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Seeking Medicines Without Surrendering Dignity: A Meta-Ethnography of Stigma, Disclosure, and Negotiated Belonging in Community Pharmacy Encounters Among Socially Marginalized Populations

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Abstract

To interpret how socially marginalized people experience stigma, disclosure, dignity, and belonging in community-pharmacy encounters and to construct a higher-order explanation through reciprocal and refutational translation. Meta-ethnography conducted using Noblit-and-Hare interpretive logic and contemporary eMERGe reporting principles. Eight PubMed-indexed discovery searches were executed on 14 September 2026 and supplemented by citation chaining and targeted verification. Searches addressed stigma and marginalization; opioid treatment; transgender and gender-diverse experience; LGBTQ+ experience; ethnic-minority medicines advice; migrant/refugee pharmaceutical care; HIV-related stigma; and homelessness/social disadvantage. Qualitative evidence was eligible when it contained service-user experience of community pharmacy among socially marginalized, stigmatized, structurally disadvantaged, or identity-vulnerable populations and contributed meanings concerning stigma, privacy, disclosure, recognition, dignity, trust, avoidance, engagement, or belonging. The searches identified 108 records. After removal of 24 duplicates, 84 unique records were screened; 47 were excluded at title/abstract screening. Thirty-seven reports were sought, two could not be retrieved, and 35 were assessed in full. Five were excluded after full-text assessment. Thirty reports representing 27 underlying studies entered the meta-ethnography. First-order participant meanings were separated from primary authors' interpretations and review-generated third-order constructs. Reciprocal translation examined concepts that travelled meaningfully across settings; refutational translation retained tensions and contradictory meanings. Across different marginalizations, pharmacy use could make socially sensitive identities, treatments, or circumstances visible. Disclosure was therefore negotiated in relation to privacy, prior treatment, trust, cultural and linguistic fit, and anticipated judgment. Dignity was strengthened by respectful recognition, non-degrading treatment, and appropriate responsiveness to difference. Avoidance, concealment, shortened interactions, and pharmacy switching could operate simultaneously as self-protection and reduced access. The synthesis conceptualized belonging as a revisable relational condition rather than an automatic consequence of pharmacy accessibility. Community-pharmacy accessibility does not by itself guarantee that marginalized people can seek medicines without social exposure or degradation. Relational accessibility depends on whether the encounter preserves control over disclosure, supports dignified recognition, and permits repeated participation without renewed defence of social legitimacy.

Keywords: Community pharmacy, Stigma, Dignity, Disclosure, Marginalized populations, Meta-ethnography

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Introduction

Meta-ethnography is designed to preserve the interpretive substance of qualitative studies while generating an explanation that extends beyond a catalogue of recurrent themes [1]. Contemporary healthcare guidance similarly emphasizes maintaining the distinction between participants' meanings, study authors' interpretations, and the synthesis developed by

reviewers [2]. That distinction is especially important when the phenomenon under review concerns experiences whose social meaning changes across populations and settings.

Community pharmacies are frequently characterized as accessible health-care settings because they are geographically dispersed, require no appointment for many interactions, and combine medicines supply with professional advice. Accessibility, however, does not determine how an encounter is socially experienced. Among people receiving opioid replacement treatment, pharmacy organization and staff behaviour have been described as capable of producing differential treatment, compromised confidentiality, stigma, and threats to dignity [3]. Pharmacy-based naloxone research likewise shows that seeking an intervention can expose a person to anticipated judgment attached to opioid use [4]. For women receiving opioid substitution treatment, privacy, stigma, trust, and the manner in which sensitive services are offered influence the acceptability of sexual-health care [5].

Other marginalized populations describe related but non-identical concerns. Ethnic-minority participants have emphasized culturally appropriate medicines advice, awareness of available support, and the quality of conversations with pharmacy staff [6]. Transgender people have described anticipatory anxiety, compromised confidentiality, challenges to gender identity, and deliberate minimization of pharmacy interactions [7]. Among 2SLGBTQIA+ pharmacy users, minority-stress processes include discrimination, microaggressions, expectation of rejection, concealment, and self-stigma [8]. Two-Spirit participants further locate unsafe pharmacy interactions within intersecting systems of racism, heteronormativity, and institutional exclusion [9].

Positive encounters are equally informative. Consumers receiving opioid agonist treatment describe trust and social inclusion when pharmacists avoid demeaning differentiation and communicate in a personable, responsive manner [10]. Transgender and gender-diverse young adults identify staff knowledge, respectful identity practices, and access to medicines and supplies as conditions shaping pharmacy experience [11]. People facing wider social disadvantage describe communication, cost, transport, housing, refugee experience, and other non-clinical circumstances as integral to medicines access [12]. HIV-related qualitative work similarly connects pharmacy engagement with stigma, privacy, relationships, and intersecting social vulnerabilities [13].

These studies suggest that stigma, disclosure, dignity, and belonging are relationally connected but cannot be collapsed into a single “barriers” theme. The review therefore asked: How do socially marginalized people experience stigma, disclosure, dignity, and belonging in community-pharmacy encounters, and what higher-order interpretation emerges when qualitative studies are translated reciprocally and refutationally?

Materials and Methods

The synthesis followed meta-ethnographic interpretive principles and was reported with reference to eMERGe guidance [1]. The analytic sequence was informed by contemporary guidance for healthcare meta-ethnography [2]: reading and familiarization; identification of first- and second-order constructs; determination of relationships among studies; reciprocal and refutational translation; and development of a line of argument.

Three construct orders were kept separate throughout. First-order constructs represented participants’ accounts and meanings. Second-order constructs represented interpretations developed by the authors of primary reports. Third-order constructs represented interpretations produced through translation across the included evidence.

Stigma, disclosure, dignity, and belonging acted as sensitizing concepts rather than fixed coding categories. An encounter was not assigned to a concept merely because a familiar word appeared in the report. Interpretation focused on what participants and authors understood an interaction, practice, or response to mean within its social and organizational context.

Eligibility

Eligible evidence contained empirical qualitative material concerning community-pharmacy encounters involving people described within the source as socially marginalized, stigmatized, structurally disadvantaged, minoritized, or vulnerable to identity-related harm. Mixed-stakeholder studies were eligible when the service-user perspective could be distinguished from pharmacists, professionals, carers, or other participants.

Eligible phenomena included discrimination; stigma; privacy and confidentiality; sensitive disclosure or concealment; recognition or misrecognition; culturally or linguistically unsafe communication; dignity and respect;

interpersonal trust; differential treatment; avoidance or minimization of contact; and experiences indicating inclusion, exclusion, or belonging.

Qualitative interviews, focus groups, narrative inquiry, phenomenological work, ethnographic or observational qualitative studies, co-design studies, and mixed-methods studies with separable qualitative evidence were eligible. Provider-only studies could inform contextual discussion but did not qualify as first-order evidence. Purely quantitative surveys, service evaluations without usable qualitative participant material, commentaries, and reviews were excluded from the primary evidence set.

Journal quartile and the manuscript's 2017–2026 final-reference rule were not used to decide review eligibility. Consequently, potentially relevant evidence predating the bibliography window was screened on scientific relevance rather than removed because of publication date.

Search and selection

Eight PubMed-domain searches were executed on 14 September 2026 using the following search expressions:

1. "community pharmacy" stigma qualitative marginalized patients
2. "community pharmacy" opioid qualitative stigma confidentiality dignity
3. "community pharmacy" transgender qualitative pharmacy experiences
4. "community pharmacy" LGBTQ qualitative discrimination privacy
5. "community pharmacy" ethnic minority qualitative medication advice
6. "community pharmacy" migrant refugee qualitative pharmaceutical care
7. "community pharmacy" HIV qualitative stigma social disadvantage
8. "community pharmacy" homelessness qualitative medication stigma

Each executed search returned 12 PubMed-indexed records, yielding 96 records before deduplication. Citation chaining, examination of reference lists in directly relevant reports, and targeted verification added 12 further candidate reports, giving 108 records identified.

Deduplication used PMID where available, supplemented by DOI, title, authorship, and publication-version checking. Twenty-three repeated PubMed records occurred across the eight search sets. One additional duplicate represented a preprint subsequently replaced by its peer-reviewed journal publication. A total of 24 duplicates were therefore removed, leaving 84 unique records for title/abstract screening.

At title/abstract screening, 47 records were excluded, predominantly because they were provider-only studies, quantitative surveys, general-population pharmacy studies without a marginalized-population focus, studies in which community pharmacy was not the relevant encounter setting, or papers without usable experiential qualitative material. Thirty-seven reports were sought for full-text assessment.

Two reports could not be retrieved in a form sufficient for full-text assessment, leaving 35 reports assessed for eligibility. Five were excluded at full text: one because first-order participant data could not be recovered from secondary clinical notes; one because community-pharmacy experience could not be separated from broader primary-care medicines use; one because the evidence consisted of provider observation without service-user constructs; one because it was a secondary report of an already represented underlying study without additional construct material; and one because it examined anticipated implementation rather than lived community-pharmacy encounters.

The resulting synthesis contained 30 reports representing 27 underlying studies. Multiple reports from the same participant dataset were retained only when they contributed distinct construct material and were linked at the study level during translation.

Quality appraisal

Appraisal considered methodological coherence, appropriateness of sampling, adequacy of data collection, analytic transparency, reflexivity, contextual description, evidentiary grounding of interpretations, and the extent to which participant voice could be distinguished from author interpretation. Methodological limitations were judged using principles compatible with GRADE-CERQual [14].

Relevance was assessed separately from methodological quality [15]. A narrowly situated study could contribute strongly to a particular translation while remaining limited in transfer beyond its social and service context. Adequacy likewise depended on the richness and quantity of data supporting each synthesis finding rather than sample size alone [16].

Appraisal informed interpretive weight but did not function as a mechanical exclusion threshold. No report was excluded solely because it contained methodological limitations. Particular caution was applied where reports provided thin contextual description, mixed stakeholder voices without consistently clear provenance, or interpretations that extended further than the participant material presented.

Reading and familiarization

The 30 included reports were read iteratively with attention to participant terminology, primary-author concepts, pharmacy context, social position, service organization, and the immediate circumstances surrounding disclosure or interaction. Familiarization notes separated what participants described from what primary authors inferred.

Apparently mundane service features were treated as potentially meaningful only where supported by participant or author interpretation. These included waiting arrangements, consultation-space use, medication-collection routines, staff familiarity, names and pronouns, language, visibility to other customers, dispensing rules, costs, and the duration or location of conversations.

Translation also required restraint. Privacy during opioid treatment, for example, could concern involuntary identification with a stigmatized treatment, whereas privacy for a transgender participant could concern disclosure of identity or medication history. The experiences could be related conceptually without being treated as socially equivalent.

First-order constructs

Across the evidence, first-order meanings repeatedly concerned how people interpreted their social position during pharmacy use. Differential waiting or dispensing processes could communicate that a person was being marked as unlike other customers. Questions about identity, treatment, or personal circumstances could be experienced as clinically appropriate in one context and exposing or suspicious in another.

Participants also described active management of interaction. Some restricted what they said, shortened conversations, avoided asking questions, changed pharmacies, delayed care, or minimized contact when they anticipated judgment or unwanted disclosure. These actions were not uniformly presented as disengagement. They frequently carried a protective meaning: reducing exposure to an encounter perceived as socially unsafe.

Positive first-order meanings commonly involved respectful recognition. Participants valued being spoken to without condescension, having confidential information protected, being addressed in identity-appropriate ways, receiving explanations suited to language and circumstances, and being treated as an ordinary person entitled to pharmaceutical care.

Table 2 presents the provenance of the principal first-order meanings carried into translation.

Table 2. First-order construct provenance in marginalized community-pharmacy encounters

First-order meaning	Encounter context	Immediate meaning retained for translation	Provenance boundary
Being treated differently from other customers	Stigmatized treatment or identity	Pharmacy procedures can communicate inferior social status	Does not establish prevalence
Watching what can safely be said	Sensitive treatment, identity or health need	Disclosure depends on anticipated response	Disclosure is not assumed desirable
Wanting conversations protected from others	Public counters, waiting areas, familiar local settings	Privacy includes social control over information	A consultation room alone does not establish privacy
Keeping pharmacy interactions brief	Anticipated judgment or repeated discomfort	Minimal interaction may function as self-protection	Cannot automatically be labelled disengagement
Wanting to be treated "normally"	Differential or stigmatizing service	Non-degrading treatment can preserve dignity	"Equal" and "identical" treatment remain distinct

Valuing staff who communicate respectfully	Repeated community-pharmacy contact	Interpersonal recognition can reduce uncertainty	Relationship effects remain context dependent
Needing language or culturally intelligible communication	Migrant, refugee and ethnic-minority contexts	Recognition includes communicative usability	Cultural groups are not treated as homogeneous
Avoiding an unsafe pharmacy encounter	Discrimination, embarrassment or exposure	Withdrawal can protect dignity while reducing access	Avoidance is not interpreted as a single-outcome behaviour

Second-order constructs

Primary authors interpreted these participant meanings through concepts including stigma, minority stress, privacy and confidentiality, person-centredness, cultural competence, trust, social inclusion, structural disadvantage, recognition, and health-service accessibility.

The studies differed in explanatory scale. Some located harmful experience primarily within interpersonal communication. Others treated the pharmacy encounter as a site through which wider racism, heteronormativity, poverty, drug-use stigma, institutional mistrust, migration-related disadvantage, or service rules became tangible.

This variation prevented the synthesis from attributing socially difficult encounters to staff attitude alone. Interpersonal respect could buffer some harms, yet organizational procedures and structural conditions shaped what any individual pharmacist could accomplish.

Determining relationships between studies

Study relationships were determined before higher-order synthesis. Reciprocal relationships were assigned where concepts could illuminate one another without erasing their original context. Refutational relationships were assigned where evidence challenged, reversed, or complicated another interpretation. A third category, context-bound relationship, was used where apparent similarity would become misleading if translated too directly.

The comparison proceeded through meaning rather than frequency. Concepts were examined for what they explained and under what conditions they appeared. The same label could therefore translate differently across reports, while different labels could sometimes express a comparable relational process.

Reciprocal translation

The strongest reciprocal translation concerned social exposure. Opioid-treatment visibility, gender-related identity challenge, HIV-related disclosure, culturally unsafe communication, and public discussion of sensitive health needs all showed ways in which pharmacy use could reveal socially consequential information.

A second reciprocal translation concerned conditional disclosure. Across populations, participants assessed whether the encounter provided enough interpersonal and environmental safety to disclose information relevant to care. Privacy, respectful language, trust, cultural fit, and prior experience altered that assessment.

A third translation connected dignity with recognition. Participants valued freedom from degrading differentiation while also valuing responsiveness to meaningful difference. Dignity could therefore be supported by ordinary treatment in one context and by culturally, linguistically, or identity-responsive care in another.

Table 3. Reciprocal translation across included qualitative studies

Translation set	Second-order concepts translated together	Reciprocal interpretation	Context preserved
Social exposure	stigma, minority stress, compromised confidentiality, conspicuous treatment	Pharmacy interaction can make sensitive social information visible	The information at risk differs by population
Conditional disclosure	privacy, concealment, trust, sensitive communication	Disclosure is negotiated according to perceived relational safety	Relevant information may concern treatment, identity, symptoms or hardship

Dignified recognition	respect, non-differential treatment, inclusive communication, cultural responsiveness	Dignity depends on recognition without degradation	Responsiveness does not require treating every difference identically
Relational safety	rapport, continuity, confidentiality, communicative fit	Predictable respectful interaction can lower uncertainty	Familiarity can also threaten privacy
Protective withdrawal	avoidance, minimal contact, pharmacy switching	Reduced engagement may protect against anticipated harm	Consequences depend on available alternatives
Negotiated belonging	inclusion, ordinary customer status, safe interaction, trust	Belonging emerges when repeated pharmacy use no longer continually threatens legitimacy	Belonging remains revisable

Refutational translation

Several findings resisted straightforward reciprocal integration. Accessibility could reduce practical barriers while increasing visibility. Familiarity could generate trust while intensifying concern that sensitive information would be recognized outside the immediate consultation. Treating everyone identically could reduce stigmatizing differentiation but could also ignore language, cultural context, gender identity, or material disadvantage.

Privacy produced another refutation. Physical consultation infrastructure could support confidentiality, yet participants described privacy as dependent on workflow, staff conduct, waiting-space visibility, and the meaning of being seen entering a consultation area. The presence of a private room could therefore coexist with experienced exposure.

Engagement itself was also ambiguous. Continued interaction could permit better advice and treatment, while avoiding or abbreviating an unsafe encounter could represent a reasoned attempt to protect dignity.

Table 4. Refutational tensions retained in the meta-ethnography

Tension	First interpretation	Refutational interpretation	Synthesis consequence
Accessibility ↔ visibility	Community pharmacies are easy to reach	Visibility can expose a stigmatized need or identity	Practical and relational accessibility are distinct
Familiarity ↔ confidentiality	Repeated contact builds trust	Being known can increase disclosure anxiety	Continuity is beneficial only when recognition feels safe
Equality ↔ responsiveness	Non-differential treatment protects dignity	Uniform treatment can ignore relevant difference	Dignity requires non-degradation plus appropriate responsiveness
Private space ↔ experienced privacy	Consultation rooms support confidentiality	Workflow and social visibility can still expose patients	Privacy is interactional as well as architectural
Engagement ↔ self-protection	Continued contact supports care	Withdrawal can protect against humiliation or judgment	Avoidance has both access and dignity meanings

Line-of-argument synthesis

The translations support a higher-order proposition: socially marginalized people encounter community pharmacy as a negotiated social space in which obtaining medicines can require decisions about visibility, disclosure, recognition, and protection of dignity.

Stigma operates through more than explicit prejudice. It can be communicated through service arrangements, questioning practices, differentiation, institutional rules, or accumulated expectations derived from previous encounters. Disclosure therefore depends partly on anticipated recognition. People decide what can be revealed after assessing the social meaning of the environment and interaction.

Dignity concerns the person's standing within that negotiation. It is threatened when medicine access requires accepting humiliation, misrecognition, avoidable exposure, or inferior treatment. It is supported when the encounter permits relevant difference to be recognized without making that difference grounds for degradation.

Belonging represents the more durable relational possibility: repeated community-pharmacy use becomes possible without continual renegotiation of whether the person is legitimate, credible, or entitled to care. Evidence concerning migrants and refugees reinforces the importance of preserving the interaction between communicative, cultural, structural, and service-level conditions when interpreting pharmacy access [17].

Reflexivity

The synthesis required vigilance against turning "dignity" and "belonging" into reviewer-imposed virtues detached from the underlying evidence. These concepts were retained only where they could be traced to participant meanings concerning respect, recognition, ordinary status, safety, trust, inclusion, or withdrawal.

Translation across marginalizations posed a second reflexive risk. Drug-use stigma, racism, colonialism, transphobia, heteronormativity, HIV stigma, mental-health stigma, migration-related exclusion, homelessness, and poverty are not interchangeable experiences. Translation therefore occurred at the level of relational meaning while preserving the social mechanism and population context from which each construct arose.

Finally, contradictory evidence was treated as analytically productive. Positive pharmacy relationships did not invalidate accounts of discrimination, and harmful experiences were not used to characterize community pharmacy as intrinsically stigmatizing. The review instead sought to explain how the same nominally accessible setting could become either a place of ordinary participation or an encounter carrying an additional social cost.

Results and Discussion

The executed searches identified 108 records. Deduplication removed 24 records, comprising repeated database hits and one preprint/final-publication duplicate, leaving 84 unique records for title/abstract screening. Of these, 47 records were excluded, leaving 37 reports sought for retrieval. Two reports could not be retrieved in sufficient form for eligibility assessment. Thirty-five full-text reports were assessed, and five were excluded: one lacked recoverable service-user first-order constructs; one did not permit community-pharmacy experience to be separated from broader health-care use; one contained provider-only evidence; one was a secondary report of an already represented study without additional construct material; and one concerned anticipated implementation rather than lived pharmacy encounters. The final synthesis therefore comprised 30 reports representing 27 underlying studies.

The included corpus was deliberately broader than any single marginalized population. Qualitative evidence concerned opioid substitution or agonist treatment, naloxone and opioid-risk services, transgender and gender-diverse people, 2SLGBTQIA+ and Two-Spirit communities, ethnic-minority and culturally and linguistically diverse populations, migrants and refugees, people living with HIV, mental-health-related care, homelessness, and wider social disadvantage. A recent meta-ethnography of culturally centred pharmacy services reinforced the importance of relationships, cultural beliefs, communication and navigation of pharmacy systems when interpreting minoritized patients' experiences [18]. First Peoples pharmacy-equity research similarly situates pharmacy encounters within broader cultural and structural conditions rather than treating inequity as an isolated communication problem [19].

The complete selection process is shown in **Figure 1**.

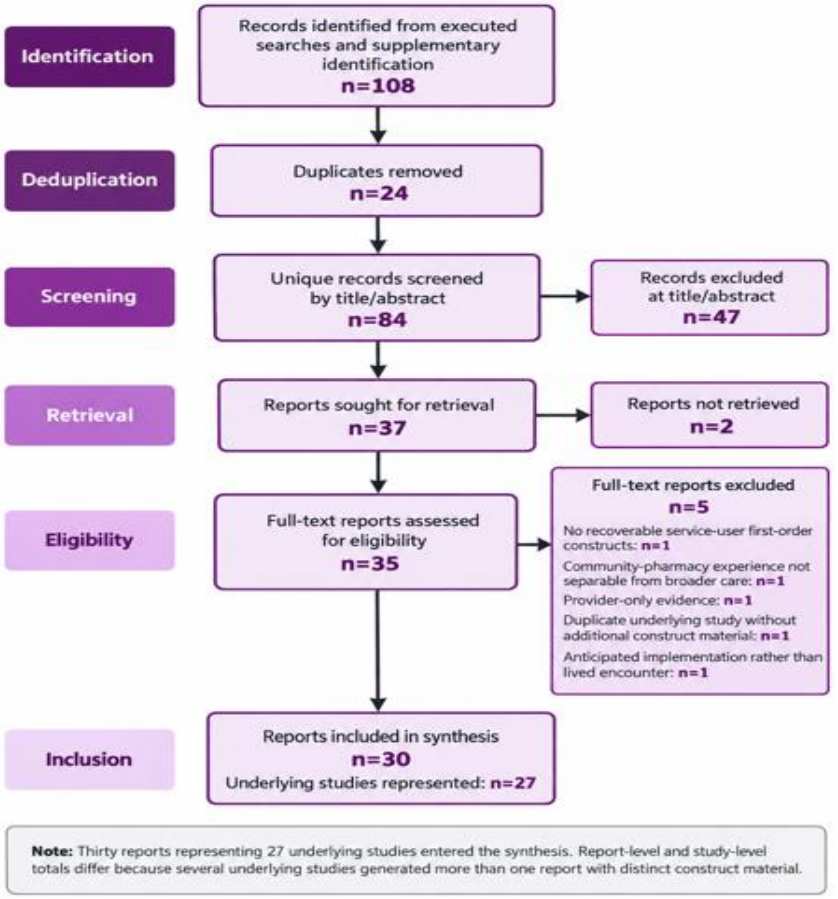

Figure 1. Selection of qualitative evidence for the meta-ethnography

Study characteristics

The included evidence varied in country, population, pharmacy service, qualitative tradition and the type of socially consequential information at stake. That heterogeneity was analytically useful because superficially similar behaviours—silence, shortened interactions, concealment, pharmacy switching or avoidance—could be compared without assuming identical social causes.

Positive gender-affirming pharmacy experiences demonstrated that community pharmacy can also operate as an explicitly supportive setting when identity-appropriate communication and clinical competence are incorporated into service design [20]. Pharmacists' accounts nevertheless identify uncertainty about transgender care, terminology, training and the practical delivery of affirming pharmaceutical care [21]. Culturally and linguistically diverse clients similarly describe how language, cultural understanding and communication shape whether pharmacy care is usable [22]. Ethnic-minority participants seeking medication reviews report limited awareness, communication barriers and difficulty accessing meaningful medicines discussions [23], while health professionals identify overlapping service- and system-level obstacles [24].

Table 1 summarizes the contextual architecture of the included qualitative evidence without ranking studies by sample size.

Table 1. Contextual architecture of the qualitative evidence contributing to the meta-ethnography

Marginalized context	Pharmacy encounter examined	Social information or circumstance at stake	Dominant interpretive contribution
Opioid substitution/agonist treatment	Repeated dispensing, supervision and medicines support	Drug-use history and treatment status	Differential treatment, visibility, stigma, trust, dignity

Naloxone/opioid-risk care	Requesting or discussing overdose-risk services	Opioid use or perceived opioid risk	Anticipated judgment, disclosure risk
Women receiving opioid substitution treatment	Sexual-health advice and services	Treatment status plus sexual-health need	Privacy, shame, rapport, intersectional stigma
Transgender and gender-diverse people	Routine medicines and gender-related pharmaceutical care	Gender identity, records, medicines	Identity challenge, concealment, affirming recognition
2SLGBTQIA+ and Two-Spirit communities	Everyday pharmacy use	Sexual orientation, gender identity and Indigenous identity	Minority stress, racism, heteronormativity, relational safety
Ethnic-minority populations	Medicines advice and review services	Language, culture, religion and social position	Communicative fit, trust, recognition
Migrants and refugees	Pharmaceutical-care access and navigation	Language, migration history, system unfamiliarity	Navigation burden, cultural responsiveness
People living with HIV	Pharmacy/HIV-care interaction	HIV status plus intersecting disadvantage	Stigma, disclosure, linkage and retention
Mental-health populations	Screening and community-pharmacy mental-health support	Mental-health symptoms or diagnosis	Confidentiality, stigma, acceptability
Homelessness/material disadvantage	Medicines access and medication use	Housing insecurity, poverty and competing needs	Structural constraint, stigma, practical dignity

Interpretive constructs concerning stigma

Stigma was not confined to explicit derogatory behaviour. Across studies it was also conveyed through organizational procedures, questioning practices, assumptions about credibility, constrained privacy and forms of differentiation that marked a person as socially exceptional.

This interpretation has implications for service design. Reviews of pharmacist-led services for minoritized populations show that tailoring is uneven and that marginalized communities are not consistently involved in designing services intended for them [25]. Transgender-health pharmacy literature similarly indicates that competent care depends on more than respectful intentions; pharmacists require clinical knowledge, appropriate language, privacy-sensitive practice and awareness of the wider barriers facing transgender patients [26]. Contemporary pharmacotherapy guidance reinforces the need to integrate affirming communication with technically competent medication care [27].

The synthesis therefore located stigma simultaneously in interpersonal encounters and in the organization of pharmaceutical care.

Disclosure

Disclosure was interpreted as negotiated rather than automatic. Patients could benefit from sharing clinically relevant information while also anticipating that the same information might expose them to judgment, misrecognition or unwanted visibility.

Language and migration status further complicated this negotiation. Migrant-background pharmacists can help bridge cultural and linguistic gaps, yet their capacity to do so remains shaped by organizational and health-system conditions [28]. Disclosure therefore depends not only on the patient's willingness to speak but on whether communication is linguistically possible, culturally interpretable and socially safe.

Mental-health evidence supports this relational interpretation. Qualitative studies of community-pharmacy mental-health services show that acceptability is linked to privacy, staff relationships and the perceived role of the pharmacist [29]. Depression-screening research likewise identifies confidentiality and stigma as relevant to how patients experience screening in pharmacy settings [30]. Informal carers using community pharmacies for mental-health support further demonstrate that sensitive information may enter the pharmacy through relationships that do not fit a simple patient-professional dyad [31].

Dignity

Dignity involved being able to receive care without being reduced to a stigmatized treatment, identity or social circumstance. Respectful communication, control over personal information and freedom from avoidable differential treatment repeatedly contributed to this experience.

The evidence also rejected a simple equivalence between dignity and identical treatment. For some patients, visibly different procedures were themselves stigmatizing. For others, language support, culturally responsive communication, identity recognition or adaptation to material circumstances was necessary for equitable participation. Dignity therefore combined non-degradation with appropriate recognition of relevant difference.

Negotiated belonging

Belonging described whether repeated pharmacy use could occur without renewed uncertainty about one's legitimacy. Trustworthy continuity, privacy and respectful recognition could progressively reduce that uncertainty, whereas one exposing or degrading encounter could destabilize an otherwise workable relationship.

Opioid-risk screening provides an instructive example. Patients and pharmacists interpret opioid-related conversations through pre-existing assumptions about stigma, legitimacy and the pharmacy's role [32]. Among people experiencing homelessness, service design must contend with stigma, mobility, competing material demands and prior health-care experiences [33]. Photo-elicitation research further shows how medication use is embedded within the everyday realities of homelessness rather than separable from them [34].

Belonging was therefore neither permanent nor binary. It was a revisable relational condition.

Third-order constructs

Four third-order constructs organized the final synthesis. Exposure without consent describes situations in which pharmacy procedures, conversation, records or visibility make a stigmatized treatment, identity or circumstance more public than the person intended.

Conditional disclosure describes the assessment of whether sufficient relational safety exists to reveal information relevant to care.

Dignified recognition describes acknowledgment of the person as legitimately entitled to pharmaceutical care while responding appropriately to relevant linguistic, cultural, identity-related or material difference.

Negotiated belonging describes the evolving possibility of returning to the pharmacy without repeatedly defending credibility, identity or entitlement to care.

These constructs are interpretive explanations, not estimates of frequency.

Line-of-argument model

The line of argument proposes that community-pharmacy accessibility and community-pharmacy belonging are distinct. A service can be geographically accessible while remaining socially difficult to inhabit.

The process begins when a person enters the pharmacy carrying information that may become socially consequential: treatment status, gender identity, sexual orientation, racialized or Indigenous identity, migration history, HIV status, mental-health need, homelessness or material disadvantage. Pharmacy organization and interpersonal interaction influence whether this information remains under the person's control or becomes involuntarily exposed.

Disclosure is then negotiated. Recognition that is private, respectful, culturally intelligible and trustworthy can support greater communication and preserve dignity. Unsafe recognition can instead produce concealment, minimal interaction or withdrawal. Directly observed hepatitis-C treatment within opioid-substitution pharmacy care illustrates how the meaning of an added service depends strongly on the pre-existing pharmacy relationship [35]. HIV-care research similarly connects engagement with stigma and broader social barriers [36]. Broader pharmacy-access scholarship reinforces the distinction between simple service proximity and the multidimensional conditions that determine whether pharmaceutical care is genuinely accessible [37].

Figure 2 presents this third-order relational field.

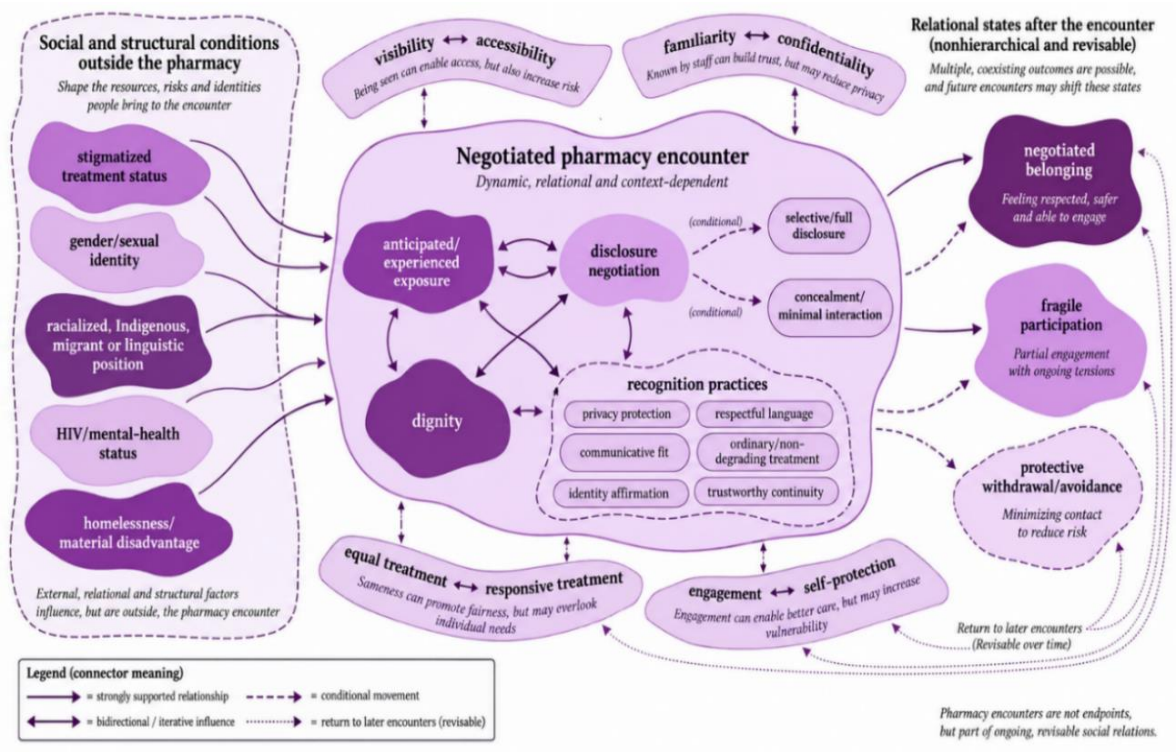

Figure 2. Negotiated belonging in community pharmacy: a meta-ethnographic relational field of exposure, disclosure, recognition, dignity and engagement

This meta-ethnography reframes inequitable community-pharmacy experience as a problem of relational accessibility. Community pharmacies may be practically easy to reach while remaining socially difficult to use. The distinction helps explain why marginalized people can continue attending a pharmacy while limiting disclosure, shortening interactions or anticipating harm.

The first contribution is the interpretation of stigma as partly organizational. Procedures that separate patients, expose treatments, constrain privacy or repeatedly require identity explanation can reproduce stigma without explicit hostile intent.

The second contribution concerns disclosure. High-quality pharmaceutical care often depends on information exchange, but the synthesis indicates that trust may be a precondition for obtaining the information needed to individualize care. Disclosure therefore cannot be treated purely as a patient responsibility.

The third contribution is the distinction between equal treatment and dignified recognition. Culturally responsive and identity-aware care can be necessary precisely because rigid sameness may reproduce inequity. Interpretive social-pharmacy scholarship supports examining medicines use within its social, temporal and moral contexts rather than treating behaviour as an isolated individual decision [38].

The fourth contribution concerns avoidance. Minimizing or leaving an encounter can reduce access to professional care, yet it may also represent an understandable attempt to avoid humiliation or unwanted exposure. Inclusive-care research among pharmacy professionals underscores the importance of preparation for LGBTQIA+ populations [39], while wider qualitative synthesis of transgender and gender-diverse young people's health-care experiences demonstrates that discrimination, provider knowledge and perceived safety influence engagement beyond pharmacy alone [40].

Reflexivity and limitations

The principal strength of the review is the preservation of construct provenance across heterogeneous marginalized populations. The executed search produced a reconciled selection flow of 108 identified records, 84 unique records screened, 35 full texts assessed and 30 included reports representing 27 studies.

Several limitations remain. The searches were executed through PubMed-indexed discovery routes and supplementary chaining rather than through a fully

independent export from every potentially relevant multidisciplinary database. Relevant qualitative research not indexed through those routes may therefore have been missed.

Evidence was unevenly distributed. Opioid-treatment and sexual/gender-minority studies contributed particularly rich direct accounts, while some marginalized populations were represented by fewer studies or by broader medicines-access work.

Translation across different forms of marginalization also requires caution. Racism, colonialism, transphobia, heteronormativity, drug-use stigma, HIV stigma, mental-health stigma, migration-related exclusion and poverty were not treated as equivalent mechanisms. Third-order translation was restricted to relational meanings that could be carried across studies without erasing their origins.

Finally, negotiated belonging is a synthesis construct rather than a validated measurement scale. It should be tested and refined through future participatory qualitative and mixed-methods research.

Practice/policy implications

Community-pharmacy equity strategies should assess the complete social pathway of care rather than physical availability alone. Privacy audits should examine waiting arrangements, conversations at the counter, consultation-space entry, records, dispensing procedures and repeated attendance.

Professional development should combine technical competence with relational and structural competence. Inclusive language, identity-appropriate records, interpreter support, culturally intelligible communication and stigma-sensitive opioid services are not peripheral additions when they determine whether patients can disclose information safely.

Service design should involve the populations expected to use it. Co-design is particularly important where routine pharmacy practices may inadvertently expose stigmatized treatments or identities.

Evaluation should also move beyond utilization. Relevant outcomes include perceived exposure, control over disclosure, dignity, trust, anticipation of future judgment, relational continuity and whether patients can obtain medicines without avoidable humiliation.

Conclusion

Socially marginalized people may encounter community pharmacy as both an accessible health-care resource and a socially risky environment. Across the qualitative evidence, stigma became consequential when treatments, identities or circumstances were made visible in ways that patients could not fully control. Disclosure was therefore negotiated through privacy, trust and anticipated recognition.

Dignity was supported when people could receive care without degradation while having relevant differences acknowledged appropriately. Belonging emerged when repeated pharmacy use no longer required continual defence of identity, credibility or entitlement to care.

Community-pharmacy equity consequently depends on more than proximity, opening hours or service availability. It depends on whether medicines can be sought without surrendering control over disclosure, social standing or dignity.

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