation, especially for those facing marginalization and precarity (Singer, 2009). By use of this framework, researchers and service providers are able to comprehensively assess both the causes and outcomes of health inequities, moving beyond earlier frameworks that most commonly operated according to the medical model (Singer, 2009). The framework was first applied to represent the cumulative impacts of substance use, violence, and AIDS for the poor health of Puerto Ricans living in Hartford, Connecticut (Singer, 1994). Since then, the syndemics lens has been widely applied to better understand population distribution and the consequences of a number of diseases, including diabetes, SARS, and perhaps most notably, HIV/AIDS (Singer, 2009).

Most prominently, in the context of HIV, Singer's syndemic framework (1994) has been extrapolated to better understand the disproportionate HIV burden and the ongoing HIV epidemic facing GBTMSM (see Stall et al., 2003). Here, the theoretical underpinnings of syndemics facilitate in an analysis that better recognizes how disproportionate rates of psychosocial problems reported by GBTMSM may influence HIV-related risk behaviour, and ultimately, the HIV burden faced by this population (Stall et al., 2003). In this context, the framework shows utility for interweaving a lifecourse perspective, recognizing how historical traumas may correlate with current psychosocial problems, which in turn, are associated with a lower propensity to engage in sexual risk mitigation strategies (Stall et al., 2003). For instance, syndemics-related research prescribing to this lifecourse perspective has demonstrated that a synergism between past victimization or familial rejection may lead to mental health challenges or precarious housing, which in turn, creates an environment where GBTMSM may engage in

heightened substance use, which has been associated with higher rates of CAI, and in turn, HIV (Halkitis et al., 2013; Herrick et al., 2013; Lyons et al., 2013).

The syndemics framework as it is applied to understand HIV risk amongst GBTMSM is a useful framework for this project, however, some issues must be noted. In particular, although the framework shows utility for recognizing the significance of the interactions between multiple psychosocial problems across the lifecourse, the theory predominantly focuses on individual behaviour as predictive of HIV-related "risk", in turn, obscuring the influence of systems and structures for the health of GBTMSM. In particular, as noted by Baral et al. (2013), no individual behaviour is inherently risky, rather, individual behaviour exists under systems and in contexts where health inequities may cluster according to overlapping marginalization's and inequities. As well, on a methodological plane, researchers have questioned whether the extant syndemics literature has clearly established the associations between these co-occurring psychosocial and structural problems of interest in the case of HIV, and other health outcomes. In particular, Tsai & Venkataramani (2016) labelled this the 'syndemic problem', in that it remains unclear whether these psychosocial and structural problems of interest co-occur independently, co-occur and are mutually enhancing, or co-occur and are mutually causal. For instance, syndemics literature commonly includes ACEs as one of the co-occurring psychosocial and structural problems of interest, which is essentially counterintuitive to the logic behind syndemics, as ACEs are experienced in the past, and therefore, are more along the pathway to adult outcomes rather than a concurrent contributor to health outcomes (Tsai & Venkataramani, 2016). Tsai (2018) further builds on this idea, describing that for the theory of syndemics to be used appropriately, new approaches to research in the area are needed that incorporate a structural-level analysis, temporally map the cascade of health risks, incorporate agent-based models, and build from

anthropological field work to capture the interplay more comprehensively between systems, structures, and the individual across the lifespan. In addition, a blanket application of the HIV-related syndemic framework to all GBTMSM can be problematic and may obscure the complexities of GBTMSM facing intersectional marginalization. In particular, as noted by Quinn (2019), traditional conceptualizations of the HIV-related syndemic facing GBTMSM lack an intersectional lens that is necessary for understanding how race and class may influence an individual's health. In fact, as demonstrated by Tan et al., (2014), a syndemics analysis that integrates an intersectional lens is able to better account for the influences of systemic racism, structural violence, and power inequities for the health of BIPOC GBTMSM.

Ultimately, the overemphasis of individual behaviour as inherently risky as well as a limited intersectional lens provided by the syndemics framework raises some questions regarding the utility of this theory for recognizing the influence of systems and structures on the health of GBTMSM. However, the logic behind this theory, in that multiple health inequities and psychosocial problems across the lifecourse overlap to influence an individual's health (Singer, 2009) is useful for prioritizing specific areas of inquiry. In particular, the disproportionate rates of depression, IPV, ACEs and substance use amongst GBTMSM demonstrated by previous syndemics-related research (see Wilton et al., 2018; Morrison et al., 2018; Tulloch et al., 2015) serve to identify priority areas for this project where an intersectional structural lens provided by Krieger (2012) and Baral et al., (2013) can be introduced to enhance the scope of the data collection and analysis.

Closing

Together, the MSEM, wellness as fairness, minority stress theory and syndemics theory create a comprehensive research lens that positions the researcher well to explore how individual

behaviour and community attitudes may predict health outcomes, but more importantly, how structural-level factors may create climates where heteronormativity and cisnormativity perpetuate less 2SLGBTQ+ affirming policies and services, and systemic and institutional racism sustain health inequities and service gaps for BIPOC GBTMSM.

Transition

Research Questions

The primary research question that this project is seeking to explore is: 1) How do structural factors influence the sexual health and broader health of GBTMSM in SW Ontario? Further, a secondary research question seeks to characterize resilience in consideration of systems and structures, asking: 2) What strategies do GBTMSM employ to strive towards maintaining positive mental, physical, and sexual health outcomes in relation to structural influencing factors?

Significance of Research

A substantial proportion of GBTMSM sexual health and broader health research employs an intrapsychic and deficits-focused lens that tends to centralize individual behavioural management as most significant for reducing the HIV burden and other health inequities facing the GBTMSM community. To date, few studies have interrogated how systems and structures might contribute to the health disparities experienced by GBTMSM. Accordingly, this project will seek to characterize how systemic-level factors contribute to GBTMSM sexual health and broader health, in turn, outlining concrete points where policy and structural change are warranted.

Recently, no qualitative project assessing the sexual health and broader health of GBTMSM in the SW Ontario region has been undertaken. Therefore, by conducting interviews with GBTMSM in this region, researchers will have the opportunity to garner insight into the nuances and lived experiences of these GBTMSM, better understanding how sexual health, physical health, and mental health manifest within the lives of these individuals.

The majority of GBTMSM health research has been undertaken in larger metropolitan regions, such as Toronto. Connectedly, region-specific data is lacking, and local 2SLGBTQ+ organizations are compelled to rely on data that may not be generalizable to the men in their regions. Accordingly, this project will serve to fill gaps in terms of data pertaining to GBTMSM in the SW Ontario region, in turn, seeking to inform service provision which best meets the needs of these men.

Method

Southwestern Ontario Gay, Bisexual, Transgender, and Other Men Who Have Sex with Men (GBTMSM) Assessment of HIV/AIDS Issues (SWOGAHI) Initiative

The Southwestern Ontario Gay, Bisexual, Transgender, and Other Men Who Have Sex with Men (GBTMSM) Assessment of HIV/AIDS Issues (SWOGAHI) Initiative is a multi-phase project seeking to foster a community-based research collaborative that explores service delivery in association with the sexual health and broader health of GBTMSM across the SW Ontario region. Phase one of the project involved completing literature reviews exploring the sexual health and broader health of GBTMSM across six domains: HIV testing, antiretroviral therapy, pre-exposure prophylaxis (PrEP), minority stress, rural MSM and the HIV-related syndemic. The second phase of the project focused in on the six ASOs from across the SW Ontario region. In this phase, researchers conducted qualitative interviews with each ASO's Executive Director and

their GBTMSM sexual health worker(s) to explore service delivery, region-specific nuances, and barriers to implementing knowledge uptake in ASO programming. Phase three of this project is where the proposed thesis is nested. For this thesis, and phase three of the SWOGAHI Initiative, qualitative interviews were conducted with a diverse sample of GBTMSM from across the SW Ontario region (N=30, five per region). These interviews sought to explore how GBTMSM experience structural barriers and facilitators to wellness, examining how systems and policies may serve to support or interfere with the wellbeing of GBTMSM. The resulting data from these interviews is the primary data source for this thesis project. A final phase of the overarching project will involve developing, piloting testing, and refining a quantitative survey that addresses priority areas across sites as well as site-specific questions to be delivered to a large sample of GBTMSM across the region.

Community Entry

My professional experience working in the GBTMSM sexual health and broader health sector began in Fall 2019 when I began volunteering at the AIDS Committee of Ottawa (ACO) as an outreach and community engagement assistant. Under this role I worked predominantly within the men who have sex with men (MSM) priority area, where I assisted in facilitating a weekly HIV and STBBI testing clinic at Centretown Community Health Centre called Gay Zone. At Gay Zone, I sought to create a welcoming and validating space for MSM to access testing, and as well, I provided sexual health, substance use and mental health education and harm reduction resources and supplies. My experience volunteering at the ACO undeniably shifted my post-graduate intentions away from counselling and psychotherapy and towards community-based research related to the sexual health and broader health of GBTMSM.

I first became involved with the overarching SWOGAHI Initiative in Spring of 2020 when I began working as a Research Assistant at the Social Inclusion and Health Equity Research Group under Dr. Todd Coleman and Dr. Robb Travers at Wilfrid Laurier University. Upon joining the project, I was provided with the space to review grant applications outlining the rationale and overarching goals for the project as well as findings from four foundational literature reviews completed during phase one of the study. As well, I completed a fifth foundational literature review synthesizing existing research on the HIV-related syndemic facing GBTMSM. Engaging with the syndemics literature helped me identify some areas in the GBTMSM sexual health and broader health sector where I recognized the need for further work. Moving into Fall 2020, Dr. Todd Coleman and I launched the second phase of the project, where we conducted qualitative interviews with the Executive Directors (EDs) and MSM workers from the six ASOs across SW Ontario. The conversations had during these interviews and the emerging findings from these interview transcripts most definitely informed the scope and goals of this thesis project.

More recently, as part of the Community Psychology Master's program at Wilfrid Laurier University I was provided with the opportunity to complete a 150-hour practicum with a local community-based organization. For this practicum I secured a position at the Gay Men's Sexual Health (GMSH) Alliance, a community-led provincial hub of learning, capacity building, and resource-campaign development for queer men's HIV prevention, sexual health, and overall health and wellbeing. Since my time as a practicum student, I have resumed my work with the GMSH Alliance as a project assistant. During my time as both a practicum student and a project assistant I have had the opportunity to collaborate with other community members, researchers, and service providers on the Party & Play (PnP) project, a developing campaign by the GMSH

Alliance seeking to provide supports and resources for queer men who engage in sexualized drug use (SDU) and best practice guidelines for the service providers who may work alongside them. Working on this project has further refined the focus of this thesis project, in part, informing the structural-level analysis assumed in this thesis.

Positionality

I come to this work as a White, cisgender, gay male, born and raised in Canada. Although my experiences with homophobia and heteronormativity influence my work, I realize that these experiences are insulated by my White and cisgender privilege. Accordingly, I aim to move beyond solely exploring the experiences of White cisgender queer males like myself, and in addition, seek to build meaningful partnerships with BIPOC queer and trans men and trans men who have sex with men who are further marginalized according to their ethnoracial and/or trans identities to better understand GBTMSM who face intersectional marginalization. Connectedly, I recognize that the GBTMSM sexual health and broader health research sector has tended to be Whitecentric and has sometimes overlooked the experiences of BIPOC GBTMSM and trans GBMSM by relying on predominantly White and cisgender samples and experiences. In recognizing the power differentials introduced into the research process by my Whiteness, the research team welcomed Fabian Fletcher on board, a Black queer research assistant with extensive experience working to support the sexual health and broader health of GBTMSM. For this thesis project, Fabian supported the research team in conducting interviews as well as in interpreting the resulting data, which the team and I are extremely grateful for.

Furthermore, it should be noted that the research in this sector has sometimes served to further stigmatize and alienate GBTMSM who are racialized, use substances, engage with multiple sexual partners and/or live with mental illness by focusing intensely on risky behaviour

rather than interrogating how systems and policies might create a context where poor health is clustered greatly for GBTMSM. Accordingly, I hope that in this work I can provide a case study for the relevance of not focusing solely on individual behaviour for understanding the health inequities facing GBTMSM, but rather, also considering how poor health is heavily driven by social inequalities and health disparities borne out of heteronormative, cisnormative and racist structures and policies.

The interviews for this project undeniably dealt with some sensitive topics that were sometimes troublesome for some to reflect on and/or share about. However, my background in working as a peer counsellor, my work with the Gay Men's Sexual Health (GMSH) Alliance and my experience volunteering and conducting research alongside AIDS Service Organizations (ASOs) were assets for ensuring this project was conducted with sensitivity and inclusion as top priorities. As well, in recognizing the benefits of self-disclosure for enhancing rapport and building comfort, I sought to engage in conversation with participants, sharing reflections on my own experiences navigating the world as a queer person.

Research Paradigm

This project is guided by an overarching constructivist paradigm. The constructivist paradigm posits that reality is socially constructed, and emphasizes phenomenology, interpretation, and humanism, focusing on communication, subjective human experience, and the meaning that people make of their experiences in their historical, social, cultural, and political contexts (Riemer et al., 2020). Constructivism is grounded in relativism, in that knowledge about reality is garnered through the constructions of reality put forth by participants situated in unique cultural, societal, and historical contexts (Riemer et al., 2020). Under constructivism, research is subjective, and the researcher and participant can be understood to be interrelated, in that

knowledge is co-constructed throughout the research process (Riemer, 2020). Moreover, constructivism recognizes that values are inextricably a part of the research process, and connectedly, research is value-bound (Riemer, 2020). Finally, as the constructivist approach seeks to understand people's lived experiences, social constructions are garnered through dialogue and reflection, seeking to garner insight into values, interests, and meanings that underlie discourse (Riemer, 2020). Accordingly, qualitative methods are preferred under the constructivist paradigm, as people's words and stories serve to more comprehensively elucidate their lived experiences than numbers or statistics (Riemer, 2020).

As this project places a particular emphasis on garnering detailed insight into the intersectional nuances associated with the unique and overlapping identities held by GBTMSM community members, the constructivist paradigm was most logical, as this framework allows for the detailed exploration of lived experiences through dialogue and reflection. As well, this framework facilitated in the researchers exploring the values, interests and meanings that underlie discourse, better understanding how certain experiences might influence the perceptions and outlooks of the GBTMSM in the sample. Further, as mentioned, a common limitation of existing GBTMSM sexual health and broader health literature is a primary focus on quantitative methods, which are limited in their ability to provide in-depth information pertaining to an individual's lived experience (Padgett, 2012a). Accordingly, by following the constructivist paradigm, the researchers sought to avoid these previous shortcomings, employing the qualitative interview method to better understand structural barriers and facilitators to wellness may manifest in the lives of GBTMSM from across SW Ontario.

For the purposes of this project, the constructivist paradigm showed utility over other paradigms. For instance, although the post-positivist paradigm shows value for producing

research that is tightly controlled and perhaps generalizable to larger populations, this paradigm posits that there is one single objective reality to be captured in the research process (Riemer, 2020). This understanding inherent to post-positivism directly contradicts the project's values and research goals, which included garnering co-constructed knowledge surrounding the lived experiences of GBTMSM. Accordingly, the constructivist paradigm showed clear utility over other frameworks for aligning well with the researcher's values and for meeting the project's research goals.

Under the overarching constructivist paradigm follows the project's guiding pragmatic and participatory frameworks. The pragmatic framework centres around using research to solve practical issues of importance to communities (Riemer, 2020). Accordingly, methods operating under this framework seek to provide the needed answers to research questions and meet the research objectives (Riemer, 2020). The pragmatic framework aligned well with the proposed project, as the researchers sought to garner knowledge characterizing how systems and policies influence the health of GBTMSM, in turn, outlining relevant areas for systems change as well as recommendations for health and social services in the region to make changes to better meet the needs of GBTMSM.

The participatory framework stems from community-based participatory research (CBPR), an approach to research that places an emphasis on partnering with communities and involving members of these communities as active and equal participants in all phases of the research process (Holkup et al., 2009). For this project, the participatory framework reflects the constructivist paradigm and the researcher's goal to build meaningful partnerships with GBTMSM. Under this project, stakeholders primarily involve ASOs and other service providers and GBTMSM in the SW Ontario region. As will be further elucidated in forthcoming sections,

existing partnerships with ASOs across SW Ontario have facilitated in this project's conceptualization, facilitated in data collection, interpretation, and knowledge mobilization. Moreover, following the project's constructivist paradigm, the researchers sought to co-construct knowledge alongside GBTMSM in the SW Ontario region. Rather than seeking to interpret survey responses, the researchers placed a special emphasis on garnering insight related to the lived experiences of participants, in turn, seeking to amplify the voices of these folks in the final thesis paper as well as in prospective knowledge mobilization tools borne out of data gathered. Accordingly, both the pragmatic and participatory frameworks align well with the research goals.

Community Partners

This thesis project is nested within the SWOGAHI Initiative, a study housed within the Social Inclusion & Health Equity Research (SIHER) Group at Wilfrid Laurier University. The SWOGAHI Initiative seeks to characterize the current situation for AIDS service organization (ASO) service delivery in SW Ontario by gathering insight from the Executive Directors (ED) and GBTMSM sexual health workers from the six ASOs across the SW Ontario region, as well as from a sample of GBTMSM community members from this region. Accordingly, the researcher is well-connected with the AIDS Committee of Cambridge, Kitchener, and Waterloo area (ACCKWA), the AIDS Network (Hamilton, Ontario), Regional HIV/AIDS Connection (RHAC; London, Ontario), HIV/AIDS Resources and Community Health (ARCH; Guelph, Ontario), Pozitive Pathways (Windsor, Ontario) and Positive Living Niagara. These partnerships were significant for facilitating in participant recruitment, data collection and interpretation, and knowledge mobilization. As well, the findings reported in this thesis will be prospectively used to inform programming and service provision at these ASOs.

Research Design

As previously mentioned, the constructivist paradigm seeks to characterize the subjective lived experiences of participants, and connectedly, qualitative methods are preferred, as they show strength in providing comprehensive understandings of an individual's lived experiences (Riemer, 2020). Accordingly, the researcher relied on qualitative methods for the project, employing a blended semi-structured/narrative interview approach to garner insight into the research questions. Broadly, qualitative methods show utility for characterizing temporal and situationally limited narratives, providing insight into specific nuances related to complex research questions (Flick, 2009). In particular, the qualitative interview implies a degree of closeness, allowing the researcher to garner insight into lived experiences and unique perceptions, positioning the researcher well to develop a comprehensive and multifaceted understanding of the research question(s) (Padgett, 2012b).

The semi-structured approach implements a set of open-ended questions which broadly capture the research topic, allowing for the interviewer to delve into particular themes or responses of significance introduced by the interviewee (Stuckey, 2013). As this research topic is comprehensive in nature, it would be naïve to assume that participants would naturally touch upon each and every point of interest through narrations. Thus, the interview guide's semi-structured foundation provides a necessary outline to encourage that all points of relevance were covered, ensuring that each participant had the opportunity to share their experiences and perspectives on all topics of interest.

In comparison, the narrative interview approach seeks to elucidate storied accounts that assist in contextualizing the lives of individuals in relation to the topic of interest (Jovchelovitch & Bauer, 2000). Importantly, communities and social groups tell stories with words and

meanings that are specific to their lived experiences (Jovchelovitch & Bauer, 2000), highlighting that the narrative method inherently prioritizes relevance fixation, as the participant reports features of the event that are most salient (Jovchelovitch & Bauer, 2000). This creates for less interpretation on the side of the researcher, and more direct reporting of the narratives presented by community members. In the context of this project, the narrative interview approach fits well with the project's overarching constructivist paradigm.

By blending these interview approaches, the researcher sought to create a data collection process whereby all relevant points of inquiry were overviewed, and as well, participants had the opportunity to share detailed and meaningful storied accounts related to their lived experiences of identifying as GBTMSM alongside other important lines of identity.

Participants

Selection Criteria

To be eligible for participation in the study, participants had to: 1) be at least 18 years old; 2) report a sexual orientation and gender identity that falls under the broad category of gay, bisexual, transgender, or other men who have sex with men (GBTMSM); and 3) currently reside within the SW Ontario region or have recent lived experience in the SW Ontario region.

Participant Recruitment

Participants for the project were recruited through two primary methods: 1) through existing connections with ASOs in SW Ontario, who fore fronted relevant participants and advertised for the study on their social media platforms; and 2) through outreach and advertisement on social media platforms, including Instagram and Facebook, with a specific focus on connecting with agencies and services in SW Ontario who support GBTMSM.

As mentioned, this thesis project is nested within the larger SWOGAHI Initiative, an exploratory project evaluating the current situation for ASO service delivery for the six ASOs from across the SW Ontario region. As such, the researcher was well connected with the AIDS Committee of Cambridge, Kitchener, and Waterloo area (ACCKWA), The AIDS Network (Hamilton, Ontario), Regional HIV/AIDS Connection (RHAC; London, Ontario), HIV/AIDS Resources and Community Health (ARCH; Guelph, Ontario), Pozitive Pathways (Windsor, Ontario) and Positive Living Niagara. As well, the findings from this thesis project are intended to fill gaps in the data pertaining to the GBTMSM from the SW Ontario region that these organizations may work with. In turn, the researcher hopes that the knowledge garnered from this project can be used to enhance service delivery and GBTMSM-related programming at these ASOs. Because of these existing relationships and the relevance of the project's findings for these ASOs, these ASOs were more than happy to support with recruitment.

As well, social media provides a useful platform for having study advertisements reach a broad audience of GBTMSM, and for making connections with organizations and services that work to support the sexual health and broader health of GBTMSM. Beyond the breadth of outreach possible by using social media to advertise for the study, social media represented a significant space for the research team to make connections with organizations and services who work alongside GBTMSM, especially as COVID-19 created barriers to engaging with these organizations and services in person. Typically, a member of the research team would first connect with an organization or service that works with GBTMSM by use of the outreach email script (Appendix B), outlining the details and goals of the project, and describing the role the organization or service could play in supporting outreach and recruitment. Most often, organizations and services from across the Southwestern Ontario region (such as Brock

University Pride, and Trans Health Coalition Hamilton) were more than happy to support in outreach and recruitment, reposting study advertisement material (Appendix C) on their Instagram, Facebook and/or Twitter pages. This form of outreach and recruitment was significant for reaching GBTMSM who may not have been as well connected to the ASO in their region. As well, this recruitment assisted in connecting with GBTMSM and GBMSM with other intersecting identities, such as those who are racialized, or those who are trans, non-binary, or GNC.

By use of these recruitment methods, the research team was able to recruit a diverse sample of 30 GBTMSM from across SW Ontario.

Sampling

A sample of 30 GBTMSM with diverse sexual orientations, gender identities, ethnoracial identities, ages, and HIV statuses from across SW Ontario (five per region) were purposively sampled through existing connections with ASOs in the region and through advertisement on social media via a research study profile, or via an agency that works to support the sexual health and broader health of GBTMSM. If a participant agreed to participate, they were provided with a consent form (Appendix D) which includes an overview of the research project, roles, and duties of the participants within the study, potential risks and benefits of the project, an outline of the compensation to be expected ($40 CAD), an overview of the project's funding, and information regarding confidentiality and anonymity.

Purposive sampling is a deliberate process of selecting respondents specifically according to their ability to provide relevant information (Padgett, 2012c). In the context of this project, criterion sampling was most logical, as the researchers were looking to recruit only individuals living in SW Ontario or with recent lived experience in SW Ontario that were over the age of 18

and who identified with a sexual orientation and/or gender identity that falls under the umbrella of GBTMSM. As well, under the broad framework of purposive sampling, specific sampling techniques exist (Padgett, 2012c). For the purposes of this study, snowball sampling is most relevant. Snowball sampling is often introduced to reach members of hard-to-reach populations and involves enabling current recruits to refer others in their network to the researcher (Padgett, 2012c). In this project, snowball sampling was most logical, as some participants were not as well connected to the local ASOs, or they were less active on social media platforms, where advertisements were posted. Accordingly, relying on existing participants to refer others in their network boosted the recruitment and inclusion of those folks who might not be as well-connected to ASOs and other 2SLGBTQ+ organizations in the SW Ontario region.

There is substantial debate surrounding the appropriate sample size needed to achieve data saturation in qualitative research (O'Reilly & Parker, 2012). However, Padgett (2012d) highlight that in studies employing an inductive approach about 20 to 30 participants is sufficient for achieving data saturation. Moreover, in analyzing the data from phase two of the overarching project, data saturation occurred with a sample of six EDs and eight MSM service workers (N=14). Positively, data saturation occurred in this project when the sample reached around 20 participants.

In regard to sample heterogeneity, by gathering a sample of GBTMSM who are diverse in regard to ethnoracial identity, sexual orientation, gender identity, age and HIV status, the researchers aimed to establish findings that are reflective of the diverse GBTMSM in these regions. To further commit to this diversity, the researchers sought to gather a sample that included at least 50% BIPOC GBTMSM, 20% GBTMSM living with HIV (LWH), 20% trans, non-binary or gender nonconforming (GNC) GBMSM and 20% GBTMSM over the age of fifty.

In order to track and establish this desired sample heterogeneity, prospective participants were forwarded a Qualtrics demographic questionnaire (Appendix E) to be completed and reviewed by the research team. In doing so, the researchers sought to ensure that those aforementioned diversity quotas were achieved. As well, these demographic identifiers are associated with the participant's quotations, if they were selected to participate in the study. By associating demographic identifiers with each quotation presented in the results and discussion section, the researcher sought to provide contextual cues that will serve to best situate narratives presented according to cultural, generational and gender norms and experiences.

Measures

GBTMSM Community Member Demographic Questionnaire

The GBTMSM Community Member Demographic Questionnaire (Appendix E) sought to capture background data on a number of identity markers relevant to the study. In particular, questions gathered data on location, age, ethnoracial identity, sexual orientation, sex assigned at birth and gender identity, HIV status, household income, Canadian citizenship, education history, employment status and parent, guardian, or caretaker status. At the end of the questionnaire, prospective participants were asked to share an email address or phone number where the research team could potentially follow up with them for an interview, facilitating in recruitment. This questionnaire was hosted securely on Qualtrics and was used to screen prospective participants to ensure they were a good fit for the project in consideration of predetermined quotas for the inclusion of BIPOC participants, trans, non-binary and GNC participants, participants living with HIV, and participants over the age of 50. The demographic questionnaire was developed in consultation amongst the research team, and by considering existing

demographic questionnaires, such as that used for the Trans PULSE Project, a previous project affiliated with the SIHER Group.

GBTMSM Community Member Interview Guide

The GBTMSM Community Member Interview Guide (Appendix F) sought to explore how structural barriers and facilitators influence the wellbeing of GBTMSM from across the SW Ontario region. Particular questions tended to favour a structural level analysis, asking participants to reflect on their experiences with heteronormativity and/or cisnormativity, racism, healthcare & social service access and sexual health education. As well, questions sought to explore how GBTMSM continue to maintain positive sexual, mental, and physical health, exploring the relevance of social support and community cohesion for the wellbeing of participants. The interview guide was based on emerging themes from phase two of the overarching SWOGAHI project as well as a detailed review of GBTMSM sexual health and broader health literature that assumes a structural-level analysis. The guide provided a set of questions and probes to guide the interview but allowed for an open discussion regarding the perspectives and experiences that were most relevant and important to the interviewee. As well, the narrative facets of the guide encouraged participants to share detailed and storied accounts of their experiences as GBTMSM, streamlining lived experiences and minimizing interpretation on the researchers' end.

Coding Guide: GBTMSM Community Member Interviews

The Coding Guide: GBTMSM Community Member Interviews (Appendix G) was developed by members of the research team upon reviewing preliminary themes within the interview transcripts. The coding guide was designed to organize information under relevant themes, favouring a structural- and community-level analysis that explores how laws and

policies might contribute to the wellbeing of GBTMSM and experiences in accessing healthcare and social services and their communities more broadly. As well, the guide is sensitive to region-specific nuances, ensuring to capture the unique experiences of GBTMSM in certain regions within SW Ontario that may not be represented in transcripts with GBTMSM from other regions.

Data Analysis

An inductive latent thematic analysis approach was introduced to analyze the data. Thematic analysis involves identifying, analyzing, and interpreting patterns or themes within qualitative data (Braun & Clark, 2006). More specifically, an inductive approach to thematic analysis encompasses a 'bottom up' approach, in that themes identified are strongly linked to the data collected; in this approach, data is coded freely of pre-existing frames or analytical preconceptions (Braun & Clark, 2006). In the context of the proposed research project's constructivist paradigm, the inductive thematic approach is logical, as the researchers sought to center the lived experiences of GBTMSM facing structural barriers and facilitators to wellness in the SW Ontario region. The inductive approach assisted in meeting this goal, as this framework facilitated in interpreting data free of pre-existing expectations, and instead, prioritized coding according to the narratives presented.

As highlighted by Braun & Clark (2006), beyond the general coding approach, it is important to specify at what level themes are to be identified. Of relevance for this project is the latent approach, which seeks to identify or examine underlying ideas, assumptions, and conceptualizations in the data (Braun & Clark, 2006). Although the semantic approach is useful for broadly describing and interpreting data (Braun & Clark, 2006), this project sought to garner a comprehensive understanding of the underlying structures (i.e., systems and policies) which

may serve to influence the health of GBTMSM. Accordingly, the latent approach was most logical.

To facilitate in the inductive thematic coding process, the research team followed Braun and Clark's 6-phases: 1) get familiar with the data, 2) generate initial codes, 3) search for themes, 4) review themes, 5) define and name themes, and 6) produce the report (Braun & Clark, 2006). To begin, the research team read through the transcripts, reflecting on, and making note of common themes reflected in the transcripts. Next, a member of the research team translated these common themes into a set of preliminary themes. Following the identification of preliminary themes, a coding guide was developed, discussed amongst the team, refined, and then applied to analyze the transcripts following a latent inductive thematic analysis approach (Braun & Clark, 2006). A final report reflective of these themes was developed.

Rigour & Trustworthiness

In order to ensure the validity and trustworthiness of the study, the research team took several precautions.

Member Checking. Member checking involves seeking verification by research participants upon the completion of data collection. This process ensures that data provided is accurate and reflects the lived-experiences and perceptions of the participant. As well, member checking ensures that the participant is comfortable with their de-identified and anonymized information being shared to a wider audience via knowledge mobilization tools (Lincoln, 2016). In the context of this research study, the research team implemented member checking at the end of each interview, providing each participant with the opportunity to reflect on the data they shared. At this time, participants were encouraged to reflect on any potentially sensitive

information shared and had the opportunity to have any such data removed from their final interview transcript without penalty.

Auditing. The process of auditing involves adopting a spirit of reflexivity, and documenting each step taken in data collection and analysis (Lincoln, 2016). As highlighted by Altrichter & Holly (2005), the use of a research journal may facilitate in the process of auditing, allowing a researcher to record their observations, questions, and critiques throughout the research process, encouraging reflection on data obtained and plans for subsequent research steps. In the context of the proposed research project, the researcher implemented auditing through the use of a research journal, which represented a space for the researcher to document planning, reflect on qualitative interviews, explore emerging themes, and pose questions for further investigation. To protect confidentiality, this research journal manifested as a password protected Word Document on the researcher's laptop. This journal will be deleted one-year after data collection was completed (March 31st, 2023).

Peer Debriefing & Support. Peer debriefing involves garnering support surrounding data collection and interpretation from an academic advisor or mentor (Padgett et al., 2004). However, in qualitative projects conducted by groups rather than an individual investigator, peer debriefing and support may manifest among the research team more generally (Padgett, 2012e). Throughout the data collection process, interviewers regularly checked in after interviews. When interviews were conducted by two interviewers, time was left at the end to reflect on the interview. In comparison, when interviews were conducted by one person, check ins with the other interviewers happened afterwards. These check ins surrounded reflecting on participant's narratives, whether interview questions were eliciting responses, and the general tone of participants' responses. As well, as mentioned, this research project is housed within the SIHER

Group at Wilfrid Laurier University. Accordingly, for the research study, the research team engaged in peer debriefing and support more broadly with the larger SIHER Group, sharing questions, concerns, and garnering support where necessary.

Triangulation. Triangulation seeks to enhance the completeness and enlargement of perspectives garnered (Flick, 2009). Of particular interest for this research study are observer triangulation and analytic triangulation.

Observer Triangulation. Observer triangulation involves the use of more than one observer in a single study to achieve intersubjective agreement (Padgett, 2012e). For this research project, Lucas Gergyek, Todd Coleman, and Fabian Fletcher conducted interviews with participants. By having at least two perspectives present during most interviews, the research team sought to establish intersubjective agreement around generalizations made from interview data. In doing so, the researchers sought to ensure that interpretations of lived experiences were not skewed or misinterpreted.

Ethical Considerations

This project sought to garner insight into the lived experiences of GBTMSM, a diverse subpopulation who continue to face a great deal of individual-, community-, and societal-level stigmatization and marginalization. Accordingly, the researcher sought to carry out this project with sensitivity and inclusion as top priorities. Regardless, there are some important ethical considerations that must be noted. Perhaps most significantly, there was a heightened risk for emotional discomfort due to self-disclosure and the nature of the interview questions. As part of the interview process, the interviewee was asked to share detailed information regarding their experiences of heteronormativity, cisnormativity and/or racism; these discussions may be triggering for some. However, upon request, participants were provided with a resource list

outlining relevant counseling/support options in the case that a participant experienced distress during or after their interview. In addition, collectively, the research team has over two years of counselling experience, and extensive experience working in the GBTMSM sexual health sector. Ultimately, if significant emotional discomfort occurred during an interview, the researchers did not hesitate to end the session if the interviewee wished to do so. In this case, the interviewee was ensured that they would still receive compensation for their time and were directed to the appropriate follow-up resource.

In addition, moral ambiguity and risk are of especial relevance to the research project. As mentioned, participants were asked to share detailed information about the ways in which systems and policies perpetuate heteronormativity, cisnormativity and/or racism, perhaps leading participants to reflect on experiences of discrimination, victimization, and violence. Entering the data collection phase, the research team felt confident that their extensive experience working to support the sexual health and broader health of GBTMSM would position them with the relevant foundation to support participants during triggering disclosures. As well, during the interviews, there was the potential for participants to potentially disclose highly sensitive information, such as childhood emotional, physical, or sexual abuse, or abuse and/or mistreatment by a healthcare or social service provider. If the participant still lived with an emotionally, physically, or sexually abusing guardian or partner, the participant and researchers co-constructed a safety plan. The interviewer provided the participant with a referral to a relevant support service (e.g., SPECTRUM Waterloo) when more sensitive and/or triggering topics arose for participants. Moreover, to protect the well-being of the interviewers, the SIHER Group created space for those conducting these interviews to debrief, and process emotional impact.

In addition, coercion is an ethical threat inherent to the data collection portion of this project, as two members of the research team hold a significant amount of privilege as White, cisgender male researchers working with a diverse sample of GBTMSM. In this context, power asymmetry is inevitable and social differences may be emphasized in this context (DiCicco-Bloom & Crabtree, 2006). In an attempt to attenuate the impacts of these asymmetries, the research team welcomed Fabian Fletcher, a Black GBTMSM-identified research assistant to conduct interviews alongside. The research team hopes that including Fabian in both the data collection and analysis processes broadened both the scope and inclusion of the project. As well, for BIPOC participants, the researcher hopes that the presence of Fabian served to increase comfortability and build rapport, curating a more meaningful space for discussion. Moreover, to minimize the influence of coercion, the researcher engaged in reflexivity before and throughout the research process, recording questions and concerns in their research journal. As well, a well-documented method for minimizing the implications of such power differentials involves integrating reciprocity into the creation of knowledge by offering some personal information during qualitative data collection (DiCicco-Bloom & Crabtree, 2006). Accordingly, the researcher included a prompt in the interview guide (Appendix F) which allowed the interviewers to share some personal details of their own, seeking to build rapport and minimize power asymmetries.

Finally, protecting the confidentiality and privacy of participants was of the utmost importance to the research team. Only de-identified and anonymized quotations are presented in this final paper, and only de-identified and anonymized quotations will be included in any resulting future publications or knowledge mobilization projects. As well, as mentioned previously, to provide adequate context for knowledge uptake, demographic identifiers are

associated with each quotation presented. However, specific cities and counties within each ASO's catchment area are not linked to these quotations. Rather, only the general catchment area is reflected, seeking to minimize the recognizability of certain quotations. Regardless, the research team outlined the limits of confidentiality prior to recruitment, and throughout the research process, in that there is the potential for de-identified and anonymized quotations to be recognized by those close to the participant.

Results

Summary of Participant Demographics

These results reflect the data collected from a sample of 30 participants. Considering regionality, a balanced sample of five participants from each of the six regions within SW Ontario were interviewed. This includes five GBTMSM living in or with lived experience in London, five from Niagara, five from Windsor-Essex, five from Cambridge-Kitchener-Waterloo, five from Hamilton, and five from Guelph. With regard to age, participant's ages were categorized according to pre-determined age groupings. Accordingly, seven participants fell into the youth category, ranging from 18-24 years old, 22 participants were categorized as adults, with seven representing young adults between the ages of 25-34 years old, eleven representing middle-aged adults between the ages of 35 and 49 years old, and four representing older adults between the ages of 50 and 64. Finally, one participant was categorized as a senior over the age of 65. Considering the ethnoracial identities of participants, 20 identified as White, while three participants identified as South Asian. The remainder of participants identified as the following, with one participant per ethnoracial identity category: one Black & Indian, one Black, one White & Latin, one Indigenous, one Indigenous & White, one Arab, and one Latin. Reflecting on the sexual orientations of participants, 14 identified as gay, five identified as queer, four identified as

bisexual, three identified as pansexual, one identified as gay/queer/Two-Spirit, one identified as gay/queer/fag, one identified as queer/pansexual/gay, and one identified as androsexual. With regard to gender identity, the majority of the sample identified as cisgender men (n=22), while five participants identified as transgender men, and three identified as non-binary. Finally, in consideration of HIV status, five participants were living with HIV, 22 were HIV-negative, and three had never been tested for HIV.

Overview of Findings

Participants reported a variety of ways in which structural- and community-level variables have impacted their sexual, mental, and physical health, sense of social cohesion and social support systems, and their experiences with accessing healthcare and social services in SW Ontario. In addition, as suggested in previous literature, the negative influence of these factors on the wellbeing of GBTMSM living in SW Ontario was exacerbated especially for GBTMSM with other intersecting marginalized identities, such as those who identified as BIPOC, living with HIV, or living with a disability. However, the positive influences of these structural- and community-level factors on wellbeing were mentioned at least once by all participants in the sample, suggesting that although structural- and community-level variables undeniably act as barriers to achieving wellbeing, there are certain factors nested under these larger variables that may serve to attenuate some of the harms that could potentially follow from faulty laws and policies, contributing to positive wellbeing.

Structural-Level Themes

Under structural-level themes, participants described how laws and policies contributed, both positively and negatively, to their wellbeing. For instance, some participants recognized how certain laws, such as the ban on conversion therapy, contributed to the normalization of

queerness and transness and promoted feelings of safety. Meanwhile, other participants discussed how the GBTMSM blood ban contributed to feelings of disempowerment, leaving GBTMSM feeling undervalued. Connectedly, many participants recognized the disconnect between laws, policies, and practices, highlighting that although certain laws and policies may be in place, there is not a direct connection between these laws and policies, and actions that follow from these laws and policies. For example, although a workplace may have an equity and inclusion policy in place protecting 2SLGBTQIA+ people from discrimination at work, these policies may not always be actively enforced, or appropriate recourse may not follow when these policies are broken.

Primary Theme 1: The Influence of Laws and the Legal System on GBTMSM

When prompted to reflect on how laws related to sexual orientation, gender identity, and/or race influenced their wellbeing, participants presented a number of unique responses. A substantial proportion of participants described that they feel they have the same number of rights and opportunities as their heterosexual and/or cisgender counterparts, and that they benefit from the laws in place. However, a greater number of participants described that the laws protecting sexual orientation and gender identity minorities from discrimination and harassment do not always lead to action, in that members of their communities and workplaces have failed to abide by these laws, engaging in discrimination regardless of potential legal repercussions. As well, certain laws, such as the GBTMSM blood ban were labelled as disempowering and based on outdated knowledge. In comparison, other laws, such as the ban on conversion therapy, were framed as positively influencing wellbeing, and were characterized as empowering and monumental.

Secondary Theme 1: Ban on Conversion Therapy. For many of the participants who touched on how the laws related to sexual orientation, gender identity, and/or race influence their wellbeing, the recent ban on conversion therapy in Canada was described as a significant win for GBTMSM. In particular, one participant recognized how the ban on conversion therapy makes it illegal to use homophobia, biphobia, or transphobia against GBTMSM, providing a source of empowerment.

> I think, for instance, of the most recent one, with the banning of conversion therapy across Canada, I think that was a major step forward, I think it was long overdue. Considering people have been speaking out against that for decades. But it's good, it's so good to see, because it's basically making it so that you can't legalize a method of using homophobia or transphobia against people, although, we still definitely have some issues. (Region 6, 35-49 years old, White, bisexual, cisgender man, never tested for HIV).

Reflecting on the implications of the ban on conversion therapy for attitudes toward GBTMSM and 2SLGBTQIA+ people held by the broader society, this participant continued, highlighting the significance of the ban on conversion therapy for setting a standard for how society should view and treat GBTMSM and the broader 2SLGBTQIA+ community.

> Again, like I said, the conversion therapy ban, for instance, was a very positive step, because again, it was saying that, no, you shouldn't be trying to convert anyone. That's not only not effective, but it's dangerous, right? I think that kind of knowledge, again, had been known for decades. But I don't feel like the general public saw it that way. But now, hopefully, as they're kind of aware that that's happened, and, you know, that idea starts to kind of fade away as even an option in people's heads, hoping that that kind of idea changes a bit in society. (Region 6, 35-49 years old, White, bisexual,

cisgender man, never tested for HIV).

Another participant recognized the benefits associated with the ban on conversion therapy, but also highlighted how more covert forms of conversion therapy may still be operating for some time, underscoring the disconnection between laws and practices.

> Yeah, I mean, so I guess the most recent one was the conversion therapy ban. And that's huge. I think that it's going to take a while for things to change. But I'm hoping that people will finally realize this doesn't work, and this isn't something that we should even consider. And I think that that has to do with looking at what counts as conversion therapy, because one of the things that I look at with my youth group is, when you're going to hospitals, and they're trying to push this one type of trans on you, they're trying to put you into this one box. They're trying to train you to be this one person that you're not. And that's not necessarily based on religion and all these other things, but I'm hoping that along with that, we'll start looking at what messages are we giving to queer people? (Region 4, 18-24 years old, White, queer, non-binary, never tested for HIV).

Secondary Theme 2: HIV Non-Disclosure Laws. For participants living with HIV, HIV non-disclosure laws were described as oftentimes harmful, creating situations where GBTMSM living with HIV have to constantly come out about their status, despite the fact that they are undetectable and get tested for STBBIs regularly. In fact, all participants living with HIV described discriminatory experiences when navigating healthcare and social services as someone living with HIV, suggesting that greater HIV-related education in the healthcare sector is needed.

> I've seen people have a little physical reaction in some of the LifeLabs locations, they try very hard to mask it and to be professional, but the moment they realize they are doing HIV viral load testing, I have seen a physical reaction change, like body language

> change in individuals. And now I can see those things because I have seen, and I have known and experienced better. (Region 4, 25-34 years old, South Asian, gay, cisgender man, living with HIV).

Similarly, another participant encountered shaming when revealing their HIV status to healthcare practitioners.

> I remember, going in for regular testing, and for STIs, and whatnot. And as soon as I disclosed my undetectable status, the person I guess, the nurse that was there, brought in someone else, and the two of them lectured me about my status, and disclosing it to my partners and what I should be doing and what I shouldn't be doing, which I already knew. But it didn't leave a good taste in my mouth, just how they, I guess their delivery was poor. (Region 2, 35-49 years old, Indigenous, gay, cisgender man, living with HIV).

Another participant spoke more directly to how the HIV non-disclosure laws create a sense of everyday stress while seeking to navigate sex and relationships, suggesting that navigating interpersonal and sexual relationships under these laws may represent a source of anxiety for GBTMSM living with HIV.

> For one, I think there is a lot of added pressure, stress, however, you may call it, for being a person living with HIV, for me specifically. Every single time I hook up, every single time I date someone, this is a big mountain that I have to climb in telling them that I am positive, undetectable. And then it goes in all kinds of directions, there are people who ghost you, people who hurl abuses at you, and you know, go in the other direction. There are people who say, I understand, but thank you, no, thank you, and then there are people who accept it. So, in all of that spectrum of things, all of the possibilities and all the experiences that you go through in this impact your mental health and overall

wellbeing. I absolutely feel the pressure of that every day. (Region 4, 25-34 years old, South Asian, gay, cisgender man, living with HIV).

Secondary Theme 3: Same-Sex Marriage Laws. In contrast to how HIV non-disclosure laws represent a significant source of stress and anxiety for GBTMSM living with HIV, other participants described how the legalization of same-sex marriage positively contributed to their wellbeing.

> Well, just that I'm able to marry my partner is wonderful. That there can be queer families that have children, that we can hold regular jobs that everybody else has, and not fear that people find out like, 'Nope, sorry, can't do that job with that lifestyle', as some people say. (Region 4, 35-49 years old, White, gay, cisgender man, HIV-negative).

Another participant suggested that the legalization of same-sex marriage trickles down to influence the attitudes of those across Canada, setting a social standard for how folks view and treat GBTMSM, and 2SLGBTQIA+ people, more broadly.

> Well, I think that our laws absolutely set a social standard. I remember when marriage equality came into effect in Canada and also in the United States, there was a shift of social views around that. And even people that maybe wouldn't have been vocal about one side or the other prior to the legalization of same sex marriage know that there's a line that they can't cross, and now they're either going to keep their mouth shut, or they're going to act in support. But then again, when they're actually in a situation when they have to support that, they might not actually follow through, but it kind of sets that social standard, and they know that that they're not going across that way. (Region 3, 25-34 years old, White, gay/queer/fag, cisgender man, HIV-negative).

Regardless of the utility of same-sex marriage laws for setting a social standard, one participant recognized how certain facets of the 2SLGBTQIA+ movement may have overly focused on securing marriage rights at the cost of overlooking other pertinent GBTMSM-related issues, such as rights to accessing sexual health services and the right to sexual expression.

> Also, [reflecting on the fight for same-sex marriage] can be a way for gay Western politics to address its own limitations. And for me, I do think it's been problematic in many ways, you know, because it is a form of mobilization that is built on getting social political rights, but the cost is, it perpetuates heteronormativity in gay marriage. There are no discussions of the fact that we have struggled, or sexual health. Historically, marriage was invented to secure lineage. So, it is a capitalist concept that was meant to control women and women's bodies were used as vessels, right? So, I'm not against marriage. But the point is that our movement has been so much about this one ideal that had really nothing to do with being gay. In the 70s, promiscuity was celebrated, now there's such shame, I constantly find that amongst gay men. I think there's the internalized homophobia, that runs very deep within our movement. (Region 3, 25-34 years old, Pakistani/South Asian, queer, cisgender man, HIV-negative).

Secondary Theme 4: Protections for Sexual Orientation & Gender Identity Minorities. On a broader scale, a number of participants discussed how the laws protecting sexual orientation and gender identity minorities from discrimination served to protect, or not to protect them from discrimination related to their sexual orientation and/or gender identity. In particular, one participant praised these laws, describing how they serve to maintain access and equality for GBTMSM.

> I think the laws around equality definitely lead to action. I feel like I get the same

> opportunities as everyone else. I feel like the laws, and everything are respected and known by everyone. You know, some people just kind of throw homophobic comments out there. But it's not like I've ever felt like I have less rights than others. (Region 6, 18-24 years old, White, gay, cisgender man, never tested for HIV).

In contrast, another participant described how the laws protecting GBTMSM from discrimination may not extend to trans and non-binary GBMSM as much as they apply to gay and bisexual men, leaving trans GBMSM privier to facing discrimination.

> Obviously, the laws around trans people are very questionable. There's a lot of things that are trying to exclude and put trans people at considerable risk. And I've been actually having this conversation a lot recently, where there's a narrative that tends to flow through politics, whenever they want to, basically get away with bigotry. They just make the person sound like they're dangerous, right? It was the same thing with gay people, they tried to claim that they were going to engage in forcible sex upon straight people, right? Like, it's always been the narrative of, you're in danger, these other people are a threat to you. And I feel like they're now just focusing on trans people, because it's getting harder for them to make that argument against all the others. (Region 6, 35-49 years old, White, bisexual, cisgender man, never tested for HIV).

Similarly, another participant mentioned how certain laws and policies pertaining to trans and non-binary GBMSM are dangerous and leave trans and non-binary GBMSM open to facing discrimination and distress. As this participant describes, until the age of 18, an individual needs their parents' consent to change their name. The inability to make this change prior to turning 18 creates a significant barrier to social transitioning, as is described below.

> The thing that's frustrating there is, I needed them to sign for my name change,

> and they didn't want to do that at first. That took a bit of coaxing, I guess. You know, I was 17 at the time, but I had wanted to change my name since I was 10. I told people when I was 10, I need to legally change my name. And it's annoying when your parents don't see that and then try and block you from this huge thing. I'm so grateful that I changed my name, it has made my life a million times easier. In university, in traveling, having the passport under the right name and gender marker, like I was so scared coming to Europe that I would be pulled aside and checked separately, all these other things, but I just walked right through. And that privilege comes from documentation and the right name. And so, I'm glad that we're allowed to do that in the first place. But definitely that challenge when you're a youth is really hard. (Region 4, 18-24 years old, White, queer, non-binary, never tested for HIV).

Another participant captured the complexity associated with the laws protecting GBTMSM from harassment on the grounds of sexual orientation and/or gender identity. Reflecting on an experience of facing homophobic discrimination from a previous landlord, this participant described how although these laws oftentimes fail to prevent individual experiences of discrimination, having them in place can provide an opportunity for legal recourse when discrimination occurs. However, the process of enforcing one's right to non-discrimination can be quite taxing.

> I actually rented a farm just outside of [city in region 6] and I was there long-term, maybe three or four years, and then the place sold. And the gentleman that bought it, he was very homophobic. And the one day, I had a rainbow bandana hanging from my rear-view mirror. And he had my car towed. I rented the spot with the whole house, and he towed my car because he said some lame excuse that he didn't okay for it to be parked

> there. And it was right in the lease that the parking spot was included. I had to contact the police and they made him pay to tow my car back. Yeah, I mean after that, he made living at that property so uncomfortable. I had to go to the landlord tenant board, and I ended up moving because I couldn't stay there with my family, there were so many homophobic slurs and everything like that. He ended up refunding me 50% of my rent over the past year that I had to live there since he bought it. It was suggested from the landlord tenant tribunal- they provide you with a duty counsel, I think it's called, where a lawyer sees you and kind of gives you suggestions. And she told me to take my case to the human rights board. But I just wanted it over with, I'd already moved. But I mean, that was the worst experience I've ever had. I mean, you're in a position where you're living in a home, you're paying to live in that home, I wasn't behind in my rent, I'm doing nothing wrong, but somebody makes you so uncomfortable for just being who you are that you have to physically move. That was that was not a good experience. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Secondary Theme 5: Protections for Racialized People. For racialized GBTMSM in the sample, participants often made connections between the laws preventing discrimination on the grounds of sexual orientation and/or gender identity to the laws preventing discrimination on the grounds of race, emphasizing the importance of recognizing intersectionality to comprehensively capture the experiences of racialized GBTMSM. Here, participants often described how the laws protecting racialized folks from discrimination fail to translate into practice, leaving racialized GBTMSM feeling like they have less opportunities, access, and capital than their White counterparts.

> The baseline or the playing field is not the same for People of Colour and White people, essentially. For example, someone who's White, they might have immigrated to Canada, when they were five years old, ten years old, or whatever. If somebody asked them about themselves, and they say I'm a Canadian, that's the end of the conversation. Someone who's not White, they might have been born here, but I am a Canadian is not an acceptable answer. You somehow still have to put a hyphenated identity that I am, you know, Nigerian-Canadian, I am Indo-Canadian, I am Filipino-Canadian, whatever. I've never heard somebody say, I am German-Canadian or Polish-Canadian, or Portuguese Canadian. I've never heard someone say that, and I've never heard somebody ask for that, you know, in that setting. So, how that impacts your sense of self and your sense of identity and your sense of belonging in this place, and in this country, in turn, has an impact on what ownership and what right you feel in being able to access and interact with those policies and systems and procedures. The playing field is not even. So, policies and other things, in theory might be the same, but the practice is very different. (Region 4, 25-34 years old, South Asian, gay, cisgender man, living with HIV).

Delving more into how systems and policies leave racialized GBTMSM at-risk for harm, another participant described how they see the police as a means for enforcing the inequality facing racialized people in Canada.

> I'm really scared of the police; I see the police as a system that is built on institutionalized racism. I very much see the police targeting People of Colour as something benefiting the rich. So, I don't support the police as a mechanism to ensure the wellbeing or protection of society. I'm not saying these officers themselves are bad, but I think policing is built on a colonial and neocolonialism system based around phobia and

> all those things. Policing is built on racialized practices, and every Person of Colour could be potentially at risk of being victimized by a police officer, so I have a lot of anxiety or fear. So, there've been times where I've stepped out with a drink in my hand, but then panic, you know, what if I end up in a federal prison? It's over, I'm going to get deported. But I know that during the day, a White police officer has discretion to kill me. Or if somebody else engages in racial violence against me, the police are not going to come and help me because I don't fit the victim narrative. Because the victim narrative is built on again, ideas of White supremacy, you know, that's why so many Women of Colour go missing and nobody does anything. (Region 3, 25-34 years old, Pakistani/South Asian, queer, cisgender man, HIV-negative).

Other participants further contextualized racism perpetuated by the police, describing experiences of harassment and discrimination from the police due to their race and their sexual orientation and gender identity.

> In [region 6], I have been carded three times. The first job I got was at [mall in region 6]. And I was late for work. And I just grabbed my uniform and my apron and everything, but I missed the bus. And I'll be honest with you, I didn't have any money. And nobody was in the house, so I started running. I ran to [street name], and the cop stopped me, and he says, well? And I said, I just left my house, you know? And then he says that somebody just reported that a Black man just robbed their house. And I said, I just left my house? And then he took down all my information. I said, listen, I'm going to be at [mall in region 6], I'm late for work. You know, if you want to come and see me, come and see me. And then he asked for my ID and everything, and I said, you need to be quick, I'm late. And my manager was calling me, but I couldn't answer the phone. And I

> said, I need to go. So, I ended up running, and then when I got there, I said, a cop stopped me and carded me. And then the second time was in front of the police station, another incident happened. But it's hard to say whether it was because of me being gay or because of me being a Person of Colour. But most of the times I got carded it was because I'm a Person of Colour. (Region 6, 35-49 years old, Black & Indian, queer, non-binary, HIV-negative).

Beyond experiences with the police, a number of participants described interpersonal experiences of racism from both the 2SLGBTQIA+ community, and the broader community. In particular, one participant described facing racism when using dating and hook-up apps.

> Racism comes up when I'm using the apps. In Toronto, I feel like I would have much better luck from both Grindr and Scruff. But here on Scruff, I've noticed that White guys don't respond to me ever. And so, I imagine that would have to do with race. And Grindr has its own kind of culture. I feel that the first question I get asked is, what's your background? And I just feel like okay, I don't mind telling you that, but if you're attracted to me enough, why do you need to ask that. Are you asking me because you think I had something to do with the UK bombings, like? If I told you I'm from Pakistan is that going to impact your decision to have sexual intercourse with me or not? But I don't know, it always gets asked. (Region 3, 25-34 years old, Pakistani/South Asian, queer, cisgender man, HIV-negative).

Secondary Theme 6: Laws Around Donating Blood for GBTMSM. In contrast to how the laws enforcing the ban on conversion therapy, for example, operate to promote wellbeing and instil feelings of safety, participants described the laws around donating blood for GBTMSM as extremely discriminatory and disempowering. When reflecting on these laws, one participant

captured how little has changed in regard to attitudes toward GBTMSM, sex, and promiscuity, despite significant advances in HIV treatment and prevention.

> I mean, if we're talking the blood ban stuff, I think it's horseshit. But I also don't feel like the need to donate my blood to a state that only cares for my blood when it's useful for them. Like the fact that it was only during COVID that they're like, oh, sure, we'll take blood now, because we're fucking desperate. And it's like, you wouldn't have cared about us if this was the 1980s. (Region 2, 18-24 years old, White, bisexual, non-binary, HIV-negative).

Another participant echoed similar thoughts, but also highlighted the irony in that organizations such as Canadian Blood Services do not hesitate to engage in pink washing, despite the presence of discriminatory and harmful policies banning GBTMSM from donating blood.

> But just the fact that we can't donate blood, and they reduced it from I don't know from what years, from something to something but you have to be celibate. So just that whole thing about donating blood? I mean, do they ask the same questions of heterosexual people? Like, they could be just as slutty as we are? I don't really understand. I don't buy into it. So, I feel it's completely discriminatory. Even I've had, especially when they were at Pride in Toronto, one time, they had a booth, Canadian Blood Services, or whatever they're called. And I walked by them. And then I came back. And I said, really? What are you doing here? And they said, oh, we're trying to open up communication. I was like, what's there to open? You guys are disgustingly discriminating against me. (Region 5, 50-64 years old, Arab, gay, cisgender man, HIV-negative).

Primary Theme 2: The Influence of Policies on GBTMSM

Similar to the ways in which laws influence the wellbeing of GBTMSM, participants noted how policies have the potential to influence their health and wellbeing. As many policies follow from laws, a number of participants highlighted the disconnect between policy and practice, similar to the discontinuity between laws and practice. However, a number of participants described that workplace and sexual health-related policies positively contributed to their wellbeing, creating climates where they felt safe to express their orientation and/or gender identity and dynamics that encouraged positive sexual health via regular testing. Nonetheless, a number of participants mentioned that certain policies did more harm than good, such as policies around sexual health education, which often prevents educators from delving into sexual health education that is relevant to GBTMSM, such as discussions around HIV, PrEP, and anal sex.

Secondary Theme 7: Community & Workplace Policies and Protections Around Equity & Inclusion. When broadly reflecting on how policies influenced their wellbeing, participants often described how the presence or absence of community and workplace policies and protections around GBTMSM equity and inclusion contributed to their experiences of safety and wellness in their communities and workplaces. In particular, one participant described how the disconnect between policy and practice left them feeling overlooked and disempowered after experiencing workplace discrimination.

> I think that they function well as setting the social standard. But when they're being put into practice, they don't always act the way we want them to. So, I have had to go to the Human Rights Tribunal of Ontario because of things that have happened in the workplace. And as an institution that sets these rules or kind of sets the standard, it helps that company, let's say that I was working for kind of know the limits of what they can

> and cannot do. But when it comes to crossing those limits, this system in place is not necessarily beneficial, or in my experience did not benefit me whatsoever. It was a really horrible experience. That was just really drawn out as well. So yeah, I think that they're good. They set a good standard. But when it comes to the actual practice of these things, they are not necessarily helpful. (Region 3, 25-34 years old, White, gay/queer/fag, cisgender man, HIV-negative).

Similarly, another participant described how a disconnect between policy and practice allowed for a racist, homophobic, and transphobic professor at their university to maintain their position, contributing to an environment where students felt unsafe in the university community.

> Yeah, we have a tenured prof, who is actively, blatantly racist, homophobic, and transphobic during lecture. And there was a petition that went around that 1000s of people signed being like, get them out of here. Like, that's not okay anymore. Like, it wasn't okay 10 years ago, it's not okay now, students are feeling unsafe. And they were like, nah. No slap on the wrist, nothing. And people were like, they should be fired. (Region 4, 18-24 years old, White/Latin, pansexual, transgender man, HIV-negative).

Thinking about how policies may contribute to their wellbeing across the lifespan, another participant described that a lack of policies ensuring safe and affirming long-term care facilities for GBTMSM and the broader 2SLGBTQIA+ community contributed to feelings of anxiety and concerns around identity concealment.

> I'm really frightened about having to go into a long-term care home. For quite a while I've wanted to get a tattoo that indicates something with the pride flag, but I'm honestly not doing it. Because if I'm old and in a setting where I can't protect myself, I don't want things to happen to me because of that. So, I'm really concerned about our

community as we get older and need safe spaces to age in. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

When considering how policies or the lack of policies around equity and inclusion contribute to safety and inclusion, some participants focused more explicitly on the workplace. In particular, one participant described their experiences of harassment and discrimination at a previous job, suggesting that a lack of workplace policies preventing discrimination on the basis of sexual orientation and gender identity can leave GBTMSM at-risk for discrimination at work.

> I had harassment at my past job as well, and I stayed there for like five years. Basically, I didn't get a promotion from my boss even though I had worked there three years at the time, because he was very Christian. And I was very open in the workplace about my political views and stuff like that. He was very anti-choice, homophobic, transphobic, whatever. And then he basically hired someone who had only been there for a year and who would argue with customers. And she had also spread lots of rumors about me like she said, I had AIDS and stuff like that, and also said that I'm very extra in the workplace, which I was not, I would talk about Drag Race with her because I thought that was something we had in common. And then basically at that point, I was like, fuck it, I've been here for years, I'm not putting up with this, and I filed a report against her. And now she's the general manager. So, she only went up from there, even though the findings are true and everything. (Region 2, 18-24 years old, White, bisexual, non-binary, HIV-negative).

In contrast to the previous participant's experience with seeking recourse in response to workplace discrimination and having their complaint ignored, another participant described that when they experienced racial discrimination at work, action was taken against this individual,

enhancing their wellbeing and feelings of safety and inclusion at work.

> A month ago, at work, I experienced racial discrimination. And that person made some comments. And I think these comments were okay, I was like, okay, whatever. And then I didn't even think about it, but then I talked to someone else, I told them, and they couldn't believe the person said this and they were crying that I had to go through this and stuff. And I was like, okay, is it that big of a deal? So, then I talked to another person, asking is that okay, or no? And they were like, this is so wrong, you have to go to your manager or HR. So I went to my manager, and I told her, and she was shocked. So, there was an investigation at work. And that person got fired. They were there for over 10 years. And I just started this year, in January. So, I think it doesn't matter who the person is, who's violating anything, if they're wrong, they are wrong. (Region 1, 18-24 years old, South Asian, gay, cisgender man, HIV-negative).

Secondary Theme 8: Funding & Support for GBTMSM & 2SLGBTQIA+ Spaces and Services. Beyond policies nested at the workplace and community levels, participants described that the presence or absence of policies ensuring funding and support for GBTMSM and 2SLGBTQIA+ spaces and services influenced their wellbeing. Thinking broadly, one participant reflected on the need for greater governmental funding and support programs for 2SLGBTQIA+ people, as coming into and navigating one's identity can be an isolating and taxing experience, leaving GBTMSM without financial support from family members, in some instances.

> I think people come into their sexual identity and their gender identity at different points in their life. But I think the critical point when someone's also building their career is really important. So, someone who's training to build skills to get a job to make an

> income, it's usually someone who's like in their early 20s, or mid 20s, it's a really critical point in their life. Someone who's queer in their sexual identity or their gender, some people have family support, I don't know, the majority of people don't, it feels that way. But so, policies that support and protect the time and energy of young people who are trying to train to get meaningful employment while they're navigating this is really important. So, I am not in touch with any family members, I completely financially support myself, I'm single. So, I'm trying to train full time and make enough money to support myself and pay for my transition, like my top surgery is $15,000, I'm still waiting for OHIP to cover that, and they might not. My rent is $1,300 a month, I'm a student full time, so I can't take a full time nine to five job. So, I piece together work. So, I have to find full-time work and produce the equivalent of a full-time workload at school, while I'm also trying to work on my health, so I'm healthy enough to be a good employee and be a good student and not have suicidal ideations every day. So, for me personally, there could be policies that allow someone like me to train and like, not have to earn every penny. We need money, I don't know how else to put it. (Region 5, 25-34 years old, White, queer/pansexual/gay, transgender man, HIV-negative).

Similarly, another participant recognized that funding and support is especially needed for 2SLGBTQIA+ folks who are living with a disability; when reflecting on the experiences of their 2SLGBTQIA+ friend, this participant highlighted how the policies around government supplementation for those living with a disability are simply not enough.

> And people who are deviant, who live on the fringes, people who don't generate profit are being marginalized, demonized, and reduced to absolutely lack of economic power. I mean, just look with the Tories abducted ODSP Ontario. How do you live like

> that? [Friend's name] has been living in his apartment, no electricity for three years. He has no electricity because he got his PhD, ran up all the debt, goes into debt, and promptly became disabled. And he got beat up by the police. And now, he can never catch up. Like I made phone calls, because it pisses me off. I'm in a two-bedroom apartment here, and the Ontario government supplement pays my hydro every month to spare. I can't use enough electricity to cover the bill that they cover. I've got a credit going. And the fucking same system won't give him his money, his electricity back because he's piled up penalties for the two and a half years he's been without. His actual use of $150 is not $3200. How is ODSP ever going to catch up? How is the system not trying to kill? (Region 3, 65+ years old, White, pansexual, cisgender man, living with HIV).

On the topic of government subsidization, another participant reflected on the barriers to accessing medications related to transitioning, underscoring the need for appropriate funding and support measures for trans and non-binary GBMSM.

> Subsidization for medication and hormones and stuff, even if you can't find a doctor and get the prescription and go through all that it's very expensive. And I'm lucky enough to have insurance. And I don't know, I don't think I could have done it otherwise. It's life changing and life threatening, also, health care. Like, it's not a choice. It's not, you know, it was never a choice, it's either take it, or do not continue existing. So that should be something that is subsidized, kind of like insulin and other things like that, it should be part of subsidized health care. (Region 4, 18-24 years old, White/Latin, pansexual, transgender man, HIV-negative).

Beyond underscoring the importance of securing funding, other participants spoke about the importance of securing support, either through obtaining specific spaces or services for the 2SLGBTQIA+ community or certain subpopulations that exist under the broad label of GBTMSM.

> So, this has been talked about a lot in this community over and over again, and it's never going to happen. We do need a wellness center like (2SLGBTQIA+ community health center in Toronto). There's been iterations of it over time, the challenge is that it always slips into alcohol, clubbing, and partying. Which is fine, that's an aspect of our community. But I just like to see something that is more health based. Yeah, I just don't know if (region 5) will ever be ready for one. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Relatedly, another participant spoke about needing greater support services and programs for GBTMSM who use substances and Indigenous and Two-Spirit people.

> I'm not sure, because I think there's a general understanding that you know, the queer community is made up of a variety of people. So, I think overall, there's general acceptance. So similar to my stating the need for specific services for gay men or, you know, people who uses substances, I think having specific services for Indigenous people in the area would be good as well. Because I think we might fall through the cracks, really. And even though there's the general idea of inclusion, I think having a specific group or organization specifically for Indigenous or Two-Spirit people, it would be better to really highlight those people and have a specific service in terms of culture and social belonging, if that makes sense. (Region 1, 50-64 years old, Indigenous/White, gay, queer & 2-Spirit, cisgender man, living with HIV).

Secondary Theme 9: Healthcare- & Social Service-Related Policies. Similar to community and workplace policies and protections, a number of participants spoke directly to how the policies or the lack of policies in place in the healthcare and social services in their communities contributed to their wellbeing. In particular, one participant reflected on the healthcare-related policies around notifying about a positive HIV or STBBI test result, and how this policy influenced their wellbeing.

> I suppose this policy is kind of a general policy- but I did find that the way I was notified of my HIV status was very negative in the fact that, I'm aware that when testing for STIs, that results can be given over the phone. So, when I was called by the nurse from the health unit, in regard to my HIV status, she said, can you come in the next day? And I said, you can't tell me over the phone? And she said, no. I knew right then that it was HIV because of that. So, I think there needs to be a better system because I spent 24 hours reeling over the fact that it must be HIV and she wasn't able to give me support and just say, you have to wait till tomorrow. So, maybe that works for people who aren't familiar with the way that they can give results over the phone for any other STI. But for HIV, it has to be in person. So, I think there could be a big improvement for that. Because granted, it was just one day, but it was a very, very bad day. Because I was 99% sure that it was HIV. And instead of, you know, getting the results that day, I had to wait a whole day. And it was very negative experience. (Region 1, 50-64 years old, Indigenous/White, gay, queer & 2-Spirit, cisgender man, living with HIV).

In a similar vein, another participant reflected on their experience of being notified about a recent partner testing positive for syphilis, but in contrast, described the experience as positive, as it demonstrated a commitment to encouraging positive sexual health from the public health

body in their region.

> I mean, our public health service is pretty on the ball. Like this is a personal thing, but I mean, this was a few months back, they contacted me because a partner that I had six months previous, had tested positive for syphilis. And I mean, it was way after I had ever been intimate with that person. But they still contacted me because I was one of the partners they'd been with in the last six months. So, I mean, they do their follow up and job pretty good in that way. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Another participant echoed similar praise of the public health body in their region, describing the utility of being followed up with for regular testing.

> Since I got in touch with this nurse and public health, they had this program. And once they put you in the system, they contact you every three months or every six months. Or the other thing is, if you had a sexual relationship, and it was just a one-time thing, and it was not safe, you know, for whatever reason, you can call them right away. And she established a friendly relationship with me because I'm open and I'm just asking for help, I'm not shying away from anything. So, she says, okay, come back next week, I will see you tomorrow, or the day after, you know, whenever she's available. And she takes swab samples from the throat area, does blood work. So, I am tested for everything. (Region 6, 50-64 years old, White, pansexual, cisgender man, HIV-negative).

Drawing a comparison between the ASO in their region and the other healthcare and social services in their community, another participant reflected on the variability in 2SLGBTQIA+-related knowledge and competencies, suggesting that some healthcare and social services in their region lack adequate policies around education programs to inform providers on

providing affirming services for 2SLGBTQIA+ folks.

> I mean, my mind is constantly thinking about truly amazing staff at [ASO in region 4], I mean they were amazing. But when I'm thinking about everything else around like LifeLabs, or wherever else, overall, as a society, and our healthcare system, we do not have the vocabulary. Staff is not equipped with the vocabulary to help the LGBTQ community. Everything is still very heteronormative and very binary in so many ways. Something as simple as using the word partner, as opposed to assuming and saying, oh, you know, how about your girlfriend, like, you know, those little things? (Region 4, 25-34 years old, South Asian, gay, cisgender man, living with HIV).

Exemplifying this lack of 2SLGBTQIA+-related competencies at some healthcare and social service centres in SW Ontario, another participant described that a hospital in their community refuses to provide services to pregnant people living with HIV, underscoring how a lack of 2SLGBTQIA+-related competencies can be potentially fatal.

> But I do know when it comes to HIV and pregnancy with HIV that the hospital in [city in region 2] is not well versed. Like they don't know how to handle it and they don't have nurses or doctors who have good education surrounding that. So, if somebody comes in there who has HIV, sometimes they'll refuse to have them give birth. And that's really wrong. So, a lot of people in [city in region 2], if they do have HIV, and they do have a baby coming, they'll go to [region 5] instead. (Region 2, 18-24 years old, White, androsexual, transgender man, HIV-negative).

Secondary Theme 10: Policies Around Sexual Health Education. Perhaps illuminating where the lack of 2SLGBTQIA+-related competencies found amongst providers at healthcare and social services across SW Ontario stems from, the majority of participants in the sample

described how the sexual health education they received in primary and/or secondary school was abysmal, and often times lacked any consideration of 2SLGBTQIA+ people. Capturing the situation broadly, one participant reflected on how heteronormativity and cisnormativity in schools perpetuates stigma, and in turn, prevents important discussions around 2SLGBTQIA+ sexual health from occurring.

> [My sex education was] really gendered? Really heteronormative. The teachers were extremely uncomfortable, which instills that stigma in you around everything to do with sex. That's probably my main memory, that whoever was teaching it was so uncomfortable talking about it, and you don't know why. Because you're too young. So, it's almost like you don't know why it's so uncomfortable? Did you have a bad experience? Should I be scared of sex? Is this bad? Is it secret? Should we not be talking about it? Are you allowed to be talking about it? It's always a gym teacher that they have teach it, which is weird. It's like, your gym teacher is someone who has a degree in how knees work, and they were a rugby player guy. It's weird. And then I'll never forget in high school grade nine, it was divided into your, like, boys and girls. So, I was obviously in a class of all girls. And the high school teacher asked us to raise our hands if we've ever had sex, or like, asked us to raise our hands if they've ever given oral sex. Then she like drew a penis on the chalkboard. And yeah, she was explaining how to give oral sex. Very like, as if she was explaining how to load a gun, that kind of vibe. It was only about how to give oral sex to someone with a penis, mind you. So, it's very implied that you are cisgender and you're going to have sex with another cisgender person and it's going to be this like heteronormative act. (Region 5, 25-34 years old, White, queer/pansexual/gay, transgender man, HIV-negative).

Highlighting alternative outlets for accessing sexual health information in the absence of comprehensive programming, another participant described accessing sexual health information via community networks, such as at bars, and through porn.

> So, I mean, I'm 43. So, during my coming out years, and my development years, the internet didn't exist yet. Which makes me seem really old, but I'm not quite that old. So, we didn't have anything like to look things up. So, there was no way to get any sexual health support, other than through my family physician, and I didn't feel comfortable at that point. So really, it was through word of mouth. I started going to gay bars when I was underage, which at least allowed me you know, they had boards where they would put up, posters with phone numbers and places to go. So really, through going to bars underage, and in bars of all places, that's where I was linked to HIV testing, condoms, etc. But no explanation, so I have never really fully had an explanation of sex by anybody for anything. I have a bit of a unique history because my dad was gay. I was lucky that he had porn. Because when I was quite young, I could see what it looked like to know what to do. But again, before the internet, of course, there's lots of porn on the internet for people to get now. But even before then, if I didn't have that outlet, I wouldn't have even known what it looked like. I think it would have taken a lot longer to come out and know what I actually wanted without that exposure. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Capturing the potential detriments associated with not having a comprehensive sexual health education program in place, another participant mentioned that the lack of information they received around MSM-related sexual health led to them seroconverting.

> I thought it was useful but aimless. Actually, all that information made me at risk. And I think the fact that I couldn't be myself when I had sex, I had sex with a guy that was there like the first opportunity, and I took it. So, I put myself at risk many, many, many times. And I think I became positive because of those risks that I took because I was holding myself in all that time and then when I couldn't be any more, I took the first chance to get sex and it was like with this stranger. It was bad. So no, I didn't have good information. After getting infected, I started, you know, talking with my specialist and with all the friends, I got to know what a normal sexual life was. (Region 5, 35-49 years old, Latin, gay, cisgender man, living with HIV).

Community-Level Themes

Beyond the ways that laws and policies were mentioned as influencing wellbeing, participants also described the ways in which their community promoted health and wellbeing or represented a source of stigma and distress. For instance, a number of participants noted a general sense of cisnormativity, heteronormativity and racism in their communities, which was described as contributing to the absence of GBTMSM or 2SLGBTQIA+ social groups, social services, and affirming healthcare services in their areas. To best understand this marginalization associated with these community climates, it is essential to consider how other forms of discrimination might intersect to influence the experiences of GBTMSM with other intersecting identities, such as those who are racialized or living with HIV. Multiply marginalized GBTMSM in the sample especially described challenges with accessing health promotion tools due to provider attitudes or cost and reflected on how presenting as visibly queer or racialized exacerbated challenges with navigating their regions.

Primary Theme 3: Healthcare, Social Services & GBTMSM in SW Ontario

Focusing specifically on the healthcare and social services in their regions, the majority of participants described having to pool providers and resources together to achieve comprehensive healthcare, either accessing services in neighbouring regions, or accessing a number of different providers and services for different health-related needs. As well, almost all of the participants described limited GBTMSM-related competencies amongst providers and at service centres, creating barriers to accessing health promotion tools, such as PrEP and HIV/STTBI testing. Ultimately, a general sense of precarity surrounded healthcare and social services in SW Ontario, leading many participants yearning for healthcare and social service centres devoted to serving the 2SLGBTQIA+ community, such as those found in Toronto.

Secondary Theme 11: Characterizing Healthcare & Social Services in SW Ontario. When asked to describe the healthcare and social services available in their regions, participants reported a variety of situations. Quite often, participants described having to travel and/or access online services based in neighbouring cities, such as Toronto, to maintain access to providers that offered 2SLGBTQIA+ affirming and competent services.

> In [region 5], and then I also leave [region 5]. [Region 5], it's a weird place because it would be classified as large urban metro, but we do not have that level of services. So, my family doctor is in a different city, I go to [city in GTA], I go to Toronto for some specialist services. But that's because I was living in Toronto, and then I moved to [region 5] in the last year. And I didn't move the services because I'm going to [hospital in Toronto] to see a specialist. And she's really good, so I don't want to lose her. Yeah, so it has been [region 5] sometimes, and then other cities other times, and depending on what it is. Lots of telemedicine with COVID too, with people who are in

Toronto. (Region 5, 25-34 years old, White, queer/pansexual/gay, transgender man, HIV-negative).

Another participant echoed a similar experience of accessing different providers for different services. In fact, this participant described being referred to a community healthcare centre because the doctors available at their university did not know how to prescribe testosterone, representing a major service gap.

> So within [city in region 2] there's a community health center called [community health center in region 2]. And that's where I am going to be going to, I'm still in the process of waiting for it. Um, I go to [university in region 2] and the doctors there are really good. Some of them actually know how to prescribe testosterone. Mine doesn't. So, they're referring me to [community health center in region 2], but some of them do. Um, because I have other trans friends who are trans males and vice versa, so they can prescribe hormones at [university in region 2]. Some of them know how. Yeah, and I think those are the only two things that I know of. (Region 2, 18-24 years old, White, androsexual, transgender man, HIV-negative).

In addition, another participant spoke to the complexity of accessing healthcare and social services prior to coming out about their orientation, accessing alternative and anonymous services to avoid coming out to their family doctor, perhaps reflecting hostile attitudes toward 2SLGBTQIA+ people held by providers in their region.

> So, primarily through my personal physician, so that would be [clinic in region 6] in [region 6], so I see [doctor's name]. I must admit, prior to coming out or in the struggles with coming out, I was going to [public health unit in region 6] as well. Because that was where I was, whilst I was coming out, and dating guys. I got married two or

three years ago. So, things have changed significantly since then. But for STD testing, I was going to [public health unit in region 6] rather than through my physician. (Region 6, 50-64 years old, White, gay, cisgender man, HIV-negative).

Secondary Theme 12: Availability & Access to PrEP, HIV & STBBI Testing and HIV Treatment. When reflecting on the healthcare and social services in their community, participants often described how the lack of 2SLGBTQIA+-informed services available in their community influenced their ability to access essential sexual health promotions tools, such as PrEP, HIV & STBBI testing, and HIV treatment. In particular, one participant recognized how the inaccessibility of the sexual health clinic in their region created barriers to accessing care, however, praised the ASO in their region for supplementing these service gaps.

> They're really spotty. The sexual health clinic in [region 3] is just really fucking bad. They have horrible hours; the staff are not friendly to queer people at all. And just like really difficult to access services through there. I've been able to access better services through the [ASO in region 3], and they used to partner with a sexual health clinic to provide services it like different hours and things, but then the sexual health clinic backed out of that. So that was - the access is more limited now. I've also been able to access good, relevant sexual health information through the [ASO clinic in region 3]. And they are very good, and not discriminatory at all, which is great. So that's I tried to kind of filter all of my sexual health needs through their services rather than going through the actual sexual health clinic. (Region 3, 25-34 years old, White, gay/queer/fag, cisgender man, HIV-negative).

Speaking more specifically to how a lack of 2SLGBTQIA+-informed providers and service centres influences access to PrEP, one participant described the barriers to accessing PrEP that permeate their community.

> I don't think a lot of primary care providers know what the hell it is either, like people are going to their doctors, and I hear this a lot, they mention PrEP, and they'll hear, well you don't need that, that's for sex workers. Or they're not even out to their primary care providers, so how are they going to have a conversation? And then even if they do, a lot of the primary care providers are like, well, why don't you just go to Freddie, or [PrEP clinic in region 1] or one of these online places? Because they don't necessarily want to learn about it. So, it is good, but just the fact that it's just not covered, like people are paying hundreds of dollars a month. (Region 1, 35-49 years old, White, queer, cisgender man, HIV-negative).

Echoing a similar situation, another participant described how a lack of funding and support programs around PrEP creates a dynamic where HIV is more of a socio-economic problem.

> I had heard of PrEP, but I wasn't economically in a position to pay for it. Which I find a huge barrier. I don't know if things have changed, but for me personally, it makes HIV a more of a socio-economic problem- because those who can afford PrEP, can you know, can access it, therefore not become positive and those who can't end up becoming positive? (Region 1, 50-64 years old, Indigenous/White, gay, queer & 2-Spirit, cisgender man, living with HIV).

Similar to participant's descriptions about difficulties in accessing PrEP, other participants spoke to challenges related to accessing HIV and STBBI testing. These barriers to

accessing testing were described as largely stemming from the stigma and negative attitudes around sexual health that circulate in their communities.

> I don't think people get tested, and I do think in [region 5], there is negative connotations around getting tested or even talking about it. Like, I even recently still heard someone used the terms clean and dirty. I think there's a lack of information that's influencing testing rates, because a lack of information is still perpetuating stigma. I think that's what the problem is. I don't think it's like, as simple, I don't think it's as direct as like, here's the information, go do it. I think there's a lag because you have to break down stigma in people first before they'll go get tested. (Region 5, 25-34 years old, White, queer/pansexual/gay, transgender man, HIV-negative).

Beyond the ways in which stigma influences accessing to HIV and STBBI testing, another participant described how inaccessible testing dates and hours create substantial barriers to accessing regular testing.

> Well, I definitely go to a place like [GBTMSM testing clinic in region 5], but once a month is definitely not enough, especially with work, if I'm working on that day, boom, I have to wait till the next month. So that's ridiculous. It's ridiculous that we have in a city like [region 5], we just have a couple of hours once a month. So, we need more hours in the first place, where you can just go to for anything that's health-related for LGBT individuals. (Region 5, 50-64 years old, Arab, gay, cisgender man, HIV-negative).

In contrast to the negative experiences faced by some participants when seeking to access PrEP and HIV/STBBI testing, one participant praised the healthcare and social services in their region for the HIV treatment they provide. However, they recognized that they are one of the few lucky ones who was able to relocate according to the presence of HIV treatment.

> Frankly, accessing care here is easier than when I was in the GTA. Because I used to live in [city in GTA] and I used to have to trek over to [hospital in Toronto] which was, you know, on a good day is an hour. So here, I'm literally three minutes from the clinic. And my GP is maybe eight minutes away, and the pharmacy delivers, and even if they didn't, they're across the street. Yeah, I mean, the medical shit here is outstanding. Frankly, outstanding, because since my life fell apart a year and a half ago, believe me, I've looked all over, I don't have to be here. I've looked all over Ontario, I mean, everywhere, for place to live, except the GTA because I can't afford to be there anymore. And there's no medical care to be found anywhere but Toronto, Ottawa, and here, if you have HIV. I mean, I phoned up the local agencies in many towns. And the message I got, quite frankly, was listen, you have medical care where you are, don't move, you won't find it here. It'll take you two years to find a GP. And if you live in Cornwall, for example, you got to go to Ottawa for HIV care. So yeah, I hate geography here. (Region 3, 65+ years old, White, pansexual, cisgender man, living with HIV).

Secondary Theme 13: Healthcare & Social Service Access and GBTMSM-Related Competencies. Likely connected to the barriers to accessing PrEP, HIV & STBBI testing, and HIV treatment mentioned by participants, GBTMSM in the sample described a general lack of GBTMSM-related competencies held by providers, underscoring the need for more providers who identify as GBTMSM, or at least hold the relevant knowledge to provide affirming and competent care. Highlighting the importance of patient-provider fit, one participant described their satisfaction with accessing a provider who identifies as gay after years of dealing with homophobic providers.

> I went a very good four or five years without seeing a doctor around here. The

> most interaction I would have was I would go to the sexual health clinic to go get tested, that was it. And I think that was because for one, looking for a doctor here in (region 2) is just so annoying, or finding a doctor who wasn't, excuse my language, a homophobic piece of shit, to be honest with you. I've straight up had doctors say like, oh, you know, you shouldn't do that. Or if I've asked about PrEP, they've been like, what's that? But I've been with [community health center in region 2] now for about two years. And they've been amazing, I got a therapist from there for a little while. It was only so many appointments were free, but after that, I was able to move on with my therapist in private practice. And then recently, I have a doctor who has me on medication to manage my mental health. And then they also have a PrEP nurse practitioner specialist kind of thing. So, he basically assesses my needs, and then the doctor makes the prescription for me. And he's also gay. So, it's been super, it's always a chill experience. I don't feel unsafe or unwelcome. It's been wonderful. (Region 2, 18-24 years old, White, bisexual, non-binary, HIV-negative).

Another participant echoed similar experiences of dealing with providers who lacked the knowledge to provide competent GBTMSM-related care. When accessing STBBI testing, this participant had to self-advocate, and educate their provider on the need for throat swabbing.

> I was laughing, because my doctor said, you can't get gonorrhea if you just had oral sex. I don't know if he knows that most of us don't use a condom for oral sex. And I don't know if he was basing it on that. But I knew that wasn't correct. But I also felt really awkward to be the one to tell him that. So, I remember, there was time when I was getting tested. He's like, don't worry, if you've just had oral sex, there's really no chance you can get gonorrhea. And I know that's not true. Because I remember, growing up, my

> only access to sexual education was Degrassi and I learned about sexual health because there was an episode story arc where this girl Emma gets gonorrhea from the mouth. So yeah, I would say that I learned more about sexual health through TV than I did through my doctor. (Region 3, 25-34 years old, Pakistani/South Asian, queer, cisgender man, HIV-negative).

Similarly, another participant spoke to the lack of GBTMSM-related knowledge held by providers in their region, reflecting on their experience of being interrogated about taking hormones, when their gender identity was besides the reason for the appointment.

> But one of the first doctors I saw after the, for lack of a better word, educated doctor left, I went in to get a strep throat test or something, something super unrelated to my identity, and he looked at my chart, and he was like, why are you taking testosterone, what's that about? And I was like, hormone deficiency, technically, what do you mean? He was like, I don't understand, like, I've never seen this, what is this? And it wasn't a question, it was almost like an attack. Like I had confused him on purpose. So, I tried to explain to him, this is why I'm going to take it, and he just wasn't getting it. He was like, that's weird. I was like, sweet, can I get that strep test now? But it's just stuff like that, even with some of the other doctors. (Region 4, 18-24 years old, White/Latin, pansexual, transgender man, HIV-negative).

In comparison, another participant recognized that their provider lacks the knowledge needed to provide competent GBTMSM-related care, but also praised their doctor for being open about their limited knowledge, seeking to build a collaborative approach to care.

> I mean, my family doctor, I think the important thing about him that makes him so special is he knows that he's new and that he doesn't know everything. And that is a

> common issue, I trust myself, I started transitioning almost six years ago now. When I came to [region 4], I knew what dose of hormones I needed to be on, I knew what medication I was on, I knew what surgeries I wanted to have and what needed to be done. You know, I had my top surgery already arranged, I got it in first year, but I had that arranged in high school. So, I wanted a doctor who would respect that, and actually listen to me, because I know that he doesn't know anything, and I know that I've spent the last several years of my life figuring it out on his behalf. So, I really appreciate that my doctor, when I said, hey, I want to up my testosterone dose, he's like, okay, cool. And then you know, I got blood work back, and it wasn't that great, my testosterone levels were really low. And he said, what do you want to do about it? And so that's when, you know, we figured out okay, I can change my dose and do it more often. But I do think sometimes I feel a bit like I'm an experiment. (Region 4, 18-24 years old, White, queer, non-binary, never tested for HIV).

Primary Theme 4: Regional, Community & Social Support Networks and Social Groups for GBTMSM in SW Ontario

Perhaps underlying the limited GBTMSM-related competencies held by providers in SW Ontario described by participants, many participants characterized their communities as homophobic, biphobic and transphobic, with little representation of GBTMSM or the broader 2SLGBTQIA+ community. However, importantly, social support from friends, partners, coworkers, and family alongside approaches to self-advocacy were described as factors which ameliorated these negative attitudes toward GBTMSM and 2SLGBTQIA+ people circulating in their communities. Highlighting the implications related to the lack of inclusion and visibility of GBTMSM & 2SLGBTQIA+ people in SW Ontario, a substantial proportion of participants

described that these discriminatory and stigmatizing climates present in their communities culminated in a desire to move away to an urban queer enclave, such as The Village in Toronto.

Secondary Theme 14: Characterizing SW Ontario and Local Communities. When prompted to describe their region and SW Ontario more broadly, participants presented a variety of responses, however, most revolved around themes of loneliness, isolation, and conservatism. In particular, one participant described how the conservatism present in their community contributes to hesitations around being open about their orientation in their community.

> It's pretty difficult. I don't like to complain, necessarily. But it is difficult here. It's a super small town, less than 2000 people, and it's a pretty conservative area. And, you know, my boyfriend lives in [city in region 2]. When he comes down this way, I feel less comfortable, being open, you know, like holding hands or whatever in public. I definitely feel less comfortable here. And I don't- I'm definitely not as open about it in public in this area. (Region 2, 18-24 years old, White, bisexual, cisgender man, HIV-negative).

Another participant described their experience of navigating their community as a queer trans man. For this participant, feelings of isolation and estrangement created challenges with connecting with their community.

> It feels really isolating. I'm obviously transgender. I mean, while it's not that obvious, unless I take my pants off, so I pass, right. So, I have passing privilege when it comes to identifying as a trans male. And so, it creates a lot of complication as to the intersection of where I fit in, depending on who I'm interacting with. And I don't feel like I have the closeness with the trans community here as what I used to, and I think that a lot of that has to do with being a middle-aged person. You know, as we get older, we have

> fewer and fewer people that we're tied together with very intimately. And, you know, when we're younger, it's easier to have a wide breadth of folks that you engage with. So yeah, I feel like as I've aged, my isolation as being a queer trans man has increased. (Region 4, 35-49 years old, White, queer, transgender man, HIV-negative).

Echoing similar experiences of loneliness and isolation, another participant drew contrast to the 2SLGBTQIA+ community in Toronto, where there are a number of spaces to come together and meet other 2SLGBTQIA+ people, unlike their community, where there are few spaces dedicated to 2SLGBTQIA+ people.

> To honest with you, it can be really lonely. I think like, where in Toronto for example, there's so many of us, so it's so easy to make friends and stuff there. Whereas here, to be honest, we have very little to like no spaces. So, you're really only meeting people on Grindr, and then it's basically that the only people you're meeting is the people you're hooking up with, and it also kind of leaves a bit of an empty feeling because, at the end of the day, I don't necessarily just want to sleep with people to make friends. And unfortunately, that's how it's just been here. I have befriended some people that I just happened to sleep with. But there's really no place for pure friendship. Not that I think there's anything wrong with friends to sleep with each other, but it'd be nice to not have to do that. I would even say most of my queer and trans friends live in Toronto at this point. So, I travel to see my friends for the most part. (Region 2, 18-24 years old, White, bisexual, non-binary, HIV-negative).

Similarly, another participant spoke about facing loneliness in their community, but also described how the conservatism in their community underlies the discriminatory attitudes toward

minority groups, creating barriers to inclusion and connecting with other community members in their region.

> It's lonely, it's very lonely. Speaking of this loneliness I dated a trans woman. But that was like, more than 10 years ago, but it was here in [region 6]. And she was Afro Canadian. And she told me that I have to be really careful in [region 6]. She worked at a time for [university in region 6]. And she told me that this is not like another city. There is so much conservativism and so much discrimination and so much, you're not from here, right? And speaking of discrimination, there is a newspaper here, a local newspaper, it's called [name of newspaper]. On page eight in this week's edition, there is an article about discrimination that is here in [region 6], and it's bad and it exists. I experienced it myself. And you know, the color of my skin is White, I'm Caucasian. But the moment I open my mouth and people hear the accent, you know, yeah, and that's the end of it. (Region 6, 50-64 years old, White, pansexual, cisgender man, HIV-negative).

Secondary Theme 15: GBTMSM & 2SLGBTQIA+ Safety, Inclusion & Social Groups. Perhaps connected to the lack of 2SLGBTQIA+ representation in SW Ontario mentioned by participants, a number of folks described challenges with accessing and navigating GBTMSM or 2SLGBTQIA+ spaces or circles in their communities. In particular, when asked to reflect on 2SLGBTQIA+ spaces in their community, one participant shared the following.

> Let me say that, in the context of Toronto, and several other cities like Montreal, people right away are like, oh, The Village, that bar, this club, there are several things that come to mind. But in [region 4] I can't think of any spaces. (Region 4, 35-49 years old, White, gay, cisgender man, HIV-negative).

In a similar vein, another participant described there being few spaces for 2SLGBTQIA+ people in their region, explaining how this lack of spaces creates barriers to connecting with other GBTMSM and 2SLGBTQIA+ people more broadly, especially as someone new to the area.

> So socially, it's limiting and limited. There's not any dedicated queer social space in [region 3]. There is some dedicated queer space designated for social services. But even that space, that's the [community center supporting the trans community in region 3] kind of has their own space. The actual [2SLGBTQIA+ pride center in region 3] doesn't really have its own space. So, there's not any queer social space, and there's very little queer space otherwise. So, it's very difficult for queer people to gather and meet each other. Also, I'm not originally from [region 3], but there's a lot of the population that live here that was born here. And I've known other people in the community their whole lives. So, as somebody who is not originally from here, it's a little bit more difficult to break into the social circles, and sometimes access queer communities or even cliques of people because they're kind of isolated in their own social bubbles when there's not a space where those bubbles overlap. (Region 3, 25-34 years old, White, gay/queer/fag, cisgender man, HIV-negative).

Beyond navigating physical 2SLGBTQIA+ spaces, another participant spoke to challenges with navigating and finding your place in the metaphorical and online GBTMSM community through dating and hook-up apps, such as Grindr.

> As far as fitting in with the community, I mean, I don't think I'm unique in this situation, but it can be tough to find your place. Even if you go on and look at the apps, for example. Grindr, and Tinder, etc., you've got an app for Grommr, chasers, chaseable,

> or whatever it is, GROWLr, and stuff like that. Like I mean, minus all the letters, then all of a sudden, you've got, are you a bear? Are you a Daddy bear? Are you a cub? Are you an otter? Are you this, are you that? I just want to be me, but I don't know where I fit. Like, I mean, I'm older, so I guess I'm a Daddy. I'm hairy, so I guess I'm a bear. But I try and look after myself. I've got a bit of a Dad bod, so I'm not really like a cub. I don't know if you've experienced this, but everybody wants to fit somewhere. I'll be honest, even with the letters, everybody wants to box you into something. Like there's got to be a symbol, I just want to identify as [participant's name], as me. I don't want to fall under a label. I don't want to be this or that. But it's almost like somebody wants you to fall into a type. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Similarly, another participant described difficulties with navigating the GBTMSM and broader 2SLGBTQIA+ community in their area, describing how a reading group in their community was Whitecentric, making them feel invisible.

> I tried to join the reading group at [library in region 6]. But what happened was, their focus was White gay men. And it's like, you know what? White gay men don't need that support, People of Colour do. There are a lot of writings by independent writers that are People of Colour, that needs the full focus. I mean, I think next week or sometime there is going to be a get together at a restaurant downtown, and again, it's about a White guy coming out with a book. It's like, you know, I don't want to read about him. I read the AIDS Memorial every day, about hundreds and 1000s of White men and my friends who have passed away from AIDS. So, it isn't like, I'm not aware of it. But I don't need to read more, it's nothing new. What they're saying to me is nothing new. What I need to see is People of Colour, what I need to see is Black men who are actually coming up, I

want to see what they're facing, you know. (Region 6, 35-49 years old, Black & Indian, queer, non-binary, HIV-negative).

Secondary Theme 16: Social Support & Social Support Networks. In response to the lack of GBTMSM and 2SLGBTQIA+ representation and spaces in their communities, a number of participants described their social support networks as being essential to feeling connected and included in their communities. In particular, one participant described the value that they gain from having other 2SLGBTQIA+ friends.

I think social support comes a lot from friends. I think a lot of the time, people within the LGBT community are very aware of other people and their issues. So, they're a lot more patient, and they are a lot more empathetic and knowledgeable than other folks. So, I think a lot of it comes from having other LGBT friends. (Region 2, 18-24 years old, White, androsexual, transgender man, HIV-negative).

Connectedly, another participant described the benefit of having other 2SLGBTQIA+ people in their social network, as these folks provide advice on who to access for sexual health services and what to do in the case of an STBBI.

I have a good social network, they're the ones that told me about [GBTMSM testing clinic in region 5] and they're the ones that told me about the reopening's. I have a good circle of friends. One time I freaked out, I got crabs. And I freaked out and I contacted this one friend of mine, and he was so cool about it. Again, non-judgmental, and just said, go to pharmacy and get this stuff. And he told me what to take. I would've even freaked out calling my own doctor about that because I felt so bad. I felt disgust that I did something wrong. (Region 5, 50-64 years old, Arab, gay, cisgender man, HIV-negative).

Importantly, another participant spoke to how COVID-19 has intersected with existing barriers to connecting with other 2SLGBTQIA+ people in their community to make gathering with other 2SLGBTQIA+ especially challenging during the pandemic.

> I have a best friend that I talk to every day. I have friends in general that I can reach out to, certainly my partner and I support each other a lot in various ways. Mostly right now, it's mostly virtual. Although, you know, this summer and moving into the fall, I actually was able to have games nights and hang out with people in my friend's garden and stuff like that. So, I feel like the consent around COVID protocols is a very well-versed conversation in my community because we basically expanded COVID as part of our sexual health conversations. (Region 4, 35-49 years old, White, queer, transgender man, HIV-negative).

Secondary Theme 17: Self-Advocacy. Beyond turning to those in their social networks to access support and bolster their wellbeing, many participants described their individual approaches to self-advocacy and practicing self-care to maintain positive health and wellness. In particular, one participant described a combining multiple approaches including exercising, mindfulness and accessing counseling to support their wellbeing.

> I spend a lot of time at the gym, I work out a lot. I listen to mindfulness, mindset, law of attraction, affirmations on YouTube, or wherever I can find a podcast that I find uplifting and helpful. I do reach out and get counseling when needed. I feel like exercise is a big thing, it seems to help distract me like walking into the gym. And yeah, it's not easy to get out of a slump. I do what I can. (Region 5, 35-49 years old, White, gay, cisgender man, HIV-negative).

Another participant similarly described exercising as central to maintaining their wellbeing, but also described the power of journaling and accessing community support resources, such as writings from other trans guys as essential to maintaining good mental health.

> I journal every day, which I've always done my whole life actually looking back. Like I journal, I look at an emotion wheel. And I pick words out and I journal my thoughts and gratitude stuff every day. Which really helps, I'd say that's like, the biggest thing that helps is journaling. And depends how I'm feeling, if I'm having bad PTSD symptoms, that's very physical and nervous system. So, I usually have to do more physical sensation stuff, which is working out and more sensory things. I use a lot of diffuser oils, and I have to be really careful about what I eat, that affects my mental health. But if it's more gender dysphoria stuff, then I read a lot of community support stuff, writing from trans guys specifically, like gay trans guys, actually. And then that makes me feel like less alone. And I like to make a lot of art. So yeah, whether it's physical or emotional, I think I take action on it. Maybe that's kind of the common theme. I try not to sit in paralysis because if I let myself do that, I'll just be there for like months. (Region 5, 25-34 years old, White, queer/pansexual/gay, transgender man, HIV-negative).

Another participant echoed similar approaches to self-care.

> Running, mediation, therapy, journaling… some great ways that I deal with things (Region 1, 25-34 years old, White, gay, cisgender man, HIV-negative).

In comparison, another participant described using CBD products, their pets, and art to manage their anxiety and maintain their wellbeing.

> I have my own business, so I make a lot of CBD products. Those I use often. I'm very artistic, I paint, and I draw a lot. So, I have a multitude of outlets. I have a few cats too. But I would say so a lot of it for me, is very artistic. Like I'm a quiet person, I'm a homebody. So, if I'm having a moment where my anxiety is triggered, or an off day or something, then yeah, I tend to find that art and music is the best way for me to kind of heal myself and shut out the world. (Region 3, 35-49 years old, White, gay, cisgender man, HIV-negative).

Discussion

With respect to the influence of laws and the legal system on the wellbeing of GBTMSM in SW Ontario, it seems that most often, laws and the legal system fail to comprehensively protect GBTMSM from discrimination. Perhaps best exemplifying this paucity between law and action were participant's experiences with laws preventing discrimination on the grounds of sexual orientation, gender identity, and race. Although some GBTMSM in the sample regarded these laws as protecting their rights and upholding equality and opportunity, many participants described that these same laws showed less utility when applied to trans, non-binary and GNC GBMSM and racialized GBTMSM. In particular, some participants described a shift toward demonizing gender identity minorities, especially in the absence of certain laws, such as those dictating at which age one can make changes to their name, creating barriers to social transitioning. This situation is especially worrisome in light of the findings reported by Poteat et al. (2016), suggesting that social gender transitioning serves as a protective factor for trans GBMSM facing community- and structural-level discrimination. Similarly, for laws protecting racialized folks from discrimination, racialized GBTMSM recognized a disconnect, describing experiences of racism in healthcare and social services, and from other GBTMSM community

members. As well, these laws were framed as doing little to prevent experiences of discrimination, as systemic and institutional racism are entrenched in society, and allow for race-related discrimination from the police, which, in turn, encourages interpersonal race-related discrimination.

These findings are especially worrisome in light of those reported by Lane et al. (2004) and Quinn (2019), suggesting that structural violence, such as the over policing of Black men and other forms of race-related marginalized, contribute to constraints on the wellbeing of Black GBTMSM, such as barriers to accessing STBBI testing services. As well, although some gay and bisexual MSM in the sample described laws preventing discrimination on the grounds of sexual orientation as contributing to their wellbeing, they also recognized that enforcing their rights following from these laws was a taxing and challenging process where the onus of advocacy and enforcement was placed onto them rather than the legal system. These findings speak to the relevance of structural violence for influencing the health of GBTMSM, suggesting that laws are significantly contributing to the wellbeing of GBTMSM in SW Ontario. As well, these findings highlight the importance of capturing intersectionality when conceptualizing the HIV syndemic amongst racialized GBTMSM. For racialized GBTMSM in the sample, limited access to affirming sexual health testing services can be attributed to systemic racism trickling down to influence the attitudes of those providing services at healthcare and social service centres in the region. As well, racism perpetuated by the police and individual community members in SW Ontario contributed to a general sense of ostracization for racialized GBTMSM in the region, perhaps contributing to a lessened propensity to accessing community networks and services, inclusive of HIV and STBBI prevention, testing, and treatment resources. Clearly, as described by Quinn (2019), capturing the HIV-related syndemic amongst racialized GBTMSM requires

conceptualizing how racism prevails across interpersonal-, community-, and systemic-levels, culminating to the stratification of racialized GBTMSM from communities, services, and resources that could support their sexual health.

In comparison, quite a few participants spoke about Bill C-4, the law banning conversion therapy in Canada (Government of Canada, 2021). The introduction of this law was consistently framed as a significant win for GBTMSM, making it illegal to use homophobia, biphobia and/or transphobia as a weapon against GBTMSM. Positively, Bill C-4 reflects a shift away from heteronormativity and cisnormativity, dismantling a system by which GBTMSM and members of the broader 2SLGBTQIA+ community were forced to reject their sexual orientation and/or gender identity to assimilate into heterosexual and/or cisgender norms. Similarly, under the Civil Marriage Act, same-sex marriage laws were praised as contributing to the normalization of queer relationships, representing a significant pedestal of justice and equity for GBTMSM (Government of Canada, 2022). However, important questions were raised around whether the 2SLGBTQIA+ movement has overemphasized same-sex marriage rights in the pursuit of 2SLGBTQIA+ justice and equality. Some participants recognized that equating marriage equality with overall equal rights can be problematic, as other pertinent issues that continue to influence GBTMSM and the broader 2SLGBTQIA+ community are overlooked, such as barriers to achieving positive sexual health and limits on sexual and queer expression. Regardless, these findings speak to the relevance of wellness as fairness, suggesting that justice and equity represent significant forces that positively contribute to the wellbeing of GBTMSM.

In contrast, a number of participants framed laws around donating blood pertaining to GBTMSM as extremely discriminatory and disempowering, bound in outdated knowledge and stigmatizing ideas around queer sex and promiscuity. At the time of these interviews, the end to

ban donations from GBTMSM had not been introduced, and men who had sex with men were barred from donating blood altogether. Since these interviews were completed, new regulations were introduced, establishing that sexual orientation alone cannot be used to determine one's eligibility to donate blood. However, updated guidelines are still discriminatory, and base eligibility around number of partners and the type of sex an individual is having, still preventing many GBTMSM from donating their blood (Canadian Blood Services, 2022). Similarly, HIV non-disclosure laws represent a murky situation. Currently, the laws state that one must disclose their status only in the case that there is a realistic possibility of transmission (Canadian HIV/AIDS Legal Network, 2019), which for many, is ambiguous and nuanced. As such, all of the GBTMSM in the sample LWH described the laws around HIV non-disclosure as harmful and mentally taxing, creating a situation where they have to constantly come out about their serostatus, despite being undetectable and engaging in regular viral load and STBBI testing.

These findings reify those provided by Hubach et al. (2015), suggesting that HIV-related stigma experienced by non-metropolitan GBTMSM LWH at the interpersonal and community levels creates barriers to disclosing their status. Connectedly, despite significant advances around the transmission of HIV, participants LWH described heinous experiences of both healthcare and interpersonal HIV-related discrimination, signifying that knowledge around undetectable=untransmittable is still not well known, even by those who work in the healthcare sector. As well, it should be noted that amongst the five participants in the sample LWH, four identified as BIPOC, highlighting the relevance of intersectional marginalization for capturing HIV incidence and prevalence amongst GBTMSM. These findings parallel those presented by Phillips et al. (2013), describing that in North America, the criminalization of HIV disproportionately impacts Black and Indigenous GBTMSM.

Similar to the experiences with laws and the legal system being only partially beneficial for protecting wellbeing, it seems that more often than not, policies fail to prevent experiences of discrimination for GBTMSM, and at times, even protect the perpetrator from appropriate recourse. As well, similar to the paucity between law and practice, policies were described as not typically leading to appropriate actions in line with these policies, leaving GBTMSM privier to facing discrimination when accessing healthcare and social services and when navigating their communities more broadly. Exemplifying the flimsiness of workplace policies and protections for GBTMSM, a number of participants shared their experiences of facing sexual orientation-, gender identity- and/or race-related discrimination in their workplaces. In fact, many participants described their workplaces as being potentially harmful, representing spaces where discrimination can occur without appropriate recourse. This lack of recourse following experiences of discrimination lead GBTMSM to feel less confident in these policies and created fears about being open about their identity moving forward.

On the contrary, some participants described experiences of reporting workplace harassment and experiencing appropriate recourse, such as the perpetrator being fired from their workplace. However, considering community policies protecting GBTMSM from discrimination, a number of participants described campuses and community spaces as unsafe, contributing to fears around being open about their identities. For instance, one participant reflected on their concerns about a lack of 2SLGBTQIA+ safe long-term care homes, whereas another participant described their university as protecting a known homophobic, transphobic, and racist professor, despite significant pushback from students. These experiences suggest that workplaces and community spaces continue to represent unsafe climates for GBTMSM and speak to the relevance of the MSEM for capturing the interplay between structures, systems, and

community attitudes – clearly, flimsy policies and practices do little to prevent harm at the community level.

Following similar themes, healthcare- and social service-related policies were described as being minimally useful for ensuring GBTMSM experienced affirming and informed care, or care that supported their wellbeing rather than causing stress and anxiety. These findings parallel those reported by Tjepkema (2008), suggesting that GBTMSM in Canada experience significant barriers to accessing HIV & STBBI testing, 2SLGBTQIA+ informed care, and healthcare and social services more generally. In particular, one participant described their experience of being notified about their HIV status, where despite not being told over the phone that they had seroconverted, they were able to discern the incoming positive diagnosis by default. Further echoing the need for education on affirming and informed care for GBTMSM, another participant described that a hospital in their region refuses services to pregnant people LWH under the belief that a risk of transmitting HIV may be present. These findings mirror those described by Hubach et al. (2019), suggesting that a lack of sexual minority-affirming policies, institutional practices and hostile cultural norms leads to reduced access to quality care for GBTMSM. In sum, these practices likely speak to a general lack of knowledge held by providers and services in the region around providing informed care for GBTMSM, representing a form of structural violence, and highlighting the need for more education and updated practices reflecting updated knowledge that better supports the wellbeing of GBTMSM.

Perhaps underlying this limited GBTMSM-related knowledge held by providers and service centres in SW Ontario are heteronormative and cisnormative policies around sex-education, which prevent important discussions around queer sex, such as education around PrEP and PEP, anal sex, and HIV. The majority of participants described the sexual health education

they received in primary and secondary school as being primarily useless, at times, overlooking the experiences of 2SLGBTQIA+ folks altogether. Alarmingly, some participants described the lack of relevant sex-education they received as, in part, contributing to feelings of shame and internalized stigma around queer sex, creating barriers to accessing HIV and STBBI testing. As well, for one participant LWH, they described that the lack of informed sexual health education they received in their youth as contributing to their seroconversion. These findings mirror those presented by McKenney et al. (2017), suggesting that for rural GBTMSM, limited access to quality care contributes to being less likely to receive condoms or other prevention tools or counselling. In the absence of relevant sex-education, some participants spoke about needing to rely on community networks or porn to access relevant information around sex, which can be problematic, as resources and information might not be accurate. These findings reflect the relevance of minority stress and the interplay between distal and proximal stressors, in that societal attitudes toward GBTMSM are reified to influence the sexual health of GBTMSM.

As well, these findings should be considered in the context of the recent sex education controversies in Ontario enacted by the Ford government, in that during his campaign in 2018, Doug Ford campaigned on a promise to change the province's sexual education curriculum, stating that the updated curriculum released by the Wynne government in 2015 was not age appropriate, comparing schools to social laboratories and children in schools to test subjects (Vomiero, 2019). Ford refused to state which parts of the curriculum he takes issue with but stated that parents were not consulted enough in the process of updating the curriculum (Vomiero, 2019). Regardless of his stated issues with the sex education curriculum in place at the time of his election, Ford did little to change the curriculum, however, pushed back discussions around gender identity to grade 8 and included a detailed exemption procedure

allowing parents to pull their children out of health education (Vomiero, 2019), reinforcing ideas that discussions around sexual health are taboo, and unimportant, in turn, stigmatizing ideas around sex, sexual health, and gender identity.

Above and beyond frail policies and procedures in place in workplaces, community spaces and schools, a number of participants spoke broadly to a lack of supportive policies in place providing funding and support for GBTMSM and 2SLGBTQIA+ folks. In particular, many participants connected a lack of dedicated GBTMSM or 2SLGBTQIA+ spaces in their regions to a lack of funding for queer people and queer initiatives. As well, on a micro level, some participants spoke about how challenging coming into one's sexual orientation and/or gender identity can be during pivotal years when an individual may be in school or transitioning into adulthood. These challenges were described as being further exacerbated due to familial estrangement, and a related lack of financial support from family, a familiar situation for young 2SLGBTQIA+ folks (Feinstein et al., 2014). As well, coming into one's identity can be financially challenging, especially for trans, non-binary, or GNC GBMSM who may be pursuing procedures related to their transition, or for GBTMSM living with a disability, who may rely on government subsidizations for support related to their disability. These situations underscore the significant need for greater governmental funding that is dedicated to GBTMSM and 2SLGBTQIA+ folks navigating their identities, contributing to justice and equity.

In consideration of community-level variables, many participants painted grim pictures of their communities, rife with homophobia, biphobia, transphobia, racism, and a general attitude of conservatism. With respect to healthcare and social services specifically, it seems that these attitudes contribute to a lack of comprehensive and affirming services and providers in SW Ontario, leaving GBTMSM having to pool together resources and providers from other regions,

or through online mediums. These findings reflect those reported by Waterloo Public Health and Emergency Services (2018), in that amongst a sample of GBTMSM in Kitchener-Waterloo, less than half (45.5%) felt that there were enough sexual health services in the region that met their needs. As well, the lack of GBTMSM-related competencies held by providers in SW Ontario seems to contribute to a service and resource gap, where GBTMSM face significant challenges in accessing health promotion tools, such as PrEP and regular HIV and STBBI testing. These findings mirror those presented by Bauer et al. (2013), describing that prior discriminatory healthcare experiences contribute to barriers to accessing HIV and STBBI testing. In the case that their provider did not hold the relevant knowledge to support their needs, a number of participants described being referred out to other providers or service centres, contributing to a general concern around accessing healthcare and social services in the future. For instance, one participant recollected their experience with being referred elsewhere when seeking to access hormones related to their transition, representing a significant service gap. In tandem, other participants reflected on concerns about coming out to their provider altogether, describing fears around being discriminated against. Altogether, these findings support those described by Rowan et al. (2019), describing that in a sample of service providers in the US, the majority (75%) automatically assumed their clients were cisgender; meanwhile 40% indicated the need for more education. Similarly, Patterson et al. (2019) reported that amongst a sample of service providers in the US, only about half felt competent to treat LGBTQ+ patients, citing discomfort with LGBTQ+ clients and being unfamiliar with the use of proper language. Again, this dynamic reflects the relevance of the MSEM for capturing the interplay between structures, systems, and community attitudes – clearly, attitudes of homophobia, biphobia, and transphobia trickle down to influence the wellbeing of GBTMSM in the region.

Connectedly, these experiences likely speak to a general lack of GBTMSM-related competencies held by providers in SW Ontario. In fact, a number of participants reflected on similar experiences, describing situations where their provider lacked relevant knowledge on how STBBIs are transmitted, which, in turn, influenced the STBBI swabs that were ordered for them when seeking testing. These findings reflect those reported by Hubach et al. (2017), suggesting that underlying stigma facing MSM in non-metropolitan and rural areas contributes to less LGBTQ+-related competencies amongst service providers, creating a significant barrier to accessing quality care. In comparison, other participants described being interrogated about the hormones they were taking related to their transition, reflecting a general lack of knowledge around trans-informed care. In a similar vein, another participant reflected on the limited trans-related knowledge held by their provider but described how their provider recognized the limits to their knowledge and introduced a collaborative approach to care, where together, the participant and their provider co-engaged in care. Although in some ways providing autonomy, this participant reflected on sometimes feeling like an experiment for their provider rather than a human being. These findings perhaps preclude those presented by Poteat et al. (2016), suggesting that both structural- and community-level discriminatory attitudes discourage trans GBMSM from accessing sexual health services. However, positively, some participants highlighted the value in accessing a provider in their region who also identified as GBTMSM, as this contributed to a better patient-provider fit, and an overall more positive experiences with accessing care. These dynamics suggest a lack of procedural justice facing GBTMSM in the absence of informed, respectful, and inclusive processes when accessing healthcare and social services.

Unsurprisingly, it seems that the lack of GBTMSM-related competencies held by providers in SW Ontario trickles down to influence access to health promotion tools, such as

PrEP and HIV & STBBI testing. In fact, a number of participants described that their providers did not know what PrEP was and, in turn, they had to educate their provider. These findings reflect those provided by Sharma et al. (2014) in their study exploring the perceptions and readiness of Canadian family, infectious disease, internal medicine, and public health physicians for the implementation of PrEP. Based on quantitative survey data, only 45.9% felt 'very familiar' with PrEP, only 49.4% felt that PrEP should be approved by Health Canada, and less than half (45.4%) were willing to prescribe PrEP. As well, 75.3% of participants did not feel that information around PrEP had been adequately disseminated among physicians. These findings are especially alarming, as although they come from 2014, it seems that little has changed regarding provider perceptions and readiness for the implementation of PrEP based on the findings captured in this study around provider familiarity with PrEP. However, positively, provider familiarity with PrEP and having been asked by patients about PrEP were positively associated with willingness to prescribe PrEP, suggesting that by engaging with their providers about PrEP, participants and other GBTMSM in SW Ontario may be increasing accessibility to PrEP in the region more generally.

As well, a number of participants reflected on situations where they had to advocate for accessing HIV & STBBI testing. Luckily, a number of participants recounted being able to turn to the ASO in their region for access to these health promotion tools, supplementing these service gaps. Beyond gaps surrounding GBTMSM-related competencies, other participants framed the sexual health services in their regions as inaccessible due to inaccessible opening hours, especially during COVID-19. This limited accessibility of HIV and STBBI testing during the COVID-19 pandemic is reflected in data presented by the Ontario HIV Epidemiology and Surveillance Initiative (OHESI), describing that in 2020, the number of HIV tests conducted

dropped by 26% (OHESI, 2021b). In addition, there was a 25% drop in first-time HIV diagnoses that researchers attribute to some missed diagnoses due to inaccessible testing related to COVID-19 restrictions, a real drop in new infections due to COVID-19 restrictions contributing to less contact between GBMSM and decreases in immigration due to global lockdown measures (OHESI, 2021b). In addition, perhaps following from negative community attitudes toward GBTMSM, a number of participants reflected on internalized feelings of shame which served as barriers to accessing HIV & STBBI testing. These findings are perhaps useful for interpreting those reported by Tjepkema (2008), suggesting that internalized feelings of shame around queer sex stemming from homophobic, biphobic, and transphobic community attitudes contribute to limited access to testing services. In connection, findings from Coleman et al. (2022) in their study exploring socio-demographic, behavioural, and psychosocial factors associated with recent HIV testing for GBMSM are useful here. Amongst a sample of GBMSM 16 or older living, working, or residing in the Region of Waterloo, Ontario, Canada, researchers found that having an increasing proportion of LGBT friends, access to their local ASO, and general sense of belonging to their local community were associated with more recent HIV testing (Coleman et al., 2022). These findings presented by Coleman et al. (2022) help explain how these negative community attitudes toward GBTMSM mentioned by participants in the sample trickle down to perhaps influence sense of belonging, and in turn, access to HIV testing. As well, these findings from Coleman et al. (2022) underscore the potential detriments that come from not having access to 2SLGBTQIA+ spaces, where GBTMSM can connect with other 2SLGBTQIA+ folks. Nonetheless, positively, some participants reflected on the public health body in their region as being attentive to their needs, following up when a recent partner had tested positive for an STBBI, or following up every three months to encourage regular testing. Altogether, these

experiences show the benefit of introducing GBTMSM-informed procedures, speaking to the need for greater education on providing affirming and competent GBTMSM-related care. ASOs simply cannot be the sole resource responding to the sexual health and broader health needs of GBTMSM living in SW Ontario – more needs to be done.

Altogether, these findings reflect the relevance of minority stress and the interplay between distal and proximal stressors, in that societal attitudes toward GBTMSM are reified to influence the sexual health of GBTMSM. These findings also perhaps highlight an emerging syndemic pathway, in that limited and/or absent policies around providing affirming and inclusive sex education that reflects the experiences of GBTMSM leads to an absence of sex-ed-related knowledge and internalized stigma around sex and sexual health for GBTMSM, which, in turn, contributes to less preparedness for accessing and implementing sexual health promotion tools, perhaps contributing to HIV incidence/prevalence amongst GBTMSM. As well, the limited GBTMSM affirming and competent providers and services in SW Ontario can be implicated as mediating the relationship between faulty sex-ed programming and limited access and engagement with sexual health promotion tools. Without access to such services, GBTMSM do not have the opportunity to engage with relevant and affirming sexual health education and resources that might encourage positive sexual health and reduce HIV risk, even if prior sex-ed programming in their youth was heteronormative, cisnormative, and overlooked their experiences. In consideration of trans GBMSM more specifically, cisnormativity can be implicated to further contextualize this syndemic pathway, in that cisnormative systemic and societal attitudes can be conceptualized as trickling down to influence the attitudes of community members and healthcare and social service providers. This dynamic further exacerbates barriers to accessing affirming care and decreases the likelihood that providers will ask the appropriate

questions and provide the most relevant and affirming services to trans GBMSM, which in turn, may contribute to less access to sexual health promotion tools, perhaps contributing to a higher risk for HIV.

Focusing more specifically on how the attitudes of their communities influenced their feelings of belonging and inclusion, a number of participants described encountering feelings of loneliness and isolation in their communities, creating challenges to being open about their identity and connecting with other GBTMSM. Undeniably related to these experiences of loneliness and isolation are the lack of GBTMSM & 2SLGBTQIA+ spaces in SW Ontario. Alarmingly, findings from Brown et al. (2015) suggest that the presence of less LGBTQ+ visibility in non-metropolitan regions contributes to barriers to accessing mental healthcare and other services, perhaps speaking to the potential consequences of having less 2SLGBTQIA+ visibility in SW Ontario. Connected to this general lack of visibility and spaces described by participants were challenges with navigating queer spaces, or breaking into new circles, especially when new to the region. In fact, a number of participants recounted barriers to fitting in with other GBTMSM and the broader 2SLGBTQIA+ community in their areas, reflecting on challenges with balancing labels, fitting into certain subgroups, and navigating online GBTMSM-related spaces, such as dating and hook-up apps, like Grindr and Scruff. These challenges with experiencing community and inclusion within GBTMSM and 2SLGBTQIA+ social groups were further exacerbated for GBTMSM with other intersecting identities, such as those who were BIPOC or living with a disability. In fact, a Black GBTMSM reflected on their experience of seeking to join a GBTMSM social group, only to encounter racism, and a predominant focus on the experiences of White GBTMSM, leaving them feeling isolated and overlooked. Connectedly, it seems that the COVID-19 pandemic only further contributed to

these barriers, exacerbating barriers to maintaining connection with other GBTMSM and 2SLGBTQIA+ folks when not being able to gather in person. Altogether, these findings reflect lived experiences of minority stress and mirror those presented by Doyle & Molix (2016), describing that for LGBTQ+ individuals, a higher prevalence of structural violence and negative attitudes toward sexual and gender identity minorities predicts fewer social ties and lower social support, highlighting the need for greater opportunities for community and connection.

In light of these challenges to experiencing community and connection with other GBTMSM and the broader 2SLGBTQIA+ communities in their areas, participants reflected on the significance of their social support networks for feeling connected and included in their communities. In particular, some participants reflected on the value of having other GBTMSM or 2SLGBTQIA+ folks in their social circles for bolstering wellbeing and garnering connections to sexual health resources, such as testing clinics and affirming providers. These findings are akin to those suggested by Woodford et al. (2015) and Toomey et al. (2018), suggesting that for LGBTQ+ folks, having other LGBTQ+ friends in their network positively influenced wellbeing, contributing to connection and psychosocial adjustment. As well, Felson & Adamcyzk (2017) provide an additional useful lens for interpreting these findings, suggesting that in areas with less favourable attitudes toward LGBTQ+ people, there were less disparities between sexual minorities and others, likely due to the significant of queer enclaves and the associated social support bolstered from surrounding oneself with other LGBTQ+ folks. Altogether, these findings reflect the significance of achieving wellbeing, and represent a testament for the importance of providing funding and support for 2SLGBTQIA+ spaces, even in smaller regions, such as SW Ontario.

Beyond bolstering wellbeing according to those in their social networks, a number of participants described the significance of their individual approaches to self-care and self-advocacy. In particular, quite a few participants reflected on the value of exercising, accessing counselling and psychotherapy services, journaling, meditation, using CBD products, spending time with pets, engaging in art, and connecting with stories from other GBTMSM via podcasts, videos, and books. These approaches to self-care were framed as beneficial for maintaining wellness, enhancing self-esteem, and managing through tough days when one's mental health is not at its best.

These findings can be interpreted both positively and negatively. In a positive light, these findings suggest that GBTMSM in SW Ontario show resilience, and have the autonomy to engage in activities and practices that bolster their wellbeing. This interpretation of these findings is supported by those described by O'Brien et al. (2021) in their study characterizing approaches to self-care of sexual minority adolescents in the United States during the COVID-19 pandemic. The researchers found that spending time with family members, friends, and pets, establishing and maintaining routines, engaging in exercise, meditation, and self-hygiene, and engaging with music, art, and reading were essential approaches to self-care during the COVID-19 pandemic (O'Brien et al., 2022). As well, the findings from Craig et al. (2015) help to explain the importance of connecting with stories from other GBTMSM via podcasts, videos, and books, to bolster wellbeing, as described by participants. In their exploration of media-based resilience-building activities, researchers found that media use enabled coping with stressors via escapism, feeling stronger, fighting back, and finding and fostering community, suggesting that engagement with media that reflects their lived experiences is important for bolstering self-esteem and wellbeing for GBTMSM (Craig et al., 2015).

Conversely, these approaches to self-care and self-advocacy presented by participants in the study at hand may be reflective of the consequences of having few services, spaces, and supports in place in SW Ontario to support GBTMSM. This situation has been explored by Gonzalez et al. (2022), in their study investigating LGBTQ coping during Trump's administration, where a multitude of anti-LGBTQ+ legislation alongside significant cuts to LGBTQ+ services and spaces have been experienced. The researchers discovered five coping-related themes: coping through connecting with people, through self-care and self-preservation activities, through relational disengagement, through activism, and through outness decisions. In light of the present study's findings, coping through self-care and self-preservation is significant for understanding how self-care and self-preservation strategies are perhaps introduced to bolster wellbeing in the absence of other community-bound opportunities to pursue wellbeing (Gonzalez et al., 2022). Via Gonzalez et al. (2022), self-care and self-preservation activities were manifested in three main ways, however, one is most relevant for the findings presented here: specific references to self-care activities, such as reading books, exercising, pursuing hobbies, and attending therapy. A number of participants in our study mentioned implementing similar approaches to self-care, highlighting the importance of exercising, pursuing hobbies, and engaging in therapy, suggesting the significance of these such approaches to self-care for maintaining wellbeing. Ultimately, individual approaches to self-advocacy should not be the only option for self-advocacy available to GBTMSM in the region, and accordingly, greater funding and resources must be introduced to support the implementation of services and spaces that encourage the wellbeing of GBTMSM in SW Ontario.

This dynamic by which GBTMSM in the region described turning to self-advocacy and self-care in the absence of other supports and services to bolster wellbeing also speaks to the

power of resiliency amongst GBTMSM. Speaking broadly, resilience represents those processes, capacities, factors, and outcomes of successful adaptations, despite life challenges and diversity (Souleymanov et al. 2020). In the case of resilience amongst GBTMSM, research has demonstrated that resiliency is a complex and multidimensional construct that manifests uniquely for each individual (Wilson et al., 2016). Existing research has also recognized the association between minority stress and resilience, in that for many GBTMSM, resilience represents an approach for coping with the detriments that follow from living in and navigating heteronormative and cisnormative services, systems, and societies (Bruce et al., 2015; McConnell et al., 2018). For instance, work by Breslow et al. (2015) highlights for trans people in the US, resilience moderates the association between minority stress and psychological stress. In the current study, for trans and non-binary GBMSM resilience emerged as a coping strategy for living under cisnormativity and heteronormativity, in that participants described turning to self-care and community supports and representations to bolster wellbeing, supporting the findings presented by Breslow et al. (2015). Similarly, Craig et al. (2015) suggests that engagement with positive queer media representation represents a form of resilience by bolstering community and strength, and positions LGBTQ youth to cope with community- and societal-stressors. Our findings support such pathways to resilience, as a number of GBTMSM in the sample described finding solace and experience community through online support groups and positive GBTMSM media representations.

Considering more material manifestations of community in connection with resilience, Felson & Adamcyzk (2017) describe that in the US, there are less mental health disparities between sexual minorities and their heterosexual counterparts in areas highly concentrated with LGBTQ+ people but that these findings also extend to states with less affirming LGBTQ+ laws

and policies, suggesting the significance of queer enclaves for bolstering resilience even in the face of structural violence. Participants in the current study perhaps provide a qualitative lens to interpret these findings; participants described living in highly conservative, homophobic, biphobic, transphobic, and racist communities, but continually described the few 2SLGBTQIA+ spaces in their communities as lifelines, and opportunities for experiencing community and affirming care and support. Further delving into these regional nuances, Lyons et al. (2014) describe that rural-urban differences alone do not account for differences in mental health and resilience among young Australian gay men, but rather, the characteristics of the group an individual participates in are strongly tied to resilience and wellbeing. The researchers underscore that wellbeing and resilience are greatest amongst those who participate in groups without hierarchies, where they have the autonomy to contribute to the direction and influence of the group (Lyons et al., 2014). The narratives presented by the participants in this study support these findings, as a number of participants highlighted the value of participating in GBTMSM social groups, but also recognized the limited wellbeing they achieved while interacting with social groups that were Whitecentric and overlooked their other intersecting identities. Clearly, resilience represents a subjective and multifaceted construct, but a significant opportunity for managing with heteronormativity and cisnormativity, and reflects a tangible point for intervention, where programs and services can be more attentive to bolstering and supporting resilience amongst GBTMSM with other intersecting identities.

Recommendations: Southwestern (SW) Ontario GBTMSM Support Plan

To address the multifaceted issues presented above, the researchers propose a regional action plan that is vital for supporting the wellbeing of GBTMSM in SW Ontario. This action plan is tailored toward federal and provincial bodies, workplaces, community spaces, and

schools in the region, and healthcare and social services in the region. The action plan follows from the modified social ecological model (MSEM) and involves three primary facets: 1) the provision of financial support for GBTMSM & 2SLGBTQIA+ spaces and services in the region; 2) the implementation of GBTMSM & 2SLGBTQIA+ sensitivity and competency training for community members and healthcare and social service providers in the region; and 3) a critical refurbishment of the laws and policies impacting the wellbeing of GBTMSM.

Funding for GBTMSM & 2SLGBTQIA+ Spaces & Services

Reflecting on the deficits associated with limited GBTMSM and 2SLGBTQIA+ spaces and services in SW Ontario and an absence of funding supporting GBTMSM and 2SLGBTQIA+ folks, the researchers recommend that government subsidies be introduced to support the development of GBTMSM and 2SLGBTQIA+ spaces in the region, as well as to support GBTMSM and 2SLGBTQIA+ folks when coming into their identities. This may involve developing specific funding pathways and programs for 2SLGBTQIA+ spaces and businesses, demonstrating a commitment to supporting 2SLGBTQIA+ communities in SW Ontario. A substantial portion of this funding should be directed toward enhancing the intersectionality of 2SLGBTQIA+ spaces and services in the region; this might involve directing funds toward Indigenous Cultural Safety (ICS) training for employees, hosting workshops around the experiences of BIPOC GBTMSM, or supporting the development of spaces specifically for queer People of Colour. Connectedly, developing subsidizations specifically for GBTMSM and 2SLGBTQIA+ individuals would serve to alleviate some of the monetary stresses facing GBTMSM coming into their identities, and navigating their communities. By supporting these funding pathways, government bodies can serve to enhance 2SLGBTQIA+ representation and

visibility in these smaller regions, perhaps alleviating some concerns around identity concealment, and creating meaningful and affirming spaces for community and connection.

However, it is important that these recommendations be considered in acknowledgement of the current state of funding directed towards services supporting GBTMSM in the region, such as ASOs. In fact, despite increased demand for HIV testing services due to backlogs in testing related to COVID-19, ASOs such as ACT (formerly known as the AIDS Committee of Toronto) received a notice that its funding will be $450,000 less over the next five years starting in 2022 (Jabakhanji, 2021). This situation has also been echoed by the Ontario HIV Treatment Network (OHTN), describing that over the prior few years, HIV clinics have faced budget cuts, related to losses in federal funding (OHTN, 2022). Undeniably, these funding cuts reflect a federal and provincial indifference when it comes to supporting the health of GBTMSM and other communities impacted by HIV. However, the findings related to this study and those reported in other similar projects underscore the need for greater funding, prospectively seeking to bolster support for increased funding despite historical cuts for services supporting GBTMSM and 2SLGBTQIA+ folks.

2SLGBTQIA+ Anti-Stigma Campaigns & GBTMSM-Related Education for Healthcare & Social Service Providers

Based on descriptions of community-level homophobia, biphobia, transphobia, and racism described by participants, the researchers recommend the implementation of anti-stigma campaigns and sensitivity training programs in SW Ontario, in addition to what may already exist. This may involve starting early and expanding anti-stigma campaigns and introducing sensitivity training curricula into primary and secondary schools in the region. For reducing stigma amongst teachers and administrative staff, Coulter et al. (2021) demonstrates the utility of

such approaches, describing that after participating in LGBTQ-focused didactic training, pre-service teachers' knowledge, attitudes, self-efficacy, and skills for serving LGBTQ high school students improved more than a control group. As well, those who participated in the LGBTQ-focused didactic training showed significantly greater active-empathetic listening and self-efficacy skills for working with LGBTQ high school students compared to those in the control group (Coulter et al., 2021). Thinking more specifically about bolstering social support and resilience amongst queer youth, Saewyc et al. (2016) highlight the utility of Gay-Straight Alliances (GSAs) and explicit anti-homophobic bullying policies in secondary schools across British Columbia, describing that lesbian, gay, and bisexual youth had lower odds of past year discrimination, suicidal thoughts and attempts when policies and GSAs had been in place for three or more years. Together, these findings speak to the importance of introducing interventions at the administrative and individual/community levels to comprehensively support the wellbeing of GBTMSM and other LGBTQ+ youth in schools.

Connectedly, on a more general plane, anti-stigma campaigns can be introduced at a community level, advocating for the equitable and just treatment of GBTMSM in community spaces, on billboard and posters, and in workplaces across the region. As well, a number of participants described their workplaces as spaces where discrimination occurred without recourse – to create safer and more affirming workplaces for GBTMSM, the researchers recommend introducing mandatory 2SLGBTQIA+ and BIPOC sensitivity training in workplaces that fall under the public sector, while strongly encouraging the uptake of this programming in the private sector. In fact, work by Perales (2022) supports such approaches to bolstering the wellbeing of LGBTQ+ employees in the workplace. Based on Australian national employer-employee workplace inclusion data in consideration of organizational-level measures of diversity training

and ally behaviours in association with LGBTQ+ employee wellbeing, Perales (2022) describes that all individual- and organizational-level measures of workplace diversity training and ally behaviours contributed to positive, large, and statistically significant associations with LGBTQ+ employee wellbeing, affirming that diversity training and ally networks may be significant for improving wellbeing amongst LGBTQ+ employees. Clearly, interventions that enhance workplace diversity and encourage allyship through education and awareness raising show utility for better supporting the wellbeing of GBTMSM and other LGBTQ+ people in the workplace.

In response to the lack of GBTMSM-related competencies held by providers and healthcare and social services in the region, the researchers recommend that providers and healthcare and social service centres in SW Ontario engage in GBTMSM and 2SLGBTQIA+ training sessions to better understand how to provide affirming and meaningful care to GBTMSM in the region. This may involve updating mandatory courses for social service workers, nurses, phlebotomists, social workers, counsellors, psychologists, and doctors to ensure these providers are equipped with the appropriate knowledge and competencies to best support GBTMSM when accessing their healthcare and/or social services. These prospective courses should include an intersectional lens that seeks to bolster cultural competency by recognizing how racialized GBTMSM and GBTMSM LWH, for example, face unique barriers to achieving wellbeing, and face exacerbated barriers to accessing healthcare and social services. Instead, this might involve introducing mandatory training programs for healthcare and social service providers that are currently employed in SW Ontario – the onus of educating providers on GBTMSM-informed care should not be on community members, rather, knowledge and expertise around providing culturally competent care should be a given. In fact, both narratives presented by participants for the current study and extant research exploring provider attitudes

and preparedness for providing GBTMSM-competent care highlight that the majority of providers do not feel equipped with the right knowledge and skills to effectively meet the needs of GBTMSM (Patterson et al., 2019). Further exemplifying this situation, research characterizing provider preparedness for supporting trans folks suggests that few providers in training (17%) predict they will feel competent to provide specialty-specific trans-care by the end of their residency, and even less (12%) feel that the training they received was adequate to position them to care for the trans population (Coutin et al., 2018).

In response to these knowledge gaps, other research has explored the efficacy of interventions seeking to enhance LGBTQ knowledge amongst medical students. Upon implementing an LGBT health curriculum for students at the University of California, Kelley et al. (2008) found that willingness to treat patients with gender identity issues increased, meanwhile, enhanced awareness that sexual identity and practices are clinically relevant was reported (Kelley et al., 2008). Similarly, Gibson et al. (2020) found that amongst medical students in the LGBTQ Health Pathway program at the University of Washington School of Medicine (UWSOM), a program aimed at enhancing LGBTQ care competencies amongst providers through a diverse set of pre-clinical and clinical components, 100% of participants described that the education and training they received from the program had improved their abilities to care for LGBTQ patients. Findings such as these underscore the utility of introducing specific measures that seek to bolster 2SLGBTQIA+ related competencies for providers in training. Connectedly, these findings from Kelley et al. (2008) & Gibson et al. (2020) reflect the significance of the University of Toronto implementing an LGBTQ+ focused health curriculum for medical residents; in 2020, the University of Toronto introduced new measures for medical residents seeking to pervade knowledge gaps reported in previous research, such as provider

knowledge around hormone replacement therapy and sexually transmitted infections (McGowan, 2020). As well, the updated curriculum captured intersectionality, and includes specific considerations for how COVID-19 has disproportionately impacted the health of the LGBTQ+ community, most especially racialized LGBTQ+ people and LGBTQ+ people living with a disability (McGowan, 2020). This programming introduced by the University of Toronto could perhaps be extrapolated and applied to existing providers in SW Ontario as well as to providers in training in the region to bolster GBTMSM-related competencies and create more meaningful climates for care for GBTMSM.

Beyond introducing 2SLGBTQIA+ specific curriculum for service providers in training, the researchers recommend prioritizing the employment of GBTMSM or 2SLGBTQIA+ in healthcare and social services in the region. Patient-provider fit is extremely important for curating a safe and meaningful environment when accessing care, in fact, research demonstrates that younger or gay-friendly doctors are more likely to be viewed as safe targets for disclosures about one's sexual orientation and sexual orientation-related questions or concerns (Qiao et al., 2018). The findings outlined in this study underscore a significant lack of GBTMSM and/or 2SLGBTQIA+ providers or 2SLGBTQIA+ friendly providers at healthcare and social service centres in SW Ontario, suggesting that greater effort is needed here to enhance diversity and in turn, support experiences of safety for GBTMSM in the region when accessing care. Fore fronting folks who are members of these communities in the hiring process would serve to diversify healthcare and social services and create opportunities for meaningful employment for GBTMSM and 2SLGBTQIA+ folks.

Overall, making these findings as widely accessible as possible to heterosexual and/or cisgender and White community members reflects the first step in ameliorating the stigma and

discrimination facing GBTMSM; however, further efforts from municipal bodies are needed to ensure these findings are reached by as many heterosexual and cisgender folks as possible.

Critical Refurbishment of Laws & Policies Impacting GBTMSM

In light of the paucity between laws, policies and practices described by participants, the researchers recommend that law makers and provincial bodies be more attentive to the laws and policies in place and make more of an effort to ensure these laws and policies are implemented effectively in workplaces, community spaces, and schools. As well, the researchers recommend that existing laws are critically examined with an eye towards equity, diversity, and inclusion. This should involve making the laws protecting discrimination on the grounds of sexual orientation, gender identity and race more well-known by general community members, either through awareness raising campaigns, or through greater education around these laws in schools, workplaces, and community spaces. For instance, introducing a mandatory human rights course or greater 2SLGBTQIA+ affirming programming and services in primary or secondary schools could serve to better inform the general community on the experiences of GBTMSM, promoting greater awareness of the discrimination facing GBTMSM and creating safer environments for 2SLGBTQIA+ youth and adolescents. In fact, work from Johns et al. (2019) supports such approaches to cultivating protective factors for LGBTQ youth which, in turn, nurture the processes of resilience in the face of stigma. The researchers describe that although schools can represent a significant space for facing stigma and discrimination, they also represent a critical site of adolescent development, and can provide important opportunities for intervention work with LGBTQ youth (Johns et al., 2019). Altogether, the researchers describe that in order to implement meaningful and useful interventions aiming to create safer school environments for LGBTQ youth, interventions need to be attentive to intersectionality, identify and train

supportive adults in schools, and introduce in-school programs tailored toward LGBTQ youth and the general school population that bolster connection, reduce bullying, and improve school climates (Johns et al., 2019). Such approaches to supporting queer youth in schools across SW Ontario could perhaps be introduced to bolster resilience and better support the wellbeing of younger GBTMSM.

However, potential pushbacks related to conservatism and bureaucratic issues should be expected. For instance, the state of Florida recently introduced the 'Don't Say Gay' bill, effectively barring educators from having discussions about sexual orientation and gender identity in classrooms between kindergarten and grade three (The Associated Press, 2022). The bill also discourages educators from being open about their sexual orientation and/or gender identity if they identify as a member of the 2SLGBTQIA+ community, further contributing to concerns around outness and discrimination at work described by participants in this study and in other literature (The Associated Press, 2022; Ozeren, 2014). Ultimately, the 'Don't Say Gay' bill effectively weaponizes heteronormativity and cisnormativity against 2SLGBTQIA+ people and raises questions around whether similar measures may be introduced in Ontario following from Ford's recent modifications to the Ontario sexual health education curriculum. Similarly, in the wake of George Floyd's murder by police in May or 2020, a number of school districts in the United States denounced White supremacy and sought to introduce education around CRT into their schools and classrooms but were met with significant pushback from conservative activists aligned with the No Left Turn in Education group (Kingkade et al., 2021). The No Left Turn in Education group is aligned with the Republican party and is bound in White supremacy, aiming to disrupt lessons on race and gender in schools across the United States via strategies of disruption, publicity, and mobilization (Kingkade et al., 2021). Although standardized

curriculum reflecting CRT in Canada has yet to be introduced, it would not be unlikely that similar pushback would prevail, especially in consideration of the Conservative party's responses to the cultural genocide of Indigenous people that occurred in Canada and attitudes toward the Black Lives Matter movement (Tasker, 2019; Boisvert, 2021).

Connectedly, critically examining the laws in place with regard to equity, diversity, and inclusion is essential for ensuring laws adequately preserve the wellbeing and human rights of GBTMSM with other intersecting marginalized identities. This might involve consulting with 2SLGBTQIA+ individuals with a background in law and human rights and critical race theory (CRT), perhaps in the form of a focus group, that provides a set of recommendations for refurbishing the laws in place to be more attune to the equity and inclusion of 2SLGBTQIA+ folks. This focus group should also include an individual with expertise around HIV non-disclosure laws and the intersections between HIV and human rights to ensure that laws most accurately reflect the current science around HIV and protect the wellbeing of GBTMSM LWH and PLWH more generally. Connectedly, in consideration of the disconnect between certain laws, policies and current science, the researchers recommend updating the laws around HIV non-disclosure and donating blood for GBTMSM to match the current science around HIV. Doing so would serve to alleviate the significant stress facing GBTMSM LWH, who have to continually come out about their status despite their being a negligible risk of transmission. Connectedly, updating the laws around donating blood which continue to be discriminatory towards GBTMSM would serve as a source of empowerment, and would work to further disseminate the current science around HIV, prospectively leading to an increased reduction in stigma around HIV. As well, perhaps contributing to a greater general awareness around the current science surrounding HIV, the researchers recommend that sexual health education

programs in primary and secondary schools be updated to include considerations for 2SLGBTQIA+ youth, including considerations around HIV, queer sex, and PrEP and PEP. These updates to sexual health programming would serve to alleviate some of the internalized stigma experienced by GBTMSM, who may manifest negative societal attitudes around queer sex, that, in turn, may influence their propensity to accessing HIV & STBBI testing and other health promotion tools.

Limitations

The results of this Master's thesis are influenced by the limited generalizability of this study's findings and the limited narrative scope captured by the study's interviews. While the researchers were able to connect with a diverse group of GBTMSM, the findings reported here do not necessarily reflect the entire diversity of the lived experiences of GBTMSM, and some perspectives may be missing. For instance, although a number of intersectional perspectives were captured, such as those who are racialized and living with HIV, or those who are living with HIV and over the age of 65, future projects could seek to further capture the intersectional perspectives and experiences of GBTMSM to better account for the full range of experiences facing GBTMSM with other intersecting identities living in SW Ontario and beyond. Reaching additional numbers and a true diversity could be better achieved with a quantitative study, which is one of the next phases of the overarching project. As such, the researchers are confident that in the forthcoming quantitative phase of the overarching project they will be able to further explore and elucidate these intersectional perspectives and experiences of GBTMSM with other overlapping identities.

Although the researchers aimed to introduce a semi-structured and narrative blended approach for the interviews, additional questions that reflected the narrative approach were

needed to better elicit narrative responses from participants. While a number of important topics were covered throughout the course of each interview by introducing the semi-structured approach, participants could have been provided with more of an opportunity to reflect on and describe their experiences through a narrative lens. Future research in this area should perhaps introduce an interview that is completely narrative-based, or predominantly narrative-based to best capture storied accounts that reflect the lives experiences of GBTMSM.

Conclusions and Implications

Ideally, these recommendations should lead to the more routine enforcement of laws and policies protecting GBTMSM from discrimination and should contribute to greater feelings of safety and inclusion at work, in community spaces, and at school. As well, updating healthcare and social service-related policies to better meet the needs of GBTMSM should contribute to more positive experiences when accessing HIV & STBBI testing, encouraging future engagement overtime. Similarly, updating sexual health education programming to be more inclusive and in touch with GBTMSM and the broader 2SLGBTQIA+ community should work to mitigate feelings of shame around queer sex, and encourage young GBTMSM to engage in regular testing and access health promotion tools earlier and with more ease, such as PrEP. Finally, updating HIV non-disclosure laws to better match the current science around HIV and making these laws more accessible and well-known should serve to alleviate a great deal of stress facing GBTMSM LWH, meanwhile, serving to continue to destigmatize HIV. Connectedly, abolishing barriers to donating blood impacting GBTMSM should represent a source of empowerment, serving to exemplify the current knowledge around HIV transmissibility.

As well, these outlined recommendations will lead to more positive experiences at healthcare and social services for GBTMSM through additional training of providers and other staff members, positioning them better to provide competent and affirming care and services to GBTMSM. Connectedly, alongside greater GBTMSM-related education, providers and service centres should be better positioned to respond to the sexual health needs of GBTMSM, providing more accessible HIV & STBBI testing, and access to PrEP. As well, these recommendations are intended to raise general awareness about the experiences of GBTMSM navigating their communities within SW Ontario. Many of the details shared by participants reflect community climates that are homophobic, biphobic, transphobic, and racist, contributing to significant stress and anxiety around being open about one's identity, as well as concerns around accessing certain spaces and places. Although awareness raising is only the first step in advocating for change, the research team hopes that making these findings widely available to heterosexual and/or cisgender community members in SW Ontario will contribute to shifting attitudes toward GBTMSM and the 2SLGBTQIA+ community in SW Ontario more broadly.

The recommendations outlined above surrounding the need for greater GBTMSM and 2SLGBTQIA+ safe spaces within SW Ontario reflect the concerns around discrimination presented by participants. By supporting the development of GBTMSM and 2SLGBTQIA+ spaces in the region, GBTMSM will have the opportunity to experience community and connection, and benefit from greater visibility. Above and beyond recommendations related to healthcare and social services and spaces and places, the recommendations described surrounding the need for more governmental funding and support are perhaps the most significant. Without adequate funding, 2SLGBTQIA+ spaces cannot operate, and GBTMSM within SW Ontario and beyond will continue to fall through the cracks when seeking to access

affirming healthcare and social services and safe spaces for gathering and connecting with other GBTMSM and 2SLGBTQIA+ folks. As exemplified by these findings, many GBTMSM and members of the broader 2SLGBTQIA+ community rely on identified affirming spaces and services to experience community, garner support, and access resources – until non-2SLGBTQIA+ spaces and services are prepared to best meet the needs of 2SLGBTQIA+ folks, provincial and federal bodies must step up to support these spaces and services that represent lifelines for GBTMSM and 2SLGBTQIA+ folks living in non-metropolitan regions, such as SW Ontario.

This project serves as one of the first to characterize the sexual health and broader health of GBTMSM in Canada outside of larger metropolitan regions, such as Toronto. As such, the findings generated from this project should be essential for healthcare and social services in the area to inform their programming and services more accurately according to the experiences of GBTMSM in the region. Connectedly, the qualitative nature of this study allowed researchers to gather intersectional details related to GBTMSM with other overlapping identities, such as those who are racialized or newcomers, and those who are living with HIV. As well, in tandem with findings related to how structural- and community-level variables negatively influence the wellbeing of GBTMSM, researchers presented findings that reflect how structural- and community-level variables represent positive influences on the sexual, mental, and physical health of GBTMSM. Importantly, by considering how GBTMSM can simultaneously experience poor health and positive health, the researchers hope to provide a testament for conducting research with GBTMSM that moves beyond focusing solely on deficits and poor health, and instead, considers the full spectrum of experiences, such as those that promote wellbeing and connection. In a similar vein, this project represents one of the few to comprehensively assess

how factors beyond individual behaviour, such as laws and policies influence the wellbeing of GBTMSM. Clearly, assessing structural violence in light of laws and policies showed merit for capturing the interplay between systems, structures, community climates, and wellbeing. The researchers hope that the approach undertaken for this study promotes future work that follows suit and moves beyond solely assessing individual behaviour as predictive of poor health.

Moving forward, the researchers recommend that future projects further explore the experiences of GBTMSM living in other non-metropolitan regions across Ontario and Canada more broadly. Based on these findings, it is difficult to determine whether the findings related to this study can be generalized to the experiences of GBTMSM living in other similar non-metropolitan regions in Ontario and Canada, such as those living in Northern Ontario, for example. Pursuing similar research questions in other non-metropolitan regions across Ontario and Canada would allow for a better understanding of whether rurality itself is associated with certain health outcomes, or if individual regions and associated community attitudes are more significant here. As well, similar explorations in other non-metropolitan regions across Ontario and Canada would provide healthcare and social services in these regions with relevant recommendations which could improve service access and experience for GBTMSM. Connectedly, future work that draws a direct comparison between the experiences of GBTMSM living in metropolitan regions, such as Toronto, and GBTMSM living in non-metropolitan regions, such as those in Northern Ontario, could surely be beneficial for understanding which specific factors found in metropolitan regions influence health that are absent or less prevalent in non-metropolitan regions.

Future phases involve the research team triangulating these data alongside interviews with Executive Directors and GBTMSM sexual health workers at ASOs across SW Ontario. This

includes undertaking a study that seeks to establish parallels between the experiences and perceptions of GBTMSM in SW Ontario and the Executive Directors and GBTMSM sexual health workers at ASOs across SW Ontario. Upon the completion of these analyses, the researchers will be more apt to provide further conclusions regarding the interplay between social services, data and knowledge, and the wellbeing of GBTMSM in SW Ontario.

Appendix A: TCPS Ethics Certificate

PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Lucas Gergyek

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **4 May, 2020**

Appendix B: Outreach Email Script

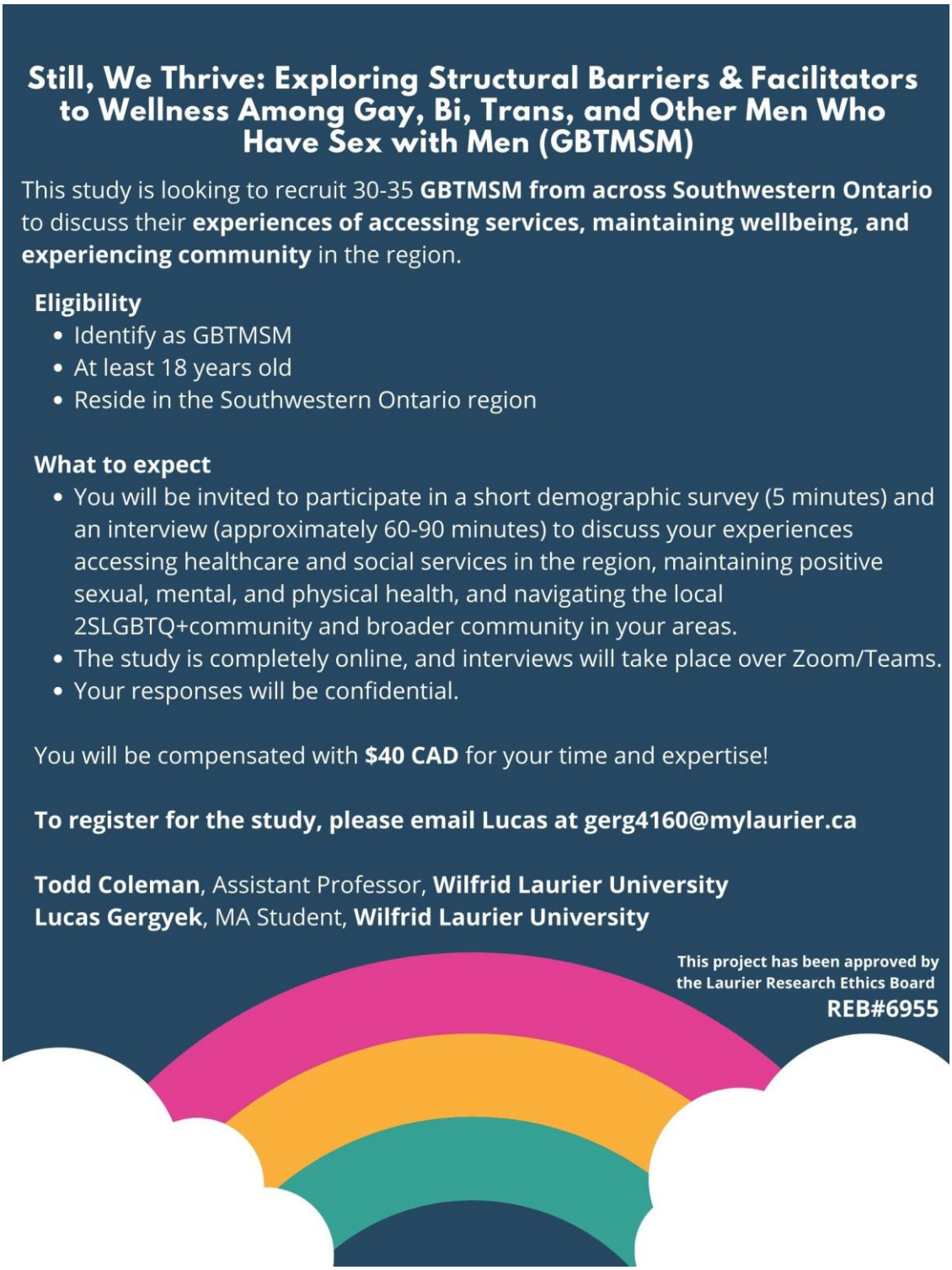
Good Morning/Afternoon,

Researchers at Wilfrid Laurier University's Social Inclusion & Health Equity Research Group are currently recruiting gay, bisexual, transgender, and other men who have sex with men (GBTMSM) from across the Southwestern Ontario region for a study conducted by Dr. Todd Coleman exploring the experiences of GBTMSM navigating structural barriers and facilitators to wellness as well as characterizing the sexual health and broader health of this population. The study utilizes interviews to explore themes, differences, and commonalities among the lived experiences of GBTMSM from across the Southwestern Ontario region. Researchers are seeking to conduct interviews with five to six GBTMSM from your region who may access your services. Connectedly, a primary goal of this project is to recruit a sample that is highly diverse regarding sexual orientation, gender identity, ethnoracial identity, age, and HIV status. Ultimately, the research team was hoping that your agency might be able to connect researchers with diverse participants who may have important insights to share regarding their lived experiences as GBTMSM navigating the community and healthcare and social services in your region. Considering the ongoing COVID-19 pandemic, interviews will be conducted online using Zoom or Teams. These prospective interviews may take up to 120 minutes to complete. If you are interested in supporting with recruitment or would like more information, please contact Lucas, at gerg4160@mylaurier.ca.

Thank you for your time and consideration!

This study has been approved by the Research Ethics Board at Wilfrid Laurier University (REB#6955)

Appendix C: Study Advertisement



Appendix D: Consent Form

WILFRID LAURIER UNIVERSITY INFORMED CONSENT STATEMENT

Still, We Thrive: Understanding How Gay, Bisexual Transgender, and Other Men Who Have Sex with Men (GBTMSM) Experience Structural Barriers & Facilitators to Wellness

Todd Coleman, PhD (Principal Investigator), Assistant Professor, Health Sciences | tcoleman@wlu.ca
Lucas Gergyek, BA (Co-Investigator), MA Community Psychology Candidate | gerg4160@mylaurierc.ca
Robb Travers, PhD (Co-Investigator), Professor & Chair, Department of Health Sciences | rtravers@wlu.ca
Ciann L. Wilson, PhD (Co-Investigator), Associate Professor, Health Sciences | cwilson@wlu.ca

You are invited to participate in a research study. The purpose of this study is to better understand how gay, bisexual, transgender, and other men who have sex with men (GBTMSM) in non-metropolitan regions experience structural barriers and facilitators to wellness. Currently, most of the literature in this area is quantitative in nature, and comes from larger urban centres, such as Toronto. As well, some of the research exploring the sexual health and broader health of GBTMSM has overly focused on individual behaviour as predictive of poor health, leaving some questions remaining about the relevance of systems, structures, and policies for influencing the wellbeing of GBTMSM. Your potential participation will serve to supplement some of these data gaps and shed light on these unanswered questions.

Information
Participants will be asked to participate in semi-structured qualitative interviews alongside one to two of the researchers. Particular questions will seek to explore how systems and policies may influence service availability, healthcare and social service experiences, community attitudes and your sexual health and broader health. As well, additional prompts will seek to explore how you continue to maintain positive sexual, mental, and physical health, despite the potential for facing structural barriers to wellness.
Data from approximately 36 research participants from across Southwestern Ontario who fall under the label of gay, bisexual, transgender, or other men who have sex with men (GBTMSM) will be collected for this study. The study will take up to 2 hours to complete. Interviews will be hosted online via Zoom or Microsoft Teams.

Risks
As a result of your participation in this study you may experience some emotional discomfort or triggering memories when reflecting on interview questions and themes. These feelings are normal and should be temporary. However, if you experience any lasting negative feelings as a result of participating in this study, please contact the researcher, who will direct you toward

the relevant mental health resource; the research team will have a comprehensive list of resources and referrals to appropriate healthcare and social services and/or providers available. Furthermore, because of the relatively small population of GBTMSM living in the Southwestern Ontario region and the interconnectedness of GBTMSM across this region, there is the potential for the inclusion of identifiable information. However, every provision will be made to eliminate this potential risk, including the de-identification and anonymization of final transcripts. As an additional measure to mitigate this risk, investigators will prompt you to review and reflect on the details and information you provided during the course of your interview after the final question has been answered. The interviewer well then ask that you notify them of any information or details that you would like to have removed from the final transcript. You may choose to skip any question or withdraw from the study at any point without consequence.

Benefits

As a participant in this study, you will contribute to the prospective development and adaptation of services provided to yourself and other GBTMSM in your region. Connectedly, the insights you share during this study will be used to identify tangible points for systems change, where greater 2SLGBTQ+ affirming policies, systems and services can be introduced. As well, the study will offer the possibility for you to reflect on those factors that contribute to your positive wellbeing, such as your social support networks and self-care techniques. Moreover, the study will assist in the development of new knowledge regarding the barriers and facilitators to wellbeing that GBTMSM face in the community. Ultimately, your involvement in this study has the potential to facilitate a positive impact in your community and across the province.

Confidentiality

As a participant in this study, you will be required to provide your full name and an email address to forward along compensation for participation. However, this identifying information will be stored on a secure SharePoint file via Wilfrid Laurier University, accessible only to Dr. Todd Coleman and members of the research team. This identifying information will be electronically shredded after compensation has been forwarded along and data analysis has been completed

For your prospective interview, you will not be required to participate with your video on, or your name displayed. As well, the research team recognizes that because of the ongoing COVID-19 pandemic, some individuals continue to work from home, potentially creating some challenges for sharing personal and potentially sensitive details in private, away from others. Accordingly, the researchers suggest that, if possible, you settle in a private location when participating in an interview. This way, potentially sensitive information is privier to remaining confidential, between the participant and the research team.

The interview will be audio recorded and transcribed. All identifying information will be excluded from final transcripts. Moreover, as an extra measure to protect your confidentiality, after the final question has been answered, investigators will prompt you to review and reflect on the details and information you have provided during the course of the interview. If there are any potentially identifiable details that you would like removed from the final transcript, you will have the opportunity to notify the interviewer of this before the interview concludes.

The eligibility/screening survey data may be used to assign an alphanumeric code that uses five identifiers (i.e., sexual orientation/gender identity, age group, race, HIV status and general region where you reside) to contextualize specific quotes in the final report.
Any paper documents (any written notes) will be stored under lock and key in a cabinet in the researcher's office at Wilfrid Laurier University. All electronic materials will be stored on a secure SharePoint file via Wilfrid Laurier University, accessible to Dr. Todd Coleman and members of the research team. Any audio recordings will be deleted and digitally shredded once interviews have been transcribed and reviewed for accuracy. All data pertaining to this research will be destroyed by Wilfrid Laurier researchers seven years after the study has been completed (i.e., by September 1, 2028). During this time, data pertaining to this study may be analyzed as part of a separate project (i.e., secondary data analysis), but only under Dr. Todd Coleman's supervision. Only anonymized data (coded) will be available to future students conducting reanalysis of the data (secondary data analysis).

Compensation
For participating in this study, you will receive $40 CAD. If you withdraw from the study prior to its completion, you will still receive this amount.

Contact
If you have questions at any time about the study or the procedures or you experience adverse effects as a result of participating in this study you may contact the researcher(s), Todd Coleman, at Wilfrid Laurier University, (519) 884-0710, extension 2127 or via email: tcoleman@wlu.ca or Lucas Gergyek, at Wilfrid Laurier University, via email: gerg4160@mylaurier.ca

This project has been reviewed and approved by the University Research Ethics Board (REB# 6955), which receives funding from the Research Support Fund. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Jayne Kalmar, PhD, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 3131 or REBChair@wlu.ca.

Participation
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study, every attempt will be made to remove your data from the study and have it destroyed.
You have the right to refuse to answer any question you choose.

Feedback and Publication
In the form of a community report, the results from this project, containing NO identifying information, may be presented to other researchers in the field, practitioners, and policymakers to improve programs and services. The results will also be presented at

conferences, and as well, may be presented in scientific articles to be published. These findings will be available through Open Access resources.

Consent

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

I understand that by agreeing to take part in this study, I am consenting to the use of my de-identified quotations. Please note that researchers will provide you with the opportunity to vet these quotations before they are included in reports of study findings.

☐ I have read and understand the above information. I agree to participate in this study. (selecting this option will open the questionnaire)

☐ I have read and understand the above information. I do not want to participate in this study. (selecting this option will return you to your browser)

Appendix E: Demographic Questionnaire

1) What city in Southwestern Ontario do you currently live in?

_____

2) How old are you?

_____

3) Are you First Nations, Inuit, or Métis?

[ ] Yes
[ ] No

4) Do you identify as part of a racialized group? If so, please describe it below. (e.g., Black, White, Latin)

_____

5) Which of the following would best describe how you currently identify?

[ ] Gay
[ ] Bisexual
[ ] Pansexual
[ ] Queer
[ ] Two-spirit
[ ] Straight or heterosexual
[ ] Not sure or questioning
[ ] Other (please specify): _____

6) What sex were you assigned at birth, meaning the sex on your original birth certificate?

[ ] Male
[ ] Female
[ ] Intersex

7) Which <u>best</u> describes your current gender identity?

[ ] Cisgender man
[ ] Non-binary (Including transmasculine, genderqueer, genderfluid, agender, bigender)
[ ] Transgender man
[ ] Two-spirit

8) To your best knowledge, what is your HIV status?

[ ] HIV-positive
[ ] HIV-negative
[ ] I have never been tested for HIV

9) Last year, what was your total household income?
   [ ] Less than $5,000
   [ ] $5,000-$9,999
   [ ] $10,000-$19,999
   [ ] $20,000-$29,999
   [ ] $30,000-$39,999
   [ ] $40,000-$49,999
   [ ] $50,000-$59,999
   [ ] $60,000-$69,999
   [ ] $70,000-$79,999
   [ ] $80,000 or more
   [ ] I'd rather not say

10) Were you born in Canada?
[ ] Yes
[ ] No

11) If you answered "No" to the above question, where were you born?

_____

12) If you were not born in Canada; how long have you lived in Canada?

_____

13) What is the highest level of education that you have completed (in Canada or any other country)?
   [ ] Some High School
   [ ] High School Graduate
   [ ] Some College or Trade School
   [ ] College or Trade School Diploma, Certificate, or Degree
   [ ] Some University
   [ ] University Degree (Bachelors)
   [ ] Master's Degree
   [ ] Doctorate Degree

14) What is your current employment status? Check all that apply.
    [ ] Employed full-time
    [ ] Employed part-time
    [ ] Self-employed
    [ ] Student
    [ ] Retired
    [ ] Not employed and looking for employment
    [ ] Not employed and not looking for employment
    [ ] On disability
    [ ] Receiving general social assistance

15) Are you currently a parent, guardian, or other form of caretaker for at least one child in your household?
    [ ] Yes
    [ ] No

16) Please indicate below an email with which we can potentially contact you for an interview:

_____

Appendix F: GBTMSM Community Member Interview Guide

GBTMSM Community Member Interview Guide

Preamble
Hi there, my name is ____, I am _____ at Wilfrid Laurier University. Today I will be conducting this interview with you regarding your experience as a gay, bisexual, transgender, or other man who has sex with men (GBTMSM) in the Southwestern Ontario region. The goal of this interview is to better understand how GBTMSM experience structural barriers and facilitators to wellness. In this context, the term 'structure' refers to the systems, policies and institutions that may predict how we experience and navigate our communities and the services in place within them. As well, this interview is seeking to gain insight into the ways in which GBTMSM may continue to maintain positive sexual, mental and physical health, despite the presence of structural forces that sometimes make achieving positive health a challenge for GBTMSM. Currently, there is a lack of qualitative data in this area pertaining to GBTMSM situated outside of large urban centres. Thus, the following questions seek to survey for detailed insight related to your lived experience navigating society as a gay, bisexual, transgender, or other man who has sex with men in a non-urban region.
Thank you for agreeing to participate in this interview. I am going to press record…

Audio recording begins

1. In your region, where do you typically access healthcare and social services? How do you know where to go and who to access?
    a. How do you feel that these organizations and providers respond to your sexual orientation and/or gender identity? Do you feel they hold the knowledge they need to best respond to your needs and experiences?
        i. *Here, the researcher shares some details regarding their own experiences accessing heteronormative healthcare services in the region.
    b. How useful do you find the information and resources you get from these organizations and providers?
    c. IF APPLICABLE, what are your perceptions and experiences of racism in the healthcare and social services in the SW Ontario region?
2. Tell me a story that describes what it is like being a 2SLGBTQIA+ person in your community.
    a. IF APPLICABLE, do you feel that your race may interact with your sexual orientation and/or gender identity to influence your experience in your community? Please explain.
    b. How safe do you feel about being open about your sexual orientation and/or gender identity in your community? Please explain.
    c. How do you experience 2SLGBTQIA+ representation in your community?
        i. Do you feel that your presence as a 2SLGBTQIA+ person is valid and welcomed in your community?
    d. What are your experiences with facing discrimination or violence of any sort because of your sexual orientation, gender identity or race in your community?
        1. Probe for microaggressions, if applicable*

        ii. Do you find yourself feeling fearful about these events happening or reoccurring? Please explain.

3. In your area, what are your experiences of accessing relevant sexual health information and resources?
    a. When accessing HIV and other sexually transmitted and blood-borne infection testing, where do you go? How often do you test?
    b. Have you heard of, or have previously or are currently taking pre-exposure prophylaxis or PrEP? What are your perceptions?
    c. How do you feel that the resources and services in place in your community influence HIV/STBBI testing and access to PrEP?
    d. Thinking back to your experiences in primary and secondary school, what was your experience with sex-education like? Do you feel that the information you received was useful and relevant?
    e. IF APPLICABLE, in your experience as a person living with HIV, what has your experience with accessing care in the Southwestern Ontario region?
    f. IF APPLICABLE, are there any factors or circumstances that influence your adherence to your HIV treatment?
    g. IF APPLICABLE, where do you go to access information and resources related to pregnancy? Do you find these resources and information useful and relevant?
4. How would you describe your mental health? Do you identify as an individual living with mental health concerns?
    a. In what ways do you feel that your sexual orientation and/or gender identity may relate to or influence your mental health?
        i. Probe if necessary* what does the concept of internalized homonegativity/transnegativity mean to you?
    b. Do you feel that your mental health is related to your sexual health? Why or why not?
    c. Tell me about how you practice self-care and check-in with your mental health.
5. How do you feel that current sexual orientation & gender identity laws and policies reflect your experience and/or protect your wellbeing and human rights?
    a. IF APPLICABLE, how do you feel that the policies and laws in place contribute to your wellbeing as a racialized person?
    b. IF APPLICABLE, as a racialized AND/OR 2SLGBTQIA+ individual, what have been your experiences with the police in the SW Ontario region?
    c. In what ways do you feel that these laws and policies influence the attitudes of those in your community or in Canada as a whole?
6. Before COVID-19, where did you go to meet other men for friendships, dates, or hook ups?
    a. Please tell me about your experiences of sex and sexual health – do you feel empowered to have the sex you want?
    b. Tell me about your experiences in dating/hooking up/meeting other men. Do you feel that your partners hold a good amount of sexual health knowledge?
    c. When you think about 2SLGBTQIA+ spaces, what comes to mind?
        i. IF MENTIONED, how do you feel about this conflation of 2SLGBTQIA+ spaces with substance use? Would you like to see more 2SLGBTQIA+ spaces that are less intertwined with substance use?

7. Along a scale of 1-10, where 1 is low and 10 is high, how would you rate your sexual, mental, and physical health altogether? Please explain.
    a. What factors do you feel encourage or support your sexual, mental, and physical health?
    b. Can you think of any policies or services that might better support your sexual, mental, and physical health?
8. How do you experience or receive social support? Please tell me about what your social support network looks like.
    a. How do these people support your wellbeing?
    b. Do you feel a sense of belonging within the local and larger 2SLGBTQIA+ community? Please explain.
        i. How might other identity statuses you hold affect your experience within the community? Please explain.
9. What do you think could be done to foster a greater level of inclusion within the local and broader 2SLGBTQIA+ community for racialized, transgender/non-binary folks and folks living with a disability?
    a. Right now, what is the community doing right to pursue greater levels of inclusivity?
10. Do you have any questions for me before we conclude the interview?

Afterword

Over the course of this interview, you have had the opportunity to provide details regarding your experience as a GBTMSM in the Southwestern Ontario region. Your participation is invaluable, as your responses will seek to inform the conceptualization of locally relevant 2SLGBTQ+ support services that meet the needs of the diverse GBTMSM in this region. As well, your responses will seek to identify tangible points for systems change, where greater 2SLGBTQ+ supportive and affirming policies and services can be introduced. As was highlighted in this study's consent form, this project relies on a small sample size. Although every provision will be made to eliminate this potential risk, including the de-identification and anonymization of final transcript, investigators ask that you reflect on the details and comments you have provided during this interview. As the interview is now complete, are there any information or details that you would like to have removed from the final transcription?

Appendix G: Coding Guide: GBTMSM Community Member Interviews

CODE		DESCRIPTION	EXAMPLE
STRUCTURAL-LEVEL			
PRIMARY	SECONDARY		
The Influence of Laws and the Legal System on GBTMSM	Ban on Conversion Therapy	Code mentions of the recent ban on conversion therapy in Canada, and its perceived impact on the wellbeing of GBTMSM and folks under the 2SLGBTQIA+ umbrella. Be sure to capture how things may or not have shifted because of the passing of this recent law.	"I think, for instance, of the most recent one, with the banning of conversion therapy across Canada, I think that was a major step forward, I think it was long overdue. Considering people have been speaking out against that for decades. But it's good, it's so good to see, because it's basically making it so that you can't legalize a method of using like homophobia or transphobia against people, although, we still definitely have some issues."
	HIV Non-Disclosure Laws	This may include any quotations that reference the state of HIV non-disclosure laws in Canada. Be sure to include descriptions of how these non-disclosure laws influence those living with HIV. Include mentions that describe how well these non-disclosure laws are known, and how the state of knowledge around HIV non-disclosure might impact those living with HIV.	"For one, I think there is a lot of added pressure, stress, however, you may call it, for being a person living with HIV, for me specifically. Every single time I hook up, every single time I date someone, this is a big mountain that I have to climb in telling them that I am positive, undetectable. And then it goes in all kinds of directions, there are people who ghost you, people who hurl abuses at you, and you know, go in the other direction. There are people who say, I understand, but thank you, no, thank you, and then there are people who accept it. So, in all of that spectrum of things, all of the

			possibilities and all the experiences that you go through in this impact your mental health and overall wellbeing. I absolutely feel the pressure of that every day."
	Same-Sex Marriage Laws	This may include descriptions of same sex marriage laws and how both historically and concurrently these laws have contributed to the wellbeing of GBTMSM. Be sure to include mentions that capture the ways in which same sex marriage laws may serve to normalize queerness. Include descriptions that capture how this law might reflect heteronormativity.	"Well, I think that our laws absolutely set a social standard. I remember when marriage equality came into effect in Canada and also in the United States, there was a shift of social views around that. And even people that maybe wouldn't have been vocal about one side or the other prior to the legalization of same sex marriage know that there's a line that they can't cross, and now they're either going to keep their mouth shut, or they're going to act in support."
	Protections for Sexual Orientation & Gender Identity Minorities	Code descriptions of the state of protections on the grounds of sexual orientation and/or gender identity in Canada. Be sure to include mentions that capture participant's perceptions of the utility of these laws – i.e., are they effective? Include quotations that reflect perceptions and experiences with Bill C-16. Code mentions that capture how laws around name changes influence the wellbeing of GBTMSM.	"You know, it's a tough question, because we're looking at, you know, discrimination in the workplace, those laws provide recourse, but it's not going to stop it from happening, necessarily. Violence on the streets, again, you can call the cops and they'll get an assault charge, but that has nothing to do with whether or not you're queer, that's just an assault charge. Your recourse is then to seek out is this a hate crime or not? And so, I mean, it's kind of a weird situation. I don't know, if

			you're asking if it's a deterrent, and a protection for queer people. I wouldn't say it's anything more special than any other law because like I said, assholes are everywhere." "Well, I was there when Bill C-16, was debated and descended, and that's like, my life. So, you know, those awkward dinner conversations, like at Christmas, when you have political fights? My family is very conservative, but I shut them up really fast, because I was like, I support the government that counted me as a human being and then tried my rights in the Constitution. And they were like, okay, I can't debate that one. So, Bill C-16, I think is life changing. I feel a lot more confident." "The thing that's frustrating there is, I needed them to sign for my name change, and they didn't want to do that at first. That took a bit of coaxing, I guess. You know, I was 7 at the time, but I had wanted to change my name since I was 10. I told people when I was 10, I need to legally change my name. And it's annoying when your parents don't see that and then try and block you from this huge thing."

	Protections for Racialized People	Code descriptions reflecting the state of legal protections for racialized GBTMSM. Be sure to capture how these legal standings may interact with legal protections on the grounds of sexual orientation/gender identity. Include mentions that reflect how these laws may or may not influence community experiences/feelings of safety and inclusion within SW Ontario. Be sure to include mentions that connect these legal protections to interpersonal experiences of racism as well as structural/systemic experiences of racism in the work sector, by the police, etc.	"I think more than that incident itself, it's the everyday pressure of being Brown that you live with. And as I say that I'm feeling really weird about having this conversation with essentially strangers right now. But it is the reality and you asked me to speak about this so I am. It is affecting everyday conversation, like when you're with a few friends, the White dude does not feel anything about, you know, speeding, it's no problem for them. And you will you be like, oh my god, no, and they'll be like, it's okay, we're going to be fine. I can't have that same mentality. I always have to constantly watch that I'm not even 5km above the speed limit, although everyone else is honking at me and staring at me or passing me, even from the wrong side. Because I'm following this law. You know, there's this kind of dilemma around who I am and how I interact with the world. Even if I want to forget, the word is not letting me forget it."
	Laws Around Donating Blood for GBTMSM	Code mentions of the blood ban and its impact on GBTMSM in SW Ontario and Canada as a whole. This may include quotations that	"But just the fact that we can't donate blood, and they reduced it from I don't know from what years, from

		describe the MSM blood ban or describe a participant's feelings/perceptions towards the blood ban. Be sure to include mentions that capture how this blood ban reflects discrimination/structural violence.	something to something but you have to be celibate. So just that whole thing about donating blood? I mean, do they ask the same questions of heterosexual people? Like, they could be just as slutty as we are? I don't really understand. I don't buy into it. So, I feel it's completely discriminatory."
The Influence of Policies on GBTMSM	Community & Workplace Policies and Protections Around Equity & Inclusion	Code mentions that capture how workplaces and communities in SW Ontario seek to create safe and affirming atmospheres for GBTMSM. Include descriptions of what these policies look like and the ease in which they can be used to provide protections and inclusion for GBTMSM. Be sure to include quotations that describe how the absence of these policies may cause harm to GBTMSM/put GBTMSM at risk for harm.	"I'll share something at my work. They have a policy for respecting diversity and inclusion. So, they have zero tolerance for anyone who goes against it." "But at my work, there is like a form that we fill, while we are being hired, and we sign on it, it's called respect in workplace and diversity and inclusion. So, they have so many PowerPoint slides and a lot of information definitions. And whoever's hired they sign on it that they would follow this and won't go against it, because there's a zero-tolerance policy, and that helps a lot in my workplace…"
	Funding & Support for GBTMSM & 2SLGBTQIA+ Spaces and Services	Include quotations that reflect how funding/a lack of funding for GBTMSM and GBTMSM/2SLGBTIA+ services, initiatives and spaces influence the wellbeing of GBTMSM. Include mentions that describe how provincial/federal government supplements work to serve GBTMSM. Be sure to include descriptions reflecting supplements supporting GBTMSM	"It was mind boggling to me that ART, anti-retroviral therapy, is not covered in the province of Ontario. It almost petrified me, the moment I realized that I have to pay for this somehow on my own. Like, what? How? That's my entire salary, that one month's worth supply of medication, like I can't."

		living with HIV, or GBTMSM who are living with a disability.	
	Healthcare- & Social & Social Service-Related Policies	This may include quotations that capture what policies are currently in place around queer/trans healthcare for providers in Ontario. Be sure to include descriptions that reflect how these policies might contribute to how certain providers practice and/or provide care to GBTMSM. Include quotations that reflect what's missing in terms of policies around GBTMSM-related education for healthcare providers. Code mentions that describe the current/historical policies in place in the healthcare & social service sectors that influence the wellbeing of GBTMSM. Be sure to include quotations that reflect how these policies influence healthcare access and experience for GBTMSM. Include mentions that reflect how policies may have been shifted/impacted by and during COVID-19. Look for connections between education and policy. Code descriptions that reflect how policies & procedures around alerting GBTMSM about HIV/STBBIs may be faulty/create unnecessary anxiety. Be sure to capture how the 'no news is good news' policy may influence the wellbeing of GBTMSM. This may include descriptions of how living with HIV influences one's ability to immigrate to Canada. Be sure to include mentions that capture how living	"I needed a doctor who had like some type of Rainbow Health training for trans care. And that was really hard to find, no one was taking new patients." "I would note though that- I suppose this policy is kind of a general policy- but I did find that the way I was notified of my HIV status was very negative in the fact that, I'm aware that when testing for STIs, that results can be given over the phone. So, when I was called by the nurse from the health unit, in regard to my HIV status, she said, can you come in the next day? And I said, you can't tell me over the phone? And she said, no. I knew right then that it was HIV because of that. So, I think there needs to be a better system because I spent 24 hours reeling over the fact that it must be HIV and she wasn't able to give me support…" "By an immigration officer, I was deemed ineligible for permanent residency, on accounts of excessive healthcare expenditures, which was all done by the Chief Medical Officer, it worked out very well at the end. But the 11 months \ waiting on that whole process, and knowing that

		with HIV, being racialized and wanting to immigrate to Canada reflects intersectionality and structural violence.	because I'm in Ontario, my medication is, you know, more expensive here than it would be if I were in BC, and it's the same medication made by the same company, like that was mentally torture."
	Policies Around Sexual Health Education	Code mentions that describe the current/historical policies in place in the healthcare sector that influence the wellbeing of GBTMSM. Be sure to include quotations that reflect how these policies influence healthcare access and experience for GBTMSM. Include mentions that reflect how policies may have shifted/been impacted by/during COVID-19. Look for connections between education and policy.	"So, I was taught abstinence only, if you Google the program that I was taught, it says, we teach abstinence only. It's this thing called (name of abstinence-based sex-ed program), they came into our school to teach it specifically. To be fair, again, I went to school in (city in Ontario), so it was a public school. The only time I got a little bit of sex-ed was how to put a condom on a coke bottle, and gay people did not exist. I went to an art school too, where gay people certainly did exist. Yeah, the only time I actually got sex-ed was in grade 12, when I organized some trans sex-ed." "Maybe it was Catholic school, but it was pretty nonexistent. Everything I learned was like, my own outside research and like, trial and error."
CODE		DESCRIPTION	EXAMPLE
COMMUNITY-LEVEL			
PRIMARY	SECONDARY		

Healthcare, Social Services & GBTMSM in SW Ontario	Characterizing Healthcare & Social Services in SW Ontario	Code descriptions of the healthcare and social services in place within the SW Ontario region – this could include services with a mandate directed toward serving GBTMSM, or service centres more generally that GBTMSM have experience accessing. Be sure to include mentions of online healthcare/social services that may exist outside of SW Ontario but are accessed by GBTMSM living in the region. Include descriptions that capture how the ASOs across SW Ontario tend to respond to the needs of GBTMSM.	"Um, so currently, I go to (community health center in region 2), which is like a community health center that serves mainly marginalized people. And it's in an area where there's a lot of homelessness. But it also serves mostly Indigenous people, like 2SLGBTQ people, immigrants. Yeah, and then obviously, like homeless people and people who use substances. However, I would say I went a very good four or five years without seeing a doctor around here."
	Availability & Access to PrEP, HIV & STBBI Testing and HIV Treatment	Code mentions that describe how the healthcare and social services in place in SW Ontario respond to the sexual health-related needs of GBTMSM. This may include quotations that describe the availability or unavailability of knowledge about PrEP, PrEP prescriptions or support programs for linking GBTMSM to affordable PrEP. Be sure to include mentions that reflect experiences of having to educate providers on PrEP/self-advocate for accessing PrEP. As well, include quotations that reflect how healthcare and social services in the region are providing HIV/STBBI testing to GBTMSM. Be sure to include mentions that capture potential barriers to accessing these testing services – i.e., limited opening hours, travel distance. Be particularly sensitive to capturing how COVID-19 may have created particular barriers to accessing HIV/STBBI testing	"The other kind of aspect of my health care has been through public health, primarily through the testing facilities. And that has been atrocious. And I have definitely over the years, given my feedback, and my experience on that process. Now, obviously through COVID, it is even more of a shit show. So, I've actually gone on PrEP, in order to access regular testing every three months. I have a lot of feelings about that." "Certainly, public health is doing nothing now because of COVID. But even before COVID, I had been in contact with a director they have, just to explain the ways in which we are not being serviced correctly. Having a walk-in system, where

		services. Include descriptions that reference how certain services may be less equipped to provide adequate and affirming testing – consider what makes certain centres more equipped versus others.	basically in the first five minutes, the entire walk-in time is done, is completely inaccessible. And again, this is kind of all moot right now, because they're not doing any of these things. And who knows if they're going to come back? Like, my understanding through some community conversations I've had is that public health wanted to get out of the STI clinic testing. And so, when COVID happened it was like, oh, great, we don't have to do this anymore."
	Healthcare & Social Service Access and GBTMSM-Related Competencies	Include mentions that describe experiences of accessing healthcare and/or social service centres in the SW Ontario region – i.e., ease of access, referral pathways, wraparound services, etc. Here, code mentions that reflect the level of care/support provided at these healthcare and/or social service centres – i.e., familiarity with queer/trans health, comfortability with providing care to GBTMSM with other intersecting identities (LWH, racialized, kinky, etc.) Be sure to include mentions that capture experiences of discrimination at these healthcare/social services centres – i.e., overt discrimination, microaggressions, misgendering, slut shaming, etc. Capture how these experiences might influence future access/comfortability with being open with providers.	"There are actually counselors at (university in region 4) who I stopped seeing entirely because it's harder to access them in general. But I feel like, while I think counselors more than the doctors have tried to be like, okay, you know, we're going to be sensitive and inclusive, they are just so undereducated about anything LGBT. And it's almost surprising, because I come from a small town and my family doctor in the small town was more knowledgeable and sensitive than people here are and I was like, it's just surprising." "But one of the first doctors I saw after the, for lack of a better word, educated doctor left, I went in to get a strep throat test or something,

			something super unrelated to my identity, and he looked at my chart, and he was like, why are you taking testosterone, what's that about? And I was like, hormone deficiency, technically, what do you mean? He was like, I don't understand, like, I've never seen this, what is this? And it wasn't a question, it was almost like an attack. Like I had confused him on purpose. So, I tried to explain to him, this is why I'm going to take it, and he just wasn't getting it. He was like, that's weird. I was like, sweet, can I get that strep test now? But it's just stuff like that, even with some of the other doctors. And so, I luckily landed on one now that I don't mention it anymore. If they see it and they say something, I'm like, it's a hormone deficiency, and they're like, sick, and I don't talk about it."
Regional, Community & Social Support Networks and Social Groups for GBTMSM in SW Ontario	Characterizing SW Ontario and Local Communities	Include quotations that reflect participant's descriptions and/or perceptions of the community climate in their particular region within SW Ontario or SW Ontario more broadly. Be sensitive to capturing BROAD experiences within the region – i.e., general statements that broadly describe the atmosphere in the region as it pertains to the experiences of GBTMSM. Include mentions that reflect how GBTMSM and the broader 2SLGBTQIA+ community	"It's pretty difficult. I don't I don't like to complain, necessarily. But it is difficult here. Like it's a super small town, less than 2000 people in (city in region 2), and it's a pretty conservative area. And, you know, my boyfriend lives in (city in region 2). When he comes down this way, I feel less comfortable, being openly, you know, like holding hands or whatever in public. I definitely feel less

		tends to be received/reflected in particular regions and across SW Ontario.	comfortable here. And I don't - I'm definitely not as open about it in public in this area."
	GBTMSM & 2SLGBTQIA+ Safety, Inclusion & Social Groups	Code descriptions that describe the presence or absence of GBTMSM or 2SLGBTQIA+ social groups/opportunities for connection in place within particular regions and across SW Ontario more broadly. Be sure to include characterizations that capture what these social groups tend to look like – i.e., demographics, intersectionality. As well, be sure to capture how these social groups are designed to meet the needs of GBTMSM and/or the 2SLGBTQIA+ community. Be sensitive to including online social groups/forums, such as Facebook pages, Discord pages, etc. Include quotations that reflect how these social groups may or may not contribute to feelings of community and cohesion with other GBTMSM and/or the larger 2SLGBTQIA+ community.	"I tried to join the reading group at the main library. But what happened was, their focus was White gay men. And it's like, you know what? White gay men don't need that support. People of Colour do. There are a lot of writings by independent writers that are People of Colour, that needs the full focus. I mean, I think next week or sometime there is going to be a get together at a restaurant downtown, and again, it's about a White guy coming out with a book. It's like, you know, I don't want to read about him. I read the AIDS Memorial every day, about hundreds and 1000s of White men and my friends who have passed away from AIDS. So, it isn't like, I'm not aware of it. But I don't need to read more, it's nothing new. What they're saying to me is nothing new. What I need to see is People of Colour, what I need to see is Black men who are actually coming up, I want to see what they're facing, you know."
	Social Support & Social	Code quotations that reflect the interpersonal social support networks of GBTMSM in the	"I think social support comes a lot from friends. I think a lot of the time, people within

	Support Networks	region. Be sensitive to including mentions that reflect how other GBTMSM or 2SLGBTQIA+ friends might serve as referral networks/guidance on safe spaces in the region. Include quotations that reflect how this form of social support serves to support wellbeing and/or ameliorate the potential harms perpetuated by systems/structures in place within the region. Be sensitive to capturing visibility/affirmation.	the LGBT community are very aware of other people and their issues. So, they're a lot more patient, and they are a lot more empathetic and knowledgeable than other folks. So, I think a lot of it comes from other LGBT friends." "And my Mom, she and I have had a very rocky relationship. And she was like, oh, do you need Mummy to call you? And I'm like, yeah, maybe. And even just talking to her on the phone just for that few minutes helps a lot. And I think even she knew it. And I think we were both like, oh, this is not really what our relationship is like, typically, but I think she knew that I needed to talk to her at the time."
	Self-Advocacy	Include mentions that describe how GBTMSM may have to turn to self-advocacy in the absence of other forms of social support. Be sensitive to including quotations that reflect what this self-care tends to look like, and how it manifests as increased wellbeing amongst GBTMSM.	"I journal every day, which I've always done my whole life actually looking back. Like I journal, I look at an emotion wheel. And I pick words out and I journal my thoughts and gratitude stuff every day. Which really helps, I'd say that's like, the biggest thing that helps is journaling. And depends how I'm feeling, if I'm having bad PTSD symptoms, that's very physical and nervous system. So, I usually have to do more physical sensation stuff, which is working out and more sensory things. I use a

			lot of diffuser oils, and I have to be really careful about what I eat, that affects my mental health. But if it's more gender dysphoria stuff, then I read a lot of community support stuff, writing from trans guys specifically, like gay trans guys, actually. And then that makes me feel like less alone. And I like to make a lot of art. So yeah, whether it's physical or emotional, I think I take action on it. Maybe that's kind of the common theme. I try not to sit in paralysis because if I let myself do that, I'll just be there for like months."

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