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INYUVESI YAKWAZULU-NATALI

An exploratory assessment of health services in meeting the sexual-health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people in Durban: a case study of students in the University of KwaZulu-Natal.

Masters Dissertation by

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DECLARATION

I, Sthembiso Pollen Mkhize declare that:

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2. This dissertation has not been submitted for any degree or examination at any other higher education institution.
3. This dissertation does not contain other person's data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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ABSTRACT

Access to health services is regarded as an essential component of good health and personal development. However, several studies suggest that the lesbian, gay, bisexual and transgender people (LGBT) are often marginalised, discriminated and socially excluded by the health care system. Studies suggest that despite guaranteed constitutional freedoms for same-sex activities, societies continually hold prejudice beliefs towards LGBT. Negative attitudes towards the LGBT in health services have indicated that, despite the progressiveness of the legislation; cultural and religious prejudice remain strong. Research evidence demonstrates that there are factors that influences the utilization of health services among the LGBT. These factors may be promoting and inhibiting to their decisions for utilizing available sexual health services. The aim of this study was to provide insights into the utilization of sexual health services among LGBT students in Durban. The qualitative data used in this study was collected from twelve LGBT individuals at the University of KwaZulu-Natal. The findings of this study showed that the inhibiting factors to use health services outweighs the promoting factors to use health services among LGBT. In the interviews, participants emphasized that the South African health system has failed the LGBT community by marginalizing them through providing heterosexual accommodating public health services. Participants noted that the clinics provided within and outside the university lack sexual health resources and preventative measure required by the LGBT. However, it was clear that private foreign health organizations focusing on reducing health disparities for the LGBT has played a pivotal role in delivery of appropriate health care that is competent and accessible for the LGBT as they have promoted justice and destabilised heterosexuality in health care. Participants also perceived health providers callous and judgemental, and they highlighted that they are not only mean towards the LGBT, but also to the heterosexual patients. This study recommends normalising of homosexuality in public health services through publicizing posters and brochures that addresses the sexual health concerns of the LGBT, unrestricted access and displaying of lubricants, dental dams and finger cots, and also establishing an advanced LGBT health training programme in medical schools and health institutions to expose medical students and health providers to the sexual health needs of the LGBT. Everyone deserves access to good quality health care regardless of their sexual orientation or gender identity.

Key words: LGBT, sexual health, access, utilize, health services

DEDICATION

Dedicated to my mother (*Miss. Happy Mkhize*) and my late grandmother (*Mrs. Thokozile Cecilia Mkhize).*
I Love You.

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Mbonge uJehova, mphefumulo wami; konke okuphakathi kwami makubonge igama lakhe elingcwele. (Amahubo 103:1)

To God; my saviour and protector, thank you for this wonderful opportunity of life and for blessing me with the good things I have in my life. Having faith and hope in everything I do has allowed me to be where I am today. Thank you Lord.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AHUM	Andersen Healthcare Utilization Model
CHASU	Campus HIV and AIDS Support Unit
DoH	Department of Health
GP	General Practitioners
HPCSA	Health Professions Council of South Africa
FDG	Focus Group Discussions
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HSSREC	Humanities and Social Sciences Research Ethics Committee
KZN	KwaZulu-Natal
LGBT	Lesbian, Gay, Bisexual and Transgender
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LMIC	Low- and middle-income countries
MSM	Men who have sex with men
NDP	Nurse Professional Development
NRMSM	Nelson Rolihlahla Mandela School of Medicine
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
SADC	Southern African Development Community
SANAC	South African National AIDS Council
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
Stats SA	Statistics South Africa
UK	United Kingdom
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
U.S.	United States of America
WHO	World Health Organization
WSW	Women who have sex with women

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CHAPTER ONE: INTRODUCTION

1.1. Introduction and Background

South Africa enshrines laws that favours every citizen's sexual orientation and gender identity. Post-Apartheid South Africa brought constitutional reform and facilitated the protection of rights for many people, enabling the non-heteronormative individuals to develop and display their identities (Roberts and Reddy, 2008). The South African constitution has been acknowledged globally as one of the most advanced and inclusive documents in the world, which demonstrates a remarkable commitment towards preserving diversity and inclusion of all people, regardless of their social differences (Jagessar and Msibi, 2015).

Same-sex engagements have had a long history in South Africa. It has been clear that the demise of Apartheid and liberalization of laws pertaining to gender and sexuality coincided with an increased visibility of Lesbian, Gay, Bisexual and Transgender (LGBT) people who came in larger public proportions (Reid, 2013). LGBT is an abbreviation referring to lesbian, gay, bisexual and transgender people who are not identified as heterosexual or heteronormative. 'LGB' refers to a sexual orientation which explains each person's profound emotional and sexual attraction, and intimate and sexual relations, in relation to the gender of the person's partner (South African National AIDS Council, 2016). 'T' refers to a gender identity which indicates a person's deeply felt experience of gender which may not correspond with the sexual identity assigned at birth. LGBT individuals are generally grouped together because they are sexual minorities who confront common issues such as rejection, stigma and discrimination. According to Muller (2014, p. 2), "what unites them as sexual and gender minorities are common experiences of stigma and discrimination, and, specifically with respect to health care, a long history of discrimination and lack of awareness of health needs by health professionals."

Being tied together as one abbreviation often suggests experiences of being socially excluded and marginalised. However, each letter represents a wide range of people of different racial and age groups, class and socio-economic status. The respective issues, experiences, and needs of the LGBT people differ significantly and in several perspectives. For instance, regarding sexual health, lesbians require a dental dam or finger cot when engaging in a vaginal intercourse, while gays, bisexual and transgender people may require condoms and lubricants when engaging in anal intercourse because the anus is not self-lubricating like the vagina and

is not wet unless one helps it to soften. Hence, lubricants help to prevent the anus to not easily break during sexual penetration. Breaking of the anal wall during sexual intercourse in GBT relationships may expose the 'top' to contract a sexually transmitted infection (STI) if the 'bottom' has one or either way. Receptive or rather bottom individuals are those who perform sexual duties equivalent to those of females during sexual intercourse, while insertive individuals are those who perform duties of a male during sexual intercourse and are referred as top.

Constitutional freedom for the LGBT has not guaranteed attitudinal shifts and changes in the heteronormative attitudes in society towards the LGBT. Policy changes and active engagement of the LGBT civil society in public discussion, has reinforced the debates towards and around same-sex relations and homosexuality in Africa. Negative attitudes towards the LGBT has confirmed that, despite policy shifts and successful legislative reforms of the constitution, socio-cultural prejudice remains strong and rife in most accepting countries (Roberts and Reddy, 2008). According to Roberts and Reddy (2008, p.9), "yet, for all these gains, gay and lesbian identities continue to be regarded as 'un-African'". Un-Africanism of the LGBT demonstrates the moral and cultural view of African societies in assuming that homosexuality and any same-sex relation is perceived as a Western imported social identity. In addition, incidences of hate crimes and homophobia against the LGBT has shown that the progressiveness of the constitutional reform has not guaranteed the end of social discrimination and prejudice towards the LGBT people (Roberts and Reddy, 2008). Studies has shown that social conditions have a direct impact on the health of LGBT in a variety of ways. These areas range from direct impact of prejudice such as exposure to violence, psychological stress and poor access to care, to failure to adequately provide and address their special needs required for their living such as prevention measures for their sexual and reproductive health (SRH) (Dean et al., 2000).

Access to health services is regarded as an essential component of good health and personal development. According to the South African National AIDS Council (SANAC) (2016), health services have been regarded as inadequate and inaccessible as most healthcare providers continue to demonstrate and display stigmatizing and negative attitudes towards the LGBT community. Knowledge obtained from cultural and religious backgrounds has been one of the main things that perpetuates the healthcare providers to deliver poor medical care. Moreover, many of the healthcare providers are not professionally trained to provide adequate services that cater for the needs of the LGBT. In addition, some of the healthcare providers have

reported their inability and inadequate knowledge of treating LGBT patients (Charles et al., 2015). This has resulted in the failure of these healthcare providers to successfully deliver adequate care, preventative resources and tools required by the LGBT to prevent themselves [LGBT] from contracting and spreading the diseases within their population.

Research has shown that the LGBT continue to be stigmatized and discriminated, ending up at a greater risk of human immunodeficiency virus (HIV), STIs and other related illnesses. According to SANAC (2016), in most public health services, preventative tools such as dental dams and condom-compatible lubricants are not always available for the LGBT to access, which often lead them to engaging in risky sexual behaviours and approaching health care facilities at a stage where an illness is challenging to be treated. For that reason, this has had a direct impact on overall health and wellbeing of the LGBT as they are disadvantaged to collect the resources and tools that may be useful to their sexual health.

Due to the historical context of HIV, being referred to a 'gay disease', most research on the sexual health of the LGBT has focused more on men who have sex with men (MSM), leaving behind other non-heteronormative groups such as lesbians and transgender individuals. In addition, little has been said and reviewed about women who have sex with women (WSW) and the health disparities of the transgender people. MSM in Southern Africa have demonstrated higher risks of HIV since the beginning of the epidemic (Lane et al., 2011). According to Lane et al. (2011), several published studies of MSM in some African countries, including Botswana, Uganda, South Africa and Malawi have noted that there are higher rates of unprotected anal intercourse in gays, bisexual men and transgender women. In the study by Sandfort et al. (2013), the HIV prevalence in the Southern Africa among WSW might be as high as 10% because half of the women in the study who engage in WSW sexual behaviour have reported that they have experienced heterosexual sexual intercourse at least once in their life. As a result, this study aims at closing the gap of not addressing the whole LGBT by looking at a broader challenge this marginalized social group face in different spheres of life, to understand their health disparities, challenges and barriers they face when they utilize and access health services. Hence, this study realizes the need to understand how the available health services can deliver the needs required by the LGBT and to explore attitudes and perceptions the LGBT have towards health services.

1.2. Motivation

Limited research in the field of sexual health among LGBT has encouraged the researcher to do a study that would explore health disparities and challenges in providing adequate care for the LGBT. The LGBT are subjected to prejudices, in addition to receiving inadequate services to meet their sexual health needs and the failure of governments to safeguard their needs. These compounding challenges motivated the researcher to explore delivery of health services in order to contribute to the efforts to reduce the challenges they face when they utilize and access health services. Inadequate delivery of proper health care for LGBT has prolonged risky sexual behaviours and approaching health care facilities at a stage where an illness is challenging to be treated. As a result, rising perceptions concerning the LGBT and the evident disparities that results from limited access to sexual-health services and delayed health-seeking behaviours have motivated the researcher to explore more on this study. Research and effective policy planning are important in the efforts to dismantle prejudice attitudes towards the LGBT.

1.3. Why focus on students?

Experiences of young people during their teenage years shapes the direction of their lives and engaging young people with their health can prevent a lifetime of bad habits (Viner and Barker, 2005; Laakkonen, 2014). This study focuses on the experiences of students in a university, where they are more likely to engage in risky sexual behaviours because of their psychological and socio-economic attributes of adolescence. In recent times, transition from adolescence to adulthood is associated with entrance into a higher education setting such as university. This event often comes with some stressful experiences as these young adults need to adapt to some changes imposed in their lifestyle. According to Janse van Rensburg and Surujlal (2013), this determined transition is accompanied with independence which results in university students gaining more autonomy over their lifestyles and behaviours. Moreover, there is an assumption that when students enter higher education institutions, they are more likely to engage in risky behaviours such as engaging in multiple sexual relationships and offering transactional sex to survive university life (Shefer et al., 2012). According to Janse van Rensburg and Surujlal (2013), research has indicated that university students are more likely to experience greater social pressures that deviates from their previously acceptable norms.

Most research on young LGBT individuals in higher education institutions has focused on homophobia and discrimination within the university and places of residence (Jagessar and

Msibi, 2015; Formby, 2017). According to Jagessar and Msibi (2015), university residences are home anyway from home, where students from different social and cultural backgrounds live together and holding norms and values that are dissimilar. The various diversities often present in higher education institutions mean many LGBT students often find space and freedom to 'claim' and negotiate their same-sex identities at these institutions (Jagessar and Msibi, 2015). The present study seeks to understand the health seeking behaviours of students where homosexuality is not normalised and to provide insights into the utilization of health service on-campus and outside campus. Hence, eliminating health-related disparities facing the LGBT students would enhance the health of the LGBT for them to live long and healthy lives. In addition, focusing on LGBT students in a higher education institution will help the researcher to improve the efforts in addressing their health concerns to reduce psychological and health-related disparities.

1.4. Objectives of the Study

The overall aim for the study is to provide insights into the utilization of sexual health services among LGBT students in Durban.

This study has the following specific objectives:

- To explore the perceptions and experiences of sexual health services by LGBT students
- To establish the LGBT students' understanding of their sexual health,
- To explore the provider-client interpersonal relationship from the perspective of the LGBT students,
- To investigate barriers to accessing and utilizing sexual health services among LGBT.

1.5. Research Questions

In line with the objectives of the study, this study has the following research questions in the study.

- What are the perceptions and experiences of LGBT students utilizing sexual health services?
- Are LGBT students aware of the importance of their sexual health?
- How do LGBT students perceive their relationship with the health providers?

- What barriers are confronted by LGBT students in accessing and utilizing sexual health services?

1.6. Theoretical Framework

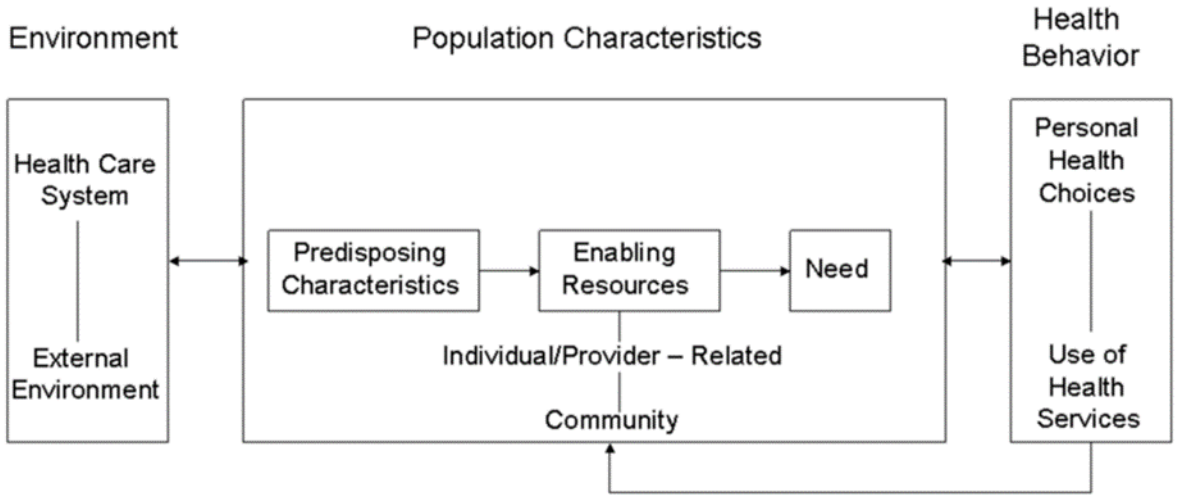
This study makes use of the Andersen Healthcare Utilization Model (AHUM) to understand utilization of health services among a specific population. The model was developed to understand and evaluate people's use of health services with regards to different functions of the predisposition to use health services, the factors that enable or impede their use of health services and their overall need to be cared for in the health services (Jahangir et al., 2012). As a result, it allows the researcher to draw conclusions on why the LGBT students utilize sexual health services and to explore certain factors that impedes the use of sexual health services among LGBT students.

Initially, the researcher thought the health belief model (HBM) would be suitable to understand the health disparities and utilization of health services among the LGBT people, however, as the study went by, the researcher realized that the HBM is only limited to understanding 'health behaviours' in dealing with the behavioral changes at the individual level (Bishop et al., 2015). HBM was adopted in response to different valid motivations of health attitudes such as being susceptible to an illness, knowing if the consequences of disease are severe and understanding the benefits of adopted behavioral changes (Rosenstock, 1974). Additionally, a health behavior of understanding if a patient or any person have accessed a health service would take a health-related action if they feel that a negative condition such as HIV can be avoided, if they have positive expectations that if they adopt or take a recommended action would make them avoid a negative health condition and if they 'believe' that they can take the recommended action successfully with confidence. For that reason, the HBM fails to make the reader or scholars to understand 'why' people access and utilize health services, the factors that promote or discourage their use of health services. Further, since this study deals with utilization, barriers and access to health services, the researcher feels like the HBM would not contribute to a better understanding of the factors influencing utilization.

According to Graham et al. (2017), the AHUM was developed by Ronald Andersen to describe the general utilization of health services among the population in the United States of America (U.S.) in the 1960s. The model has been very useful in understanding the health-related situations of different countries with regards to the utilization of health services among the population to assist the government with identifying the factors that discourage individuals

from accessing and utilizing health services to improve the public health policy of the country. According to Andersen (1995), various versions of the model that have been presented all suggest that the utilization of health services is a function of predisposing characteristics such as the gender, age and imposed health beliefs, enabling characteristics to access health services such as money, family or social support and, most importantly, the need to access the health services if either the individual is feeling unwell or need help regarding their health.

Figure 1.1. Andersen Healthcare Utilization Model



Source: Andersen (1995)

This model helped the researcher to gain more insights into the conditions and factors that influence the LGBT students from utilizing health services. Hence, it was felt that this was the most appropriate theory for this study because it allows the researcher to seek more explanations regarding health disparities of the LGBT, the barriers they face when they access health services and the conditions that influence their utilization of health services. Additionally, the model also provides a way to make assumptions, draw further conclusion, and conceptualize variations regarding the utilization rate of health services and consumption of health care resources and tools (Jahangir et al., 2012).

1.7. Organization of Dissertation

This dissertation is organized into five chapters; the first chapter is the introduction, which introduces the study and its significance in the health research body of knowledge. Second chapter is the literature review, which reviews research that has been conducted both locally and internationally. Third chapter is the methodology, which explains the research techniques

and methods used during data collection. Fourth chapter are the findings that emerged during in-depth interviews. The final chapter includes the discussion of the findings, the recommendations and the conclusion.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter focuses on the review of literature conducted both locally and internationally. As was elaborated on the previous chapter, the overall aim for this study is to provide insights into the utilization of health services by the LGBT students in Durban. It has been clear that there has been limited research on the health of the LGBT, as most research has focused on MSM and failed to elaborate on the health of the other marginalized groups including WSW and transgender people, however this literature review aims at closing the gap of not addressing the whole LGBT community by looking at a broader literature addressing the challenges this [LGBT] marginalized social group face in different spheres of life.

2.2. LGBT in health research

Research has made it clear that disenfranchised groups have difficulties in gaining access to health care because of their race, socio-economic status, sexual orientation and gender identity (Heck et al., 2006). It has been clear that research on the LGBT has been limited due to the lack of population-based data involving probability samples (Heck et al., 2006). In addition, information on sexual orientation is not collected in most national surveys, and data on health care utilization among LGBT individuals becomes limited to local surveys for access. Globally, there is limited evidence on access to sexual health services for young LGBT individuals (Centre for Disease Control and Prevention, 2018). While there have been several reported cases of homophobia within higher education institutions, many studies have predominantly focused on how LGBT students negotiate their same-sex identities when they reach higher educational spaces (Jagessar and Msibi, 2015). As a result, it has been clear that LGBT students are faced with a variety of challenges when it comes to health care because the paucity of research on their health limits the adaptations of health systems to better meet their needs during their years in higher education institutions.

According to Heck et al. (2006), it has been evident that gay men may use health services less frequently than their heterosexual counterparts. This is due to the negative treatment they receive within the boundaries of health services, because of their sexual orientation (Heck et al., 2006). According to the World Health Organization (WHO) (2013), stigma and discrimination in the healthcare setting are a critical concern that have been discussed in the

context of health. Several countries in the continent of America have seen and identified the need to address and end stigma against the LGBT individuals accessing health sectors to promote adequate utilization of health services to reduce the sexual health illnesses that are mostly prevalent in the LGBT population (WHO, 2013). Homosexuality and same-sex relations are becoming more visible in the African context, but it is still a highly stigmatized and taboo practice. This stigmatization and prejudice against the LGBT in Africa often disadvantage their same-sex activities, which leads to increased vulnerability to STIs, including HIV (Esom et al., 2015).

Several African countries have openly legislated against same-sex relations to uphold and sustain the belief that such relations are un-African (Matolino, 2017). Africa is known as the most homophobic continent in the world, comprising more countries preventing any form of same-sex behaviours and activities in the world (Carroll and Itaborahy, 2015; Jagasser and Msibi, 2015). In a study in Cameroon on the experiences of the MSM, researchers were able to note that homosexual behaviour was seen as an import from the western nations, elaborating on the fact that people see it as Un-African and Un-Cameroon (Kalamar et al., 2011). Unlike South Africa's progressive constitution that prevents all forms of discrimination and violence against the LGBT, most of the African countries have failed to provide equality laws for the LGBT that would allow them to perform any form of same-sex activity. In Africa, emphasis is placed on cultural and religious principles that regard homosexuality or any other same-sex activity as sinful, immoral, an affront to God and natural order (Kalamar et al., 2011). In addition, this has been accompanied by inadequate information and lack of research on the health of the LGBT, which has resulted in limited access to diagnosis and treatment services (Esom et al., 2015).

In most of the countries in the global North and outside Africa, reduction of health disparities has been one of their fundamental goals in improving public health research and practice (Branstrom and van der Star, 2015). According to Branstrom and van der Star (2015), in the past several years, the public health policy and research in many countries of Europe have began to address the substantial health disparities that exist between the LGBT, as compared to the heterosexual population. Governmental public health agencies in these countries have called for policy and intervention programmes to address the specific sexual health needs of LGBT individuals. It has been clear that in most economically advanced and developed countries, the constitutional reforms favour the lives of the LGBT, however, this does not really mean that the LGBT in these countries are living flourishing and standard lives, and they meet

all their required needs for their sexual health needs met. Moreover, Roberts and Reddy (2008) note that despite guaranteed constitutional freedoms, prejudice against the LGBT in different spheres of society still remain strong and rife. According to WHO (2013), stigma and discrimination in the healthcare setting are a critical concern that have been discussed in the context of health. Several countries have seen and identified the need to address and end stigma against LGBT individuals accessing health sectors to promote adequate utilization of health services to reduce the sexual health illnesses that are mostly prevalent among them (WHO, 2013).

LGBT individuals have specific vulnerabilities to STI and HIV infections due to their specific way of engaging in sexual practices, stigma-related issues and lack of knowledge about their sexual-health needs (Campbell, 2013). It has been clear that in countries where same-sex relations are illegalized, the LGBT fail to exercise their rights to health care due to various disparities such as the unavailability of resources they require for the sexual health. Further, in countries where same-sex relations are criminalized, the LGBT individuals find it difficult to meet their sexual-health needs, which often lead to delays in seeking treatment (National Women's Law Center (NWLC), 2014). In addition, this lack of care is often exacerbated when health providers refuse to provide needed care and treatment for the LGBT individual because of personal or religious beliefs (NWLC, 2014). These denials to provide and deliver appropriate health care has resulted in serious emotional, physical, and financial consequences for patients (NWLC, 2014). Furthermore, actual discrimination in healthcare settings related to sexual orientation has hindered health-seeking behaviours among the LGBT (Macapaga et al., 2016).

As a result, this chapter aims to review studies that have dealt with health disparities faced by the LGBT, which have determined their utilization and access to health services. This chapter intends to review all the available literature from cross-sectional surveys, systematic reviews, qualitative and modelling studies. Considering the limited literature that focuses on the LGBT, the researcher will make use of any available research, even if it was conducted a decade ago.

2.3. LGBT research in higher education institutions

Not so long ago in Africa, same-sex relations was not considered a developmental issue. Same-sex relations belonged to a category of nature or perhaps culture, whereas development was associated with economics, infrastructure and good governance (Epprecht, 2013). According to Epprecht (2013), since the late 1990s, there has been a big shift, an awakening to the fact

that the claim of no same sex relations in Africa was misleading; hence the topic of homosexuality still remains quite insignificant to mainstream Africanist scholarship. Looking at the historical writings of same-sex identities in Africa dispels the misperception that African scholars historically were unaware of or uninterested in sexual orientation and gender variance. Although there are several studies internationally on sexual minorities, these are limited in the global South (Nduna et al., 2017). Additionally, there is very limited literature on the experiences of university LGBT students in health centres. Further, studies have indicated increasing research that addresses the socio-cultural challenges confronted by young sexual minorities in higher education institutions (Jagasser and Msibi, 2015; Nduna et al., 2017).

Globally, research suggest that heterosexual students hold homophobic views towards same-sex identities because of negative attitudes, prejudice and discrimination against LGBT identifying students (Hames 2007; Mavhandu-Mudzusi and Sandy 2015). Higher education institutions are educational spaces where students from different socio-cultural backgrounds come together, hence they embrace diversity through personal norms, values and beliefs. Studies have shown that some heterosexual students tend to not understand how a man can be in a relationship with another man and engage in a sexual intercourse together (Nduna et al., 2017). The lack of acceptance and understanding from heterosexual students has contributed to the daily challenges faced by sexual minorities in higher education institutions, which results in homophobic attacks, violence and discrimination. A qualitative study among LGB students in a South African university show that many LGB students often negotiate their same-sex identities when they reach higher education institutions (Jagasser and Msibi, 2015). The findings demonstrated that students were likely to tolerate homophobic attacks by claiming that the negative treatment they get from heterosexual students is not that bad and happened in a state of intoxication. Another study by Nduna et al. (2017) found that higher education institutions in the Southern African Development Community (SADC) are still heteronormative-based, and that the LGBT students in these institutions are continually marginalized, prejudiced and face a great deal of discrimination.

2.4. Perceptions and Experiences

Health utilization of services among the LGBT are still tremendously affected by marginalization and exclusion, as most have reported not seeking health care services due to their past negative experiences at medical facilities (Quinn et al., 2015). LGBT in the U.S. have

continuously experienced numerous health disparities, such as HIV, mental health and substance abuse relative to cisgender people (Macapagal et al., 2016). According to Macapagal et al. (2016), potential contributors to these disparities have included lack of access to healthcare and low healthcare utilization among the LGBT. However, it has been clear that attitudes towards the LGBT have shifted significantly in the recent decades (Bolderston and Ralph, 2016). Advancements in human rights advocacy in many countries, pertaining to granting access to legal same-sex marriages and anti-discrimination legislations which have allowed a remarkable change to the rates of criminalization of the LGBT, allowing them a chance to become visible in different government-provided services such as health services (Bolderston and Ralph, 2016). However, despite policy shifts and successful legislative reforms, discrimination against the LGBT have continually persisted across most contemporary societies (Roberts and Reddy, 2008; Bolderston and Ralph, 2016).

Religious and personal beliefs of individuals play a pivotal role in allowing change and acceptance within communities. These beliefs have a significant contribution in most people's career professions, as they impose their personal beliefs in the work environment. In addition, these values have a direct impact on the careers of most individuals. As Hemingway (2005) emphasizes that people's personal values are influential in affecting individual's interpersonal, decision making and performance behaviours in the workplace. Hemingway (2005) adds that the concerns for social responsibility and change is not dependent on the economic factors, but also on personal morality. Moreover, this unwillingness of health providers to be professional within the work environment has a direct effect on the overall health of most patients within health services. As a result, this part of the chapter reviews literature pertaining to the perceptions and experiences of health services by the LGBT.

2.4.1. Attitudes of health providers

Despite elevated health risk, in research, it has been clear that lesbians are more likely to avoid health care, and they are less likely to engage in preventive screening of cancer compared to their heterosexual counterparts (Sabin et al., 2015). Most lesbians elaborated that they fear to be discriminated against, ending up delaying their health care seeking behaviours (Sabin et al., 2015). According to Tracy et al. (2010), one quarter of the lesbian patients reported that they delay seeking health care for Papanicolaou screening due to the fear of being discriminated by the healthcare providers in the U.S. In the study, it was clear that most lesbian reported feeling

discriminated at the doctor's office, while some believed that discrimination was not an issue in the public health clinic. In another study in the U.S. on the Veterans Health Care Administration, it was clear that 25% of lesbian veterans avoided seeking assistance because of the concerns of stigma they receive from both the health providers and the people who access the clinic (Simpson et al., 2013). In another study in U.S. among the LGBT, it was noted that 54% of physicians, 32% of dentists, 39% of nurses and 31% of hospital staff were reported to be discriminating towards the LGBT (Schuster et al., 2005; Sabin et al., 2015).

The experiences of stigma among the LGBT within health services have prevented them from disclosing their sexual orientation to health providers because they felt this would allow the health provider to ask more questions about their sexual health and engagement in sexual activities (Sabin et al., 2015). In Zimbabwe, LGBT participants reported humiliating responses and inadequate care from health providers when sexual orientation was disclosed (Hunt et al., 2017). According to Clark (2014), in countries such as Uganda and Zimbabwe, where there is an existence of laws criminalizing same sex activities, MSM are often too afraid to seek medical treatment. It has been clear that not only the LGBT are under pressure, but also the health providers as they are the ones who dissuade the LGBT from seeking treatment and information about safe sex (Clark, 2014).

According to Petroll and Mosack (2011), MSM whose health providers knew that were engaging in sexual relationships with other men were forced to do a HIV test whenever accessing health services for their sexual health needs. For instance, if a MSM comes to the clinic with a pimple in their anal wall, health providers would assume that they are engaging in anal intercourse which have resulted in them contracting STIs, even when they did not disclose their sexual orientation to health providers. In the United Kingdom (UK) in Midlands region, 3% of the psychiatrists and 9% of the general practitioners perceive same-sex relations and homosexuality as an illness (Bhugra, 1990). In California in the U.S., it was also clear that most physicians were not comfortable treating and providing care to gay patients (Petroll and Mosack, 2011; Mathews et al., 1986).

In South Africa, a study in Umlazi on the experiences of the homosexual patients' access to primary health care, it was clear that homosexual patients found it challenging to seek appropriate health care because of past experiences with health providers in the health centres, hence putting their health in danger (Cele et al., 2015). In addition, this study was able to elaborate that LGBT participants felt stigmatised by health providers, as they reported to be

judged by health providers the moment they entered the consultation room (Cele et al., 2015). Other participants believed that the way they dressed, talked and walked had an influence on the treatment they received by the health care providers. In addition, the lesbian participants added that nurses would ask if they were in the clinic for family planning, even before they said a word about what they were consulting for, and some gay participants added that nurses would continually ask if they were male or female since they were engaging in anal sexual intercourse (Cele et al., 2015). Other participants noted that they were comfortable with talking to their health providers because they emphasized that they are different, and it depends on who you meet at that specific time when utilizing the health service (Cele et al., 2015).

In another study in two provinces in South Africa, it was found that health providers' attitudes towards the LGBT patients were unprofessional and failed to abide by the ethical codes of Health Professions Council of South Africa (HPCSA) (Muller, 2014). The findings demonstrated that health providers would refuse to provide care to LGBT patients, as some expressed their moral judgements and negative attitudes towards same-sex relations. In addition, one lesbian was able to point out that they were turned away by the health provider because the health provider believed that lesbians can never contract HIV, only straight people can (Muller, 2014). This clarifies the lack of training and capability to preserving care and treatment for the LGBT community.

2.4.2. Delayed health seeking behaviour

Delayed health care has been associated with past negative experiences that the LGBT patients have faced in the health centres. According to Seelman et al. (2017), few of the studies have assessed the relationship between delaying health care because of fear of discrimination and non-inclusivity of health services to address the concerns of the LGBT, which have led the LGBT population to delay seeking health in those environments. Transgender individuals have faced difficulties in accessing health facilities that offers gender-affirming hormones and surgical procedures to allow themselves to live the life they always wanted from birth (Seelman et al., 2017).

Health services has always been incompetent towards transgender individuals, due to the issues of discrimination and non-inclusivity of health care as they believe that transgender people have always been forced to navigate a healthcare system that is resistant at best, and at times that are openly hostile towards the provision of health care for the needs of the transgender

people (Roberts and Fantz, 2014). In a study in the Rocky Mountain region of the U.S., it was clear that most transgender individuals delay seeking health care because of fear of discrimination and non-inclusivity of health providers to provide care for transgenders because statistically, the results were significantly positive with the outcome variables in the logistic regression models. (Seelman et al., 2017).

Stigma against HIV have forced many people, including both heterosexual and LGBT to delay seeking assistance. The stigmatization of HIV has been a factor that contributes to the delay of HIV testing for most at-risk persons such as MSM, women and transgender women (Chesney and Smith, 1999). According to Stall et al. (1996), in a survey of 828 MSM residing in Tucson and Portland, it was found that almost all the participants were unaware of their HIV status, and two thirds endorsed that this was due to the stigma attached to HIV-positive persons, and they implied that this was one of the reasons that they delayed seeking HIV testing. Most participants elaborated that they were afraid of losing the people they loved if they were found to be HIV positive, hence they feared rejection and discrimination by their loved ones. According to Chesney and Smith (1999), some MSM were hesitant to utilize general health services because they believed that the health providers would ask other sensitive questions which would force them to disclose their HIV status, and that they would be forced to do an HIV test if maybe they had symptoms concerning the illness they were consulting for.

In another study that was done in San Francisco General Hospital, it was found that most high-risk individuals would even delay care and treatment after they found that they were HIV positive (cited in Chesney and Smith, 1999). In addition, it was clear that participants had additional comments such as wishing that the virus would go away, some would even internally refuse to believe that they were HIV positive, resulting in 24% specifying that they never seek prior care and one third waited until they have worse symptoms of HIV to seek medical attention (cited in Chesney and Smith, 1999). In another study in India, it was found that most MSM delayed their health seeking behaviours because of the stigma attached to HIV (Steward et al., 2013).

According to Mprah (2016), in South Africa, different studies do not provide specific information on the prevalence of HIV and STIs among the LGBT population. This was due to the fear that some patients did not disclose their sexual orientation when they access health care. A study in Zimbabwe found that when LGBT patients disclose their sexual orientation, health providers showed unwillingness to pursue treatment and care for them (Hunt et al.,

2017). Stigma and discrimination in the health services have compounded the isolation of the LGBT from public health care and utilization of foreign supported LGBT organizations (Mprah, 2016). In these foreign supported LGBT organizations, researchers have elaborated that most LGBT individuals fear to access public health services because of lack of confidentiality and being asked biased questions related to the sexual health of heterosexuals (Mprah, 2016). Mprah (2016) added that some in the LGBT would delay their access and utilization of health services because of the beliefs that if they present health complications such as haemorrhoids, rectal bleeding and genital transmitted infections, it would be very easy for the health providers to discover their engagements in same-sex sexual relations. In Malawi, a nurse displayed homophobia against a gay patient after the patient disclosed his sexual orientation (Kaliza, 2017). In addition, the nurse even called her colleagues to come and see the gay patient, violating the confidentiality and privacy of the patient, hence this patient noted that the reason why he would delay seeking medical care, was because of the past experiences he had with the health provider (Kaliza, 2017).

2.4.3. Personal beliefs and values

The ability of LGBT patients to feel comfortable in sharing their sexual orientation and gender identity with their health providers allows trust and honesty to be established for the health provider to deliver the best health care. However, the problem begins when the health provider is not accepting and not willing to understand the sexual identity of the LGBT patient, by imposing their own personal beliefs and values onto the LGBT patients. According to Hemingway (2005), one's personal values are influential in affecting individual's interpersonal, decision making and performance behaviours in the workplace, especially when the individual is working with people who are marginalized and discriminated against due to the sexual orientation or gender identity. According to Charles et al. (2015), LGBT have continually faced numerous barriers when it comes to accessing and utilizing health care services. In addition, cultural, religious and personal beliefs can affect the level of comfort in accessing health care because of the concerns related to disclosing their sexual orientation or gender identity to health providers (Charles et al., 2015). Most LGBT have experienced negative judgements from physicians because of the personal beliefs the physicians impose on the workplace (Charles et al., 2015).

According to Banerjee et al. (2018), delivering culturally competent health care depends on the attitudes, beliefs and communication behaviour of health providers towards the LGBT. In a study by Shetty et al. (2016), it was found that health providers believed that health risks of the LGBT are just difficult to understand, and they believed that everyone in the clinic should be treated equally irrespective of their sexual orientation. According to Eliason et al. (2011), most early studies that attempted to measure homophobia of health providers towards the LGBT, homophobia was rated 58% in 1982, 26-36% in the late 1980s and 19% in 1999. Another study conducted in Chicago in the U.S. found that among medical students who were pursuing a career in health care, 25% believed that same-sex relations were immoral and 9% believed that it was just a mental illness that needs to be treated (Klamen et al., 1999).

According to Eliason et al. (2011), in their study in selected medical schools in the U.S., it was found that little education and lack of knowledge about the health issues of the LGBT have caused some heterosexual physicians to have negative attitudes towards LGBT patients or working with LGBT co-workers, setting the stage for non-inclusivity and unwelcoming workplace health services. According to Mitra and Globerman (2014), access to health services for the LGBT have been influenced by the social, behavioural, and structural factors including deep-rooted stigma and discrimination. In a study of 173 lesbians in three American cities, it was found that health providers were heterosexist and homophobic towards lesbian patients (DeHart, 2008). In Malawi, it was found that health providers were likely to impose their religious beliefs and affiliations on the LGBT, which results in poor health outcomes and delayed health seeking behaviours (Kaliza, 2017). In addition, one of the participants in Kaliza's study was able to elaborate on the disappointment he had after the nurse treated him badly after he informed her that he was a homosexual, as the nurse replied that he was evil and that his behaviour was against God. This emphasizes the inability of some health providers in Africa to accept change because of the beliefs and values they have towards certain things.

The Health Professions Council of South Africa (HPCSA) has aimed to promote empathy and sensitivity to social situations facing patients and allowing health providers to respect the choices of the LGBT despite the beliefs they have towards same-sex relations (HPCSA, 2016). However, religion has been largely implicated in the negative attitudes towards the LGBT in most societies. According to Gnuse (2015), there are seven Biblical texts that most Christians use to condemn homosexuality. In a study by Sopitshi (2016) in South Africa, the LGBT patients were disadvantaged to seek for medical care because most health providers would impose their religious beliefs during the consultation time. In a study by Cele et al. (2015), it

was clear that health providers displayed inappropriate curiosity towards homosexuality in health services. In addition, participants were able to note that religious beliefs of health providers were problematic as it influenced their access to health services (Cele et al., 2015). The interviewees were able to elaborate on the fact that some health providers would impose their religious beliefs on them, with expectations that they would change their homosexual behaviours (Cele et al., 2015).

2.4.4. Factors influencing the use of health services

The Andersen Health Utilization Model has elaborated on the factors that influence use of health services including pre-disposing factors such as sex, age and race, enabling factors such as the responses of medical providers and affordability of health insurances and lastly the need for care factors such as an individual realizing the need of utilizing health services due to the sensitiveness of the illness (Graham et al., 2017). According to Whitehead et al. (2016, p.1) "several studies have identified that fears or experiences of stigma and disclosure of sexual orientation and/or gender identity to health care providers are significant barriers to health care utilization for LGBT." The utilization of health services among the LGBT has been dependent on their level of comfortability with their health providers, knowing that a health service is culturally competent and inclusive in addressing the concerns of the LGBT, and being forced to utilize health services due to the fact that the disease has significantly spread within their bodies, hence they seek medical attention (Whitehead et al., 2016; SANAC, 2016).

It was clear that in a study in the U.S. that gay men were likely to utilize health services because they were able to disclose their sexual orientation to the health providers (cited in Mitra and Globerman, 2014). In addition, some believed that these health providers were culturally competent and gay friendly to address the needs of the LGBT. In another study in Canada by Geddes (1994), lesbian women believed that disclosing their sexual orientation to the family doctors improved their use of health facilities because they would feel comfortable discussing their sexual and reproductive health. In another study in Canada by Bergeron and Senn (2003) among 254 lesbians, the participants believed that knowing that the health provider was well educated about the concerns of the LGBT improves their utilization of health services because they would know that they would find adequate care that they require for their sexual health.

A study that was conducted in South African cities among MSM concerning the utilization of health services was dependent on the perceptions of available health services, and their service

preferences (Rispel et al., 2011). After conducting the interviews, it was clear that the MSM participants believed that public health services aimed at addressing the health concerns of MSM, but their utilization of health services were constrained by stigma against their health and the negative attitudes of health providers towards them (Rispel et al., 2011). In some developed countries such as the U.S., it was found that the several changes in the legal and policy frameworks have served to increase access and utilization of health services for the LGBT (Ranji et al., 2014). However, in South Africa it was clear that despite policy changes and legislative reform of the constitution, the LGBT are still hesitant to access and utilize clinics because of their past experiences (Roberts and Reddy, 2008).

2.5. Provider-client interpersonal relationship

Health services are supposed to be welcoming spaces for all the people who access them. No one should be mistreated and marginalized because of the way they look, or their own self-identity. According to Albuquerque et al. (2016), accessing healthcare is a right and a duty for all countries to make services and facilities easily accessible to the surrounding population. The relationship between patients and health services is considered significant and essential in strengthening the quality of life and care (Albuquerque et al., 2016). LGBT individuals have frequently reported negative health care encounters, as most healthcare providers possess poor medical knowledge, care and training for the LGBT (Parameshwaran et al., 2017). These negative attitudes range from healthcare workers using inappropriate gender pronouns or attitudinal statements regarding the sexual experiences of the LGBT patient and refusal to provide appropriate treatment for this non-heteronormative society (Parameshwaran et al., 2017). In addition, this endangers the lives of the LGBT through delays and denials of necessary health care as some LGBT individuals are hesitant to disclose their sexual orientation or gender identity which leads to them not receiving appropriate and standard health care. This part of the study reviews literature on the interpersonal relationships between LGBT patients and healthcare workers in clinics or other medical facilities.

2.5.1. Knowledge and training

The remarkable progress on reducing the incidence of HIV among the whole population have resulted in a higher number of the population having access to HIV testing services and anti-retroviral drugs (ART). However, this progress has come at a price for the LGBT, as they have

come across difficulties in accessing appropriate care and treatment, especially MSM and the transgender (Sekoni et al., 2017). According to Sekoni et al. (2017), these negative consequences were recognised after the impact of HIV-related discrimination among the LGBT because they continue to face the burden of new HIV infections. Hence, the call for urgent action to remodel health education of the healthcare workforce because they are interfering with the progress of reducing the prevalence of HIV. In addition, Sekoni et al. (2017) research has suggested that specific training on LGBT health would reduce stigma and discrimination towards the LGBT patients accessing health facilities.

In the research findings by Unger (2015), Moll et al. (2014), Klotzbaugh and Spencer (2015) and Torres et al. (2015), it was found that there was a common knowledge gap of clinical competencies of health providers, as there is limited formal education on LGBT patient care provided to future clinicians and physicians. In addition, it was clear that education on LGBT health care was lacking in both formal educational and informal staff training sessions in the U.S. (Flesenstein, 2018).

The role of doctors and medical schools have been regarded as the gatekeepers in addressing health disparities faced by the LGBT (Awosogba et al., 2013). Higher education institutions have played a pivotal role in addressing social determinants through health education and clinical service. However, most LGBT patients believe that health providers are not prepared to care for them (Lambda Legal, 2010; Awosogba et al., 2013). In the survey undertaken by Lambda Legal in the U.S., it was clear that 49% of LGB individuals and 89.4% transgender individuals reported that the health care is insufficient because there are not enough health practitioners who are able to address their concerns, and who are adequately trained to care for the health concerns of the LGBT (Lambda Legal, 2010). This emphasizes that the LGBT have seen that gap regarding the training of the health providers for the concerns of the LGBT populations, which have led to their reluctance to utilize health services because of fear that they might not get any care because the health providers have limited training when it comes to their concerns. In another study that was conducted in the U.S. it was found that most health providers have failed to ask questions relating to sexual orientation, even if patients acquire depression and suicidal thoughts symptom (Kitts, 2010). In addition, 41% of these health providers stated that they would not ask any additional sexual health-related questions even if the LGBT patients have elaborated that they were not sexually active. This emphasizes that that the physician fails to probe deep even after they believe that the LGBT patient has lied regarding the question of sexual activeness.

According to Henderson and Almack (2015), Ireland, Australia and UK were seen to have an improved comprehensive health education for the LGBT population as compared to other countries. A study in the South-East region in Ireland found that most LGBT participants that were interviewed expressed a high level of positivity as they noted positive comments about their general practitioners (GP) (Crowley, 2015). In addition, these positive comments point to the nature of the relationship and interaction between the health providers and LGBT patients. However, some lesbian and transgender individuals believed that there is still a long way to go for the health of the LGBT population because there are still gaps regarding the training of providers for their health concerns. Primary care for the LGBT has been aligned and compromised with the gaps in the clinical care and practice systems in most countries (McNair and Hegarty, 2010). According to McNair and Hegarty (2010), these gaps are clearly demonstrated by the deficiencies in the LGBT-specific knowledge and skills of health care providers, which corresponds with inadequate training of providers in Australia, Canada, Ireland, New Zealand, the UK, and the U.S. These six countries have slightly similar experiences when it comes to the health of the LGBT and their results are often similar (McNair and Hegarty, 2010). In a study by Arbeit et al. (2016) in the U.S., it was clear that 18% of the bisexual youth believed that their doctors were knowledgeable about the issues of sexual health affecting the LGBT.

According to Hafeez et al. (2017), some health providers are not well trained in addressing the concerns of the LGBT. In a study in Washington DC in the U.S., 68% of sexual minorities were dissuaded to report and discuss their sexual orientation due to the fear of being judged, as they saw that clinicians were not capable to address their concerns in an appropriate and mature way. In addition, they believed that disclosing their sexual orientation would reduce their chances of being assisted by health providers because they believed that the clinicians' attitudes towards them displays lack of training and knowledge in addressing their concerns (Hafeez et al., 2017). As a result, the LGBT patients believe that this lack of training puts strain on the therapeutic relationship between LGBT patients and the health providers because it influences their quality of care and provision of appropriate health care that they should be getting.

South Africa is one of the countries in Africa that have recognized the need to provide adequate LGBT health care, however there are no curricula for teaching that was established before 2013 that dealt with the LGBT health related issues in South African universities (Muller, 2013). According to Nduna et al. (2017), most findings reported in their paper indicated that the higher education institutions in the Southern African Development Community (SADC) are still

heteronormative-based, and the LGBT in these institutions are continually marginalized, prejudiced and discriminated. This implies a negative consequence in providing adequate teaching and learning of issues directly affecting the LGBT, which have affected students from understanding more about this community.

In a study that was undertaken in Botswana, it was clear that almost all LGBT participants suffered the realities of societal disapproval, ranging from lack of access to LGB friendly health care providers, isolation and fear of outing (Ehlers et al., 2001). It was also clear that most participants in this study were largely in the closet, which disadvantaged their care because non-disclosure to healthcare professionals indicated symptoms of internalized homophobia leading to inappropriate care. However, if health care providers had appropriate health education regarding the health of the LGBT, it would be easier to assist them. This emphasize the challenges the LGBT face when they utilize health services, resulting in them providing false information to health providers because of fear of judgement.

2.5.2. Cultural competence

It has been clear that in almost all countries, no surveys ask questions about gender identity or sexual orientation. This lack of data has hampered efforts to design and implement programs that would effectively serve all the LGBT populations (Krehely, 2009). In the U.S., the nurse professional development (NDP) has made it possible to access for LGBT cultural competencies in healthcare settings to initiate interventions that would increase competencies (Felsenstein, 2018). In the 2012 Gallup survey in the U.S., 3.4% of adults were identified as LGBT, with 9 million LGBT adults and 1.4 million adults identified as transgender (Gates, 2011: Felsenstein, 2018). However, one of the problems that was faced in identifying the exact number of the LGBT was that there is limited data collection in national surveys and within individuals' healthcare settings, which have created the invisibility of LGBT patients in the health services (Makodon, 2011; Felsenstein, 2018). In the 2010 Census in the U.S., it was found that over 10,000 same sex couples were residing in Minnesota, with 28 LGBT friendly health services, however after the preliminary assessment of the primary care clinic setting used for quality improvement initiative, it was found that limited LGBT cultural competencies were present (Felsenstein, 2018; Gates, 2015). In addition, within the 28 clinics that were mapped as LGBT friendly, there was nothing friendly or welcoming for the LGBT patients because everything was heterosexually constructed (Felsenstein, 2018). The clinics' admission

intake forms did not include questions pertinent to providing an opportunity for patients to freely self-identify themselves as LGBT, however only one clinician chart form was found to have these question (Felsenstein, 2018). The health care providers explained during another survey that there was not enough done to address the concerns of the LGBT population, as it showed in the baseline assessment findings that none of the health providers had LGBT health courses and 77.8% felt the need to enhance and improve clinical services for the comfort and care of LGBT patients (Felsenstein, 2018).

It was clear that poor health outcomes occur when there is a lack of cultural competency in the healthcare settings that are meant to be utilized by the LGBT (Krehely, 2009). According to Surreira (2014), increasing cultural competency has been one of the significant methods that improves care and health outcomes. According to Felsenstein (2018), in order to show that a health care facility provides adequate care for the LGBT, there should be posters and pamphlets in the health service to indicate that the health services offers care and treatment for the LGBT. In a study conducted in the U.S. on the perspectives of bisexual youth on their utilization of sexual health information and services (Arbeit et al., 2016), 73% of the participants noted that their regular doctors assume that they are heterosexual and 30% said they were comfortable at opening up to their doctors regarding their sexual health (Arbeit et al., 2016). In addition, 18% of the bisexual participants noted that they have spoken about the identities of the LGBT during the consultation time and 73% were worried that these doctors would tell their parents about their LGBT identity (Arbeit et al., 2016).

In the study in 138 allopathic medical schools of Puerto Rico and the U.S. where only 69 of these medical schools completed the survey, 9% of the institutions were able to note that they already partake in the procedures of identifying competent physicians before they start practising in the medical centres (Khalili et al., 2015). The concerns of the LGBT were addressed through introducing LGBT health in their medicals schools. Moreover, the study also found that 4% of the institutions had a policy in place that identifies LGBT competent physicians, however 3 of those institutions allowed the physicians to personally view their services as LGBT-competent (Khalili et al., 2015). In the study, it was also found that out of 69, only 10 of the health services were identified to be LGBT friendly, however 55 out of 69 were willing to make improvements regarding their health education and training for LGBT health issues (Khalili et al., 2015).

As of 2015, 34 African countries has outlawed same-sex relations, including teaching and training of health providers to adequate meet the health needs of the LGBT (Ard and Makadon, 2016). According to Ard and Makadon (2016), African LGBT individuals who have sought asylum in America have been hesitant to connect with social service providers, especially from their own countries for fear that those providers would report them back home for practising same-sex behaviours. In addition, this fear has made it challenging to access culturally competent health care in America. In South Africa, considering the supportive legislation of the country, different organizations such as Anova Health Institute have identified the need to work on providing culturally competent and LGBT-friendly healthcare facilities to increase the utilization of health services for the LGBT within the country. According to Muller (2014), many LGBT individuals believe that access to healthcare in South African public services has been very challenging, due to the fact that the majority of the population depend on health services, which are already under-resourced and overburdened even for heterosexual individuals to access. This emphasize that, the country might have successful constitutional freedoms, but it has failed to adequately invest their budget to the health of different sectors of the population because health in the country is still a problem. In the study by Muller (2017), it is clear that the key disparities in health in South Africa is a result of lack of competency and training of health providers in the health sector to address the concerns of the LGBT populations. In addition, it was clear in all the interviews, the LGBT participants noted that healthcare providers' lack of knowledge about different gender identities and sexual orientations was a great concern for accessing adequate health services for the LGBT (Muller, 2017).

2.6. Barriers to accessing health services

Past experiences of accessing health services by the LGBT has caused them to delay their health-seeking behaviours because of the negative treatment they received on their first visit in health facilities. Many LGBT individuals have reported their reluctance to disclose their sexual orientation or gender identity to health professionals because of fear of being judged and denied medical care (Mitra & Globerman, 2014). According to Mitra and Globerman (2014), the degree to which an individual feels comfortable in disclosing their sexual orientation or gender identity demonstrates proper health care access and utilization. In addition, greater openness and their ability to disclose their sexual identity appears to increase willingness to disclose information to healthcare workers, which leads to better care and improved access. In countries where same-sex arrangements are punishable and criminalized by law appears to have lower

utilization rates by LGBT accessing health care and disclosing their sexual identity to health professionals because of the fear that the healthcare providers may report them for engaging in something that is punishable by law. These countries often have limited research on the health of LGBT because if one is found to continue discussing matters that includes same-sex relations that is banned by the legislative bodies there is a strong likelihood that they could be imprisoned and punished by the law. As a result, this part of the study sought to expand more on the social, legislative and economic barriers that restricts the accessibility of LGBT individuals to access health services that will benefit their sexual health.

2.6.1. Stigma and Discrimination

Stigma and discrimination act as formidable barriers to effective, adequate and equitable healthcare for most individuals. According to Mallory et al. (2017, p.41), "experiences of discrimination and harassment, as well as living in a state with unsupportive laws and social climates, have been shown to contribute to health disparities for LGBT." The LGBT have faced a common set of challenges and difficulties in accessing competent health services and achieving a potential level of health. According to Muller (2014), gender identity and sexual orientation, like other social determinants of health results in health disparities, compared to the heterosexual people, LGBT individuals are more likely to face barriers in accessing appropriate health care.

Several studies suggest that LGBT have continually faced stigma, discrimination and homophobia in almost all spheres of life. Stigmatization generally derives from the 'general' or heteronormative society, faith-based organizations (FBO), and in their [LGBT] families due the expectations they have regarding their child, and significantly from public health service employees such as healthcare workers. The right to health has been considered as universal, however, health care as a right and duty of the state is regarded as an ideal (Albuquerque et al., 2016). According to Albuquerque et al. (2016), the reality is that many countries such as Uganda, Brazil, Mexico and Ghana are crossed by frames of exclusion and violation of fundamental human rights, especially for the minority social groups such as the LGBT. Despite the tremendous progresses made over the past few years in reducing new HIV infections and STIs among the LGBT, they continue to be stigmatized because of their actual or perceived sexual orientation or gender identity (Albuquerque et al., 2016). Further, it has been clear that

the LGBT does not receive the similar medical attention equivalent to the heteronormative population in responses to sexual health care (SANAC, 2016).

In Africa, the LGBT has been discriminated in most social services, since the continent is identified to be the most homophobic compared to other continents (Carroll and Itaborahy, 2015). A majority of homophobic African countries have legislated against same-sex activities through establishing penalties ranging from fines, corporal punishments, prison terms of varying lengths and death penalties (Carroll and Itaborahy, 2015). McGoldrick (2016) found that in Africa, 34 countries have criminalised against homosexual activities in comparison to 21 countries where homosexual activities were found to be legal. It has been clear that gay and bisexual men are disproportionately burdened by HIV or acquired immune deficiency syndrome (AIDS) in Africa (Hagopian et al., 2017). According to Kalamar et al. (2011), it has been clear that in most African countries, the national HIV/AIDS programmes do not explicitly target the MSM. Hence, the denial, stigma and criminalization against male homosexuals have created social climates in which the MSM remain in the closet because of fear of rejection or arrest (Kalamar et al., 2011). According to Hagopian et al. (2017), it has been clear that African nations have the highest reported incidences of HIV among MSM adults compared to other regions. These higher statistics are accompanied by the laws criminalizing homosexuality in African countries, as they dissuade the LGBT and other key populations from seeking treatment and health care. In addition, these high levels of discrimination have been associated with punitive social and legal environments for the MSM, as they have criminalized the sexual behaviours of the LGBT population (Hagopian et al., 2017). According to Hagopian et al. (2017), these punitive laws have incited deeper levels of stigma against the LGBT population, noting that same-sex relations are often perceived as shameful, leading to a lack of disclosure of sexual orientation to the health providers.

In a study by Mavhandu-Mudzusi (2017), in most African countries, engaging in non-heterosexual relations and gender non-conforming activities has been considered a taboo, however a few countries such as Kenya and South Africa have protected LGBT individuals from exposure to stigma and discrimination. However, this has never protected MSM who are HIV positive in the health centres. In another study by Mavhandu-Mudzusi and Sandy (2015) in South African rural university, it was found that it is very difficult for the LGBT individuals to access post-exposure prophylaxis (PEP) from the health services because there was institutionalised stigma and discrimination against the LGBT sexual identities. A study conducted in the U.S. found that 29% of the recruited participants reported experiencing racial

and sexual orientation stigma from healthcare providers in health services, while 70% of transgender individuals experienced discrimination in healthcare settings (Hujdich et al., 2016). In addition, in another study in the deep South of the U.S. among high risk populations, it was clear that HIV-related stigma was reported as pervasive and resulted in lowered participation in HIV testing and treatment (Reif et al., 2018). This lowered participation was due to the myths and misinformation about HIV because participants were able to elaborate that some HIV negative people would emphasize that HIV can be even contracted when you talk with someone who was HIV positive and breathing the same air that they breath (Reif et al., 2018).

2.6.2. Outright denial of care

According to the NWLC (2014), refusing to provide health care for patients coming from different socio-economic backgrounds can have serious emotional, physical and financial consequences for the patients. According to Lambda Legal (2010), most previous studies have found that LGBT individuals and people living with HIV are often refused care and treated in a discriminatory manner because of their sexual orientation, gender identity or their HIV status. In a study by Lambda Legal (2010) it was found that approximately 8% of the LGB individuals, 27% of transgender individuals, and 20% of HIV positive people reported that they have been denied health care during difficult times. In addition, Rounds et al. (2013) have elaborated that the LGBT identifying patients have long reported to be receiving substandard care from health services. They have continually faced fear and disturbing realities of discrimination when accessing health care (Rounds et al., 2013).

It has been clear that the health of the LGBT is sensitive and should be treated cautiously. The refusal of health care leads to irreversible consequences to the LGBT patients. In the article by Vegh (1998), there was a lesbian who died as a result of delayed medical attention. This lesbian teacher was taken to the hospital immediately after her family realised that her sickness was getting worse and was not attended to for the longest hours until she fell into a coma where she died after several days (Vegh, 1998). This emphasize the role of nurses or physicians in determining which patients should be attended to first and why other patients' health care should be delayed. In another study by Lambda Legal (2013), one transgender woman was deprived of hormonal prescription medication by a health centre in the U.S. and was forced to be in conflict with her feminine lifestyle. This delay of health care forced this transgender

woman to experience severe health consequences and emotional distress due to withdrawal symptoms after being forced to go without treatment (Lambda Legal, 2013). In a survey by Human Rights Watch conducted in 2015, it was clear that almost 28,000 transgender people found in the year preceding the survey, 23% of them did not seek any medical care because of concern about mistreatment based on gender identity by the health providers (Human Rights Watch, 2018).

In a study in South Africa by Muller (2017), the LGBT experienced the challenges of long waiting times and being told that the service is not offered at the clinic they are accessing. During the interviews, one young black gay man was told by the nurses that the health facility was not culturally competent to address his sexual health needs and he was told to go somewhere else without being told where. In addition, some LGBT health services users confirmed that the unavailability of information and specialised services in the public health services forced them to turn towards non-governmental organizations when they sought knowledge about their LGBT specific health risks and concerns (Muller, 2017). Other participants commented that as soon as health providers knew about their sexual orientation, they would turn them away to other facilities without being given appropriate health care (Muller, 2017). In addition, some LGBT participants in a study conducted by the Human Rights Watch (2018), noted the difficulties in accessing hormone replacement therapy, HIV prevention and treatment options, fertility and reproductive services, and even just welcoming primary care services in some of the states in America.

2.6.3. Under-resourced health services for LGBT

The LGBT require certain preventative sexual health resources and tools when engaging in sexual behaviours. The lack of sexual materials required by the LGBT have hindered prevention efforts in most countries (Romijnders et al., 2015). According to Muller (2014), health services should ensure that health prevention and materials are able to address the needs of the LGBT, as the MSM require condoms and lubricants for anal sex, WSW require dental dams for oral sex and transgender individuals need additional support and advice about their specialised services. In Tanzania, lubricants were banned due the belief that they promote homosexuality (Fallon, 2016). According to Fallon (2016), the MSM in Tanzania found it a barrier to access lubricants because the unavailability in public health services and being expensive in the pharmacies. The government of Tanzania banned the imports and sale of

lubricants in the country because they claimed that it was promoting homosexuality (Fallon, 2016). In addition, Tanzania is one of the countries that legislated against same-sex behaviours, with a law prescribing life in jail (Fallon, 2016; Carroll and Itaborahy, 2015). As a result, the country was experiencing high rates of HIV incidences and STIs because the lubricants help soften the anus during anal sexual intercourse. According to Romijnders et al., 2015), it was found that since the beginning of the HIV epidemic, not using lubricants or using petroleum-based lubricants for anal intercourse increases the risk of condom rupture or rectal lesions. Hence, without a lubricant, the anal wall is likely to break and contract sexual transmitted illnesses.

In another study in Tanzania, it was found that two-thirds of MSM reported always using lubricants for anal intercourse (Romijnders et al., 2015). It was clear that fewer MSM and those men who have sex with women knew about lubricants, some have difficulties finding them in the health services, and some find lubricants to be expensive (Romijnders et al. 2015). In this study, it was found that 12.7% of the MSM did not use lubricants during anal intercourse due to the unavailability and accessibility, while 87.3% did not respond to the survey. In addition, 49% of the MSM had difficulties in finding and accessing lubricants, while 48.3% reported to buy their lubricants in the pharmacies (Romijnders et al., 2015). According to SANAC (2016), preventative tools such as dental dams for lesbians and condom-compatible lubricants for MSM are not available in public health facilities in South Africa. For transgender individuals, Nduna (2012) found that the lack of access to comprehensive SRH and rights in the transgender community are often linked to new HIV incidences.

2.7. Summary

This chapter has reviewed literature that was conducted both internationally and locally. It was clear that most studies on the LGBT have been published in the U.S., however Africa is also coming along as some of the studies were referenced. The researcher was able to review both qualitative and quantitative studies. The structure of this literature review was according to the objectives of this study and the researcher tried to emphasize on every point elaborated during the discussion. Research on the experience of sexual minorities in higher education institutions is more or less likely the same as the literature reviewed on the experiences of LGBT youth on the perspective of health care. Discrimination, negative attitudes and prejudice was clearly indicated in both perspectives where LGBT students access health services and if they are

within the spaces of the university. It was also clear that the Andersen Healthcare Utilization Model (AHUM) is relevant to this study as most headings elaborated on the factors that evaluated the utilization of health services among the LGBT.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

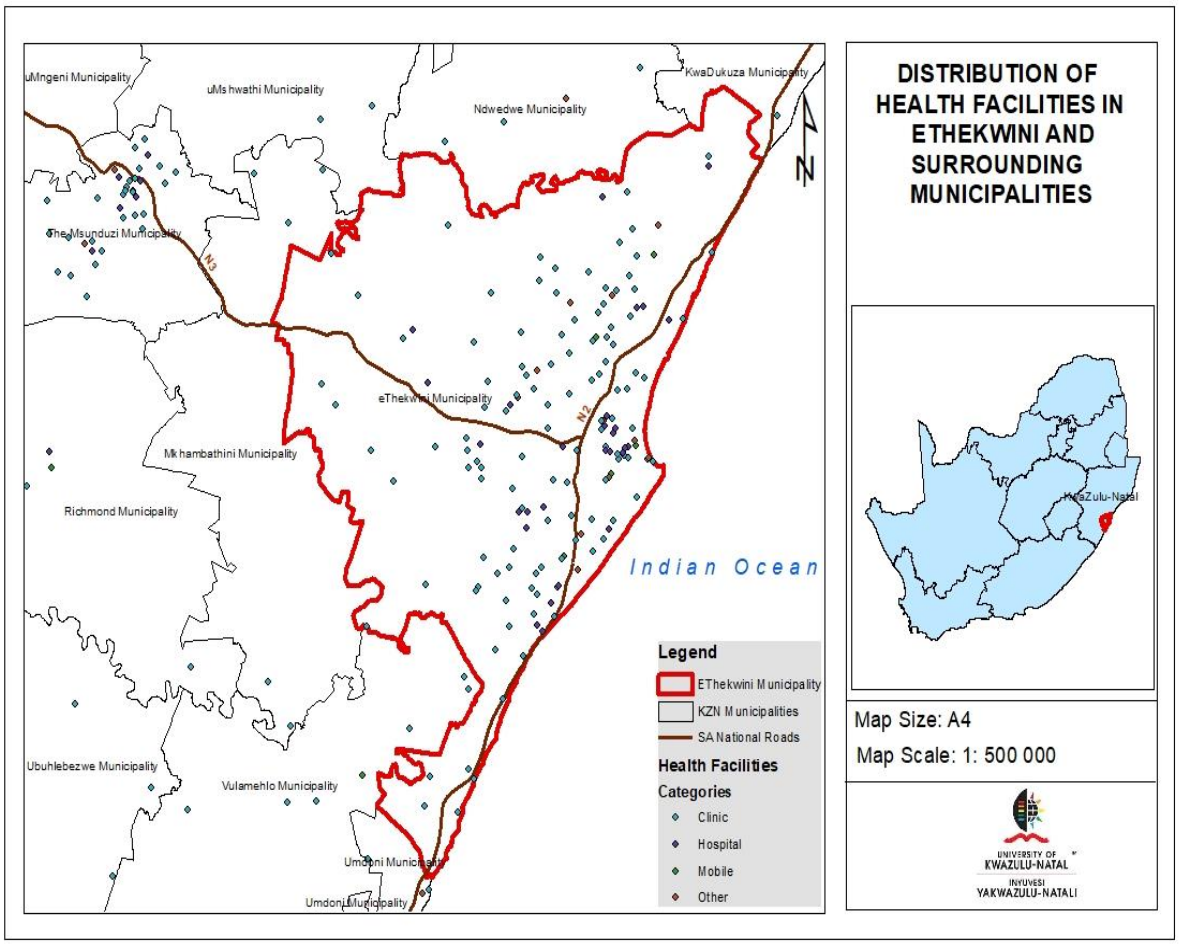
In the previous chapter, the researcher was able to provide an overview of literature from local and international scholars on the prevalent health disparities, the barriers to seeking health care and utilization of sexual health services among the LGBT students in higher education institution clinics and outside the university. In this chapter, the focus is on the data generation process followed in this research to allow the reader to understand how the researcher went about to collect data in order to fulfill the overall aim of this study. This chapter is divided into four sections; where the first section is on giving a brief overview of the background of the study area. The second section explores the philosophical underpinnings adopted for this study such as the qualitative research and the interpretive paradigm. The third section outlines the data collection and generation process, whereby the researcher outlines the chosen methodology, which is the case study research, purposive and snowball sampling, the chosen research instrument and the discussion of the chosen sub-population for this study. The fourth and final section focuses on the reflexivity and analytical frameworks such as the data analysis process, matters of ethics, reliability and the limitations of the study. These four sections help the researcher to answer the research questions of the study which were elaborated on the first chapter of this dissertation.

3.2. Study Context

Located in the east of South Africa, KwaZulu-Natal (KZN) is a second largest population as recorded in the mid-year population estimates from Statistics South Africa (Stats SA) (Statistics South Africa, 2016). According to Department of Health (2018), KZN has improved health outcomes through strengthening of health systems and implementing quality health care services in response to the burden of diseases and identified needs. The province has recorded remarkable progress, as the total life expectancy improved from an estimated average 56.4 years in 2011 to 60.7% in 2016 (cited in Department of Health, 2018). For that reason, this study was conducted at the University of KwaZulu-Natal (UKZN), located in KZN. This public university comprises of five campuses, however only four were selected for this study. All four chosen campuses are situated in Durban, under eThekwini Municipality. According to the Department of Health (2015), eThekwini Municipality has faced few challenges in delivering efficient health care for its population. The life expectancy of eThekwini Municipality has

remained low, as a result of HIV, Tuberculosis (TB), chronic illnesses and deaths due to injury and violence (Department of Health, 2015). UKZN as a bureaucratic institution has allowed students to access clinics on campuses, as there is a clinic in each campus, but has shortages of doctors who specialise in sexual health related problems such as STIs (University of KwaZulu-Natal, 2017). Additionally, UKZN has a centre that allows students to access HIV testing and counselling called Campus HIV and AIDS Support Units (CHASU). CHASU has allowed students to collect condoms, lubricants and dental dams to improve and protect their sexual health.

Figure 3.1: Map of Health Facilities in EThekwini Municipality and around KZN.



3.3. Philosophical Underpinnings

Philosophical underpinnings are very crucial in shaping the research design and for explaining the approaches taken in the study to support the credibility of research outcomes (Jackson, 2013). It has been clear in most research that when the researcher has successfully justified the chosen methodology of the study corresponding to the proposed research questions, the

credibility of the study is often strengthened in the final piece. For that reason, this study has embraced the qualitative research and an interpretive paradigm which will be both explained further to make the reader understand certain decisions the researcher took in order to strengthen the credibility of this research. Further, the qualitative research and interpretive paradigm will be explained according to the overall aim of the study to make sure that the researcher is able to fulfil all the objectives proposed in this study.

3.3.1. Qualitative research

Qualitative research has been a very useful technique that allows researchers to become subjectively immersed and engaged in the subject matter. According to Al-Busaidi (2008, p.11), qualitative research is defined as "an umbrella term covering an array of interpretative techniques which seeks to describe, decode, translate and otherwise come to terms with the meaning of certain more or less naturally occurring phenomena in the social world." This type of research has been able to allow people to share the deep experiences about the social world in order to have an analysis that will allow the researcher to be subjective. According to Bradley et al. (2007), qualitative research is well suited for understanding a socio-cultural phenomenon within their context, allowing the uncovering of all the links among concepts and behaviours of that phenomenon. Qualitative research has allowed health researchers to make use of a variety of techniques to identify what really matters to patients and carers, and has been able to detect various obstacles and barriers faced by patients in utilizing and accessing health services. Hence, these kinds of techniques have a beneficial impact into improving the quality of health care for most patients and health providers since it they have the potential to deliver essential insights into why non-adherence occur.

It is against this backdrop this study adopted a qualitative research approach to understand the behaviours, attitudes, experiences and perceptions of LGBT students towards utilizing and accessing health services in Durban, to allow the researcher to have a deep and subjective analysis of their [LGBT] experiences towards health services. This study seeks to identify and explore barriers to seeking health care and provide insights into the utilization of sexual health care services among LGBT students in Durban. To identify and confront these issues, the qualitative research allows the researcher to gain rich and detailed information about the perceptions, attitudes and experiences of LGBT students concerning their use of sexual health services on campus and outside campus.

3.3.2. Interpretive paradigm

Adopting and deciding to have a research paradigm and the underpinning oncological and epistemological assumptions comes with a great responsibility because it gives the researcher a chance to understand the vital importance of conducting a study because it provides an outline to think about a research in both a rigorous and logical manner. The research paradigm that has been chosen to inform this study is an interpretive paradigm with the assistance of the phenomenology approach to allow the researcher to gain insights into the lived experiences of the LGBT who have accessed and utilized health services. According to Cohen et al. (2000), interpretive paradigm attempts to understand the behaviours, attitudes, perceptions, beliefs and experiences of participants concerning the social phenomena occurring in the world.

The researcher is concerned with the phenomena that is being studied; hence, the phenomenology approach has assisted the researcher to be more open about the research problems. During the interviews, the researcher has appreciated the differences between the participants to reflect on multiple aspects that contribute to the study. The phenomenology approach was used to seek an understanding of how LGBT students experience marginalization and social exclusion within health services, to make the participants fully describe their experiences from their own view point, and to allow participants to reflect on their lived spaces, lived time, live body and lived human relation to make the researcher get the sense of an idea about how they have experienced prejudice and discrimination in the health environments where there are different people who believe in different opinions. The bracketing process in the phenomenology approach enabled the researcher to have a fresh and clear look at the phenomenon, which in this case, the lived experiences of the LGBT when they accessed and utilized health care facilities.

3.4. Data Collection and Generation Processes

For researchers to support their arguments, they usually collect and generate data that will allow them to understand the social phenomena better, in order to draw stable conclusions regarding the experiences of the participants. Data collection and generation process is a process that allows the researchers to gather data through the chosen research instrument and the relevant research methods and techniques. This study used a case study research methodology, in-depth interviews, and the purposive and snowball sampling techniques to gather qualitative data from

the recruited participants. These processes will be explained further to show the reader how the researcher went about collecting and generating qualitative data for the study.

3.4.1. Case study research method

Case study research methodology has been one of the several ways of doing research in the socially related contexts because it allows the researcher to understand human behavior within a chosen social context or environment. This type of method is usually conducted in a group of people or community that qualifies with the primary criteria of the study. According to Yin (2014), case studies are most relevant when a researcher tend to ask 'how' or 'why' questions. Additionally, the case study method entails that the researcher selects a single group receiving specific treatment which is the same in all aspect. However, the LGBT individuals are only tied together in one abbreviation due to their experiences of social exclusion and marginalization in sexual and reproductive health interventions. As a result, in the case of this research, the aim of the study is to shed insights into some of the challenges facing the LGBT in their utilization of sexual health services.

3.4.2. Sampling techniques

This study used a purposive and snowball non-probability sampling techniques. The non-probability sampling techniques are most relevant to studies that tend to ask questions such as 'why' and 'how' and all individuals in a population are not given equal chances of being selected for the study because the researcher tend to be judgmental and selective when choosing a subset of individuals which will be able to share their experiences regarding what is required for the study.

3.4.2.1. Purposive sampling

This type of sampling technique allows the researcher to use his or her judgements to choose the suitable respondent for the study, as they pick only those who best meets the criteria and purposes of the research. According to Bernard (2013), in the purposive sampling, the researcher decides on the purpose they want the participant to serve and informants are usually judged according to their qualities before they partake in the study. According to Tongco (2007), with this type of sampling technique, the researcher personally decides on what needs

to be known and sets out to recruit informants who can and are willing to provide knowledgeable information acquired from their past experiences who have a virtue of knowledge that can be useful in assisting the researcher to draw conclusions regarding the proposed research questions of the study. The purposive sampling has been exemplified through the key informant technique, where the participants are likely to act as guide of the cultural domain. According to Tongco (2007), key informants comprises of people regarded as observant, reflective actors of the community that the researcher is interested in, who are more willing and able to share knowledge that is reliable and valid information on their experiences that they have went through in the past.

This study's objectives wish to explore the perceptions and experiences of the LGBT students towards health services, to establish the LGBT students' understanding of their sexual health, to explore the provider-client interpersonal relationship from the perspective of the LGBT students, and to investigate the barriers to accessing and utilizing health services. Hence, this requires the identified 'LGBT' informants to share their experiences when they utilize health services to allow the researcher to gain insights in order to draw conclusions on this social phenomenon. LGBT participants are regarded as hard-to-find participants, as some are 'in the closet', hence the researcher first approached the UKZN LGBTI forum from each campus and identified people who possess the qualities required for this study. It was clear that the forum has more gay and lesbian identified individuals, as compared to the transgender and bisexual individuals which made it difficult for the researcher to have an equal distribution of each sexual orientation or gender identity that represents the LGBT within the university. Hence, the researcher first approached those participants who were openly gay or lesbian about their sexual orientation in the UKZN LGBTI forum, and asked them to kindly participate in the study. Through snowball sampling, the researcher was able to find additional participants such as bisexual and transgender participants who fit the inclusion criteria of the study and were share their experiences.

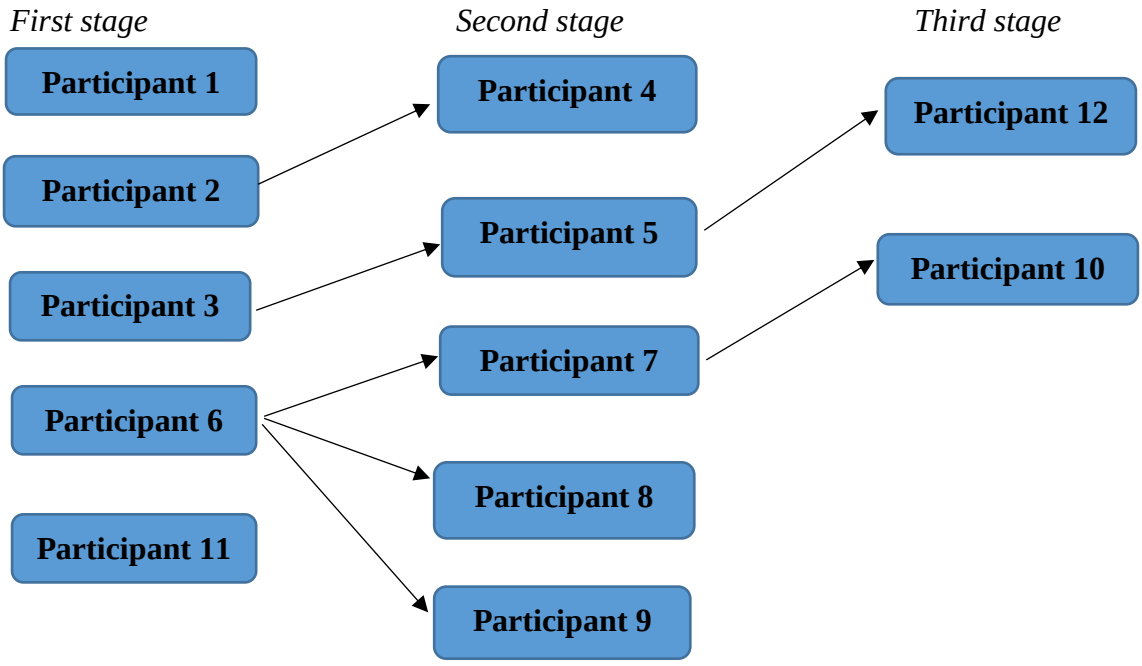
3.4.2.2. Snowball sampling

According to Heckathorn (2011), the snowball sampling was developed as means for studying the social network structures and it was relevant in studies that requires hard-to-reach and hidden populations. This type of sampling has different stages whereby the researcher first conducts interviews with participants that were easily to find, and those people assist the

researcher to identify more people for the study. Purposive sampling was the first stage, whereby the researcher was able to identify the people who had rich qualities required by the study, then the second stage was people who were referred by the people in the first stage, the last stage was the participants who were referred by the second stage interviewees. Figure 3.2 below illustrates how participants were recruited for the study. Participants were given a classification number to protect their identity.

The flow chart (Figure 3.2) illustrates the process of the snowball sampling that was followed in recruiting the participants of this study. Explaining the process, Participant 1 could not refer the researcher to other participants because he said that in the Nelson Rolihlahla Mandela School of Medicine (NRMSM), the LGBTI forum is not well established and it is very difficult to identify a person identified as LGBT because they are treated as a minority. Other participants such as Participant 2, 3 and 6 were recruited through UKZN LGBTI forums in Edgewood and Howard College campus and they successfully assisted the researcher to recruit more people using the snowball sampling and by referring the researcher to them. Participants communicated through WhatsApp on behalf of the researcher, before they even accepted to talk to the researcher. After they agreed to talk to the researcher, the researcher then went through the procedure of explaining the implications of the study and what is expected of them as participants. Participant 11 came through after reading the study post outside the Edgewood Library.

Figure 3.2: The Recruiting Process



3.4.3. Sampled participants

Data gathering is important for every research, as the data is meant to contribute to a better understanding of the chosen theoretical framework and the literature review evaluated in the study (Tongco, 2007). This study has successfully recruited all twelve participants that were meant to be recruited for the research. However, the researcher wished to recruit participants from all four chosen campuses, but failed to recruit those in Westville campus due to their LGBTI forum not being active like Howard College and Edgewood campus. Overall, the researcher was able to reach four gay-identifying students. Three bisexual and lesbian students were also part of the study and two transgender students who were sure about their gender identity even when they have not transitioned to being a woman. Some people would consider twelve as the smallest number for this study, but even one participant for this marginalized group means success because this group consist of people who are marginalized and hard to find, hence knowing about the experiences of even one person would be advantageous to the study because the information they provide is rich and not easy to find.

The purposive sampling was first implemented in identifying the informants who will produce information that is of excellent quality, then the snowball sampling took place since the researcher could not recruit the participants without assistance. The participants were first approached by the researcher are friends of the researcher or part of the UKZN LGBTI forum. The researcher visited a forum in Howard College and Edgewood campus and was able to find people who were open about their sexuality. Then other participants were recruited by first stage informants who spoke on behalf of the researcher. The participant from NRMSM is a friend of the researcher and could not help the researcher with more participants since the forum in NRMSM was not well established. Given the sensitivity of the study, the researcher did not force any participant to come ‘out of their closet’, even when the researcher could see that some in Westville Campus qualify for the study, but one had to be conscious about outing people who were not ready to be known by others.

As a result, all participants who participated in the study were from UKZN and were above the age of 18, as advised in the ethics form. It was clear that eleven of the twelve participants were familiar with the campus clinic, and it was clear that all of them have started engaging in sexual activities, which requires them to protect and maintain their sexual health. Hence, one participant could not utilize the campus clinic due to past experiences in the clinic back home but was familiar with other health services outside campus and around Durban.

Table 3.1: Profiling of Participants

Participant number	Age	Self-described sexual identity	Campus
1	24	Gay	NRMSM
2	21	Lesbian (Butch)	Howard College
3	20	Gay (Bottom)	Howard College
4	21	Bisexual woman	Howard College
5	21	Transgender woman	Howard College
6	19	Lesbian (Butch)	Edgewood
7	20	Bisexual man	Edgewood
8	21	Gay (Bottom)	Edgewood
9	21	Lesbian (Butch)	Edgewood
10	18	Gay (Versatile)	Edgewood
11	24	Transgender woman	Edgewood
12	22	Bisexual man	Howard College

3.4.4. In-depth interviews

In-depth interviewing involves a qualitative research technique which seeks to conduct individual interviews with a smaller number of respondents to explore their perspectives on the social phenomenon that is being studied (Boyce and Neale, 2006). In-depth interviews were used to understand the lived experiences of the participants, which in the case of this study is to understand how they perceive the care provided in health services provided around Durban to identify barriers to access health services, the attitudes they have towards the health providers and their perceptions of the health services that they utilized. Given the sensitivity of this study, the researcher decided to conduct one-on-one critical conversations with the participants, because some participants would feel uncomfortable to answer some questions

truthfully if the interviews were in focus groups. Hence, the researcher decided to conduct research on a one-on-one format because it allows the interviewee to expand more on their experiences and perceptions regarding the social phenomena.

The in-depth interviews for this study were aimed to be less than an hour, but some participants were confident to give the researcher more information that was valuable. During the interviews, the researcher was able to ask follow-up questions after the participant had responded and the interviewees were free to talk to the researcher regarding the follow-up questions since they were not in the interview schedule guide. All participant gave consent for their interviews to be audio-recorded. In addition, the researcher allowed participants to speak in any South African official language they felt comfortable in, however almost all interviewees preferred to respond in IsiZulu because they said it would be very easy for them to speak and share their experiences in the language they felt most comfortable. However, interviews that were conducted in IsiZulu were translated and then transcribed for the purposes of this study.

Most participants lived on off-campus residences, where they share with one or two students the residence room. Hence, the researcher booked the South African Research Chairs Initiative (SARChI) boardroom located in Shepstone building for students who studied in Howard College, and one of the rooms in the Edgewood clinic, which was used for emergency circumstances for the students who studied in the Edgewood campus. The researcher found these two locations much safer for the students who were recruited because the rooms were quiet as they allowed the students to explore themselves truthfully. Additionally, the researcher did not force anyone to come to these locations, as the participants were asked peacefully and calmly if they were going make it to these locations, if they did not, the researcher asked for the location or venue that they would feel comfortable in responding to the questions that were asked.

Table 3.2: Profile of Interviews

Participant number	Registered Campus	Start time of the interview	End time of the interview	Venue of the interview
1	NRMSM	18:22	19:03	Albert Luthuli Residence
2	Howard College	11:42	12:20	SARCHI Boardroom
3	Howard College	11:26	12:21	SARCHI Boardroom
4	Howard College	12:25	12:46	SARCHI Boardroom
5	Howard College	14:02	15:00	SARCHI Boardroom
6	Edgewood	08:36	09:30	Edgewood Clinic
7	Edgewood	09:54	11:15	Edgewood Clinic
8	Edgewood	11:20	12:00	Edgewood Clinic
9	Edgewood	12:31	13:25	Edgewood Clinic
10	Edgewood	13:34	14:15	Edgewood Clinic
11	Edgewood	17:50	18:40	Kingwoods Residence
12	Howard College	12:54	14:04	SARCHI Boardroom

3.5. Reflexivity, Ethics and Analytical frameworks

For this section, the researcher takes the reader to the matters of ethical concerns, how the data was analysed and managed, and the reliability of the study and the limitations of the study. These features allow the reader to understand what the researcher feels would have done more significantly to improve the quality and reliability of the study, how the researcher went about to find ethical clearance for the study, how the qualitative data that was collected was analysed, and the limitations and problems the researcher faced when they gathered data for the study. These components play a significant role in assisting the reader to understand the challenges

the researcher faced and what can be done in future to allow aspiring researchers to prevent these challenges in their future research.

3.5.1. Ethical concerns

Ethics in research has been involved with protecting the dignity of people and the publication of the information in research (Fouka and Mantzorou, 2011). All documents including the ethical clearance application form, proposal form, consent form and the interview guide were submitted to the UKZN Humanities and Social Sciences Research Ethics Committee (HSSREC) on the 11th of April 2018 and were reviewed on the 25th of April 2018. After the ethical reviews and the researcher having done the corrections required by the ethics committee, full approval was granted on the 25th of May 2018 and the researcher was able to collect data for the study. All participants in this study are above the age of 18; hence, there was no need to acquire any permission from the legal guardians or caregivers of the participants. Since this study is sensitive, the researcher was conscious about outing people because all participants who were recruited were 'out of closet' to their friends who referred them to me. The researcher was coherent in clarifying to the referred participants that everything they were going to share during the interview were going to be between the researcher and them, as the researcher wanted to maintain confidentially since it was stressed by the ethics committee.

Before recording the interview, the researcher made sure that they explained everything clearly to the participant, and why the researcher brought the ethics approval letter, gatekeeper's letter and the consent form in the interview venue, which are also attached as appendices at the end of this research. Each document was explained in detail and the interviewees were able to ask some additional questions before the audio-recording of the interview. In the consent form, the interviewee was asked if they give consent to audio-recording their interview since the researcher was unable to copy everything fast discussed during the interview. Luckily, all participants gave the researcher the consent to audio-record the interview. Moreover, they were informed to not mention their name during the interview to protect their identities and were given a participating number as an alias. All recordings are saved on the supervisor's computer desktop folder, which has a password that is only known, by the researcher and the supervisor. All notes taken during the interview and signed consent forms were submitted to the office of the supervisor and are kept safe in the cabinet of the office until five years where they will be

permanently destroyed and shredded. The researcher emphasized that all participants were going to be given feedback after the final submission of the dissertation. In addition, the researcher elaborated that if they want to see the final thesis, they should contact the researcher so that they would see how their responses were written and presented in the final piece.

3.5.2. Data analysis strategy

This study has adopted a thematic analysis, which allows the researcher to categories data into salient themes. For readers to accept this study as trustworthy, the researcher has made sure that the themes coded for this study are precise and consistent to make the reader understand the credibility of this research. According to Nowell et al. (2017), thematic analysis provides core skills for conducting many other forms of qualitative analysis because it can also be widely used across a range of epistemologies and research questions. In addition, it is a method that allows researchers to identify, analyze, organize, describe and report themes found within the qualitative data set. (Braun and Clarke, 2006). In the case of this study, the researcher was able to collect qualitative data through in-depth interviews and coded each significant point into a suitable theme that would represent the similar information that the interviewees possessed.

3.5.3. Trustworthiness, fairness and authenticity

This study has put every effort to ensure trustworthiness, credibility, dependability, confirmability, fairness and authenticity. Participants from various sexual orientations and gender identity were selected and recruited for this study to allow the researcher to have a deeper understanding of each sexuality's experiences in the utilization and accessibility of health services. The researcher made sure that participants were able to make an informed decision regarding their participation because the study is voluntary. In research, credibility and comfortability poses questions of whether the data analysis of the researcher corresponds with the answers of the participants that they provided during the interview. After transcribing each interview, the researcher allowed the participants to look at their answers to check if the captured responses correspond to the experiences that they shared during the interview and that if they wanted to add or remove something, they were allowed to do so.

Dependability in research is often related to the reliability and reflexivity of the whole study. It emphasizes on the stability of the findings of the current study over time (Bitsch, 2005). This includes the researcher's ability to realize how his or her own responses, values, experiences

and beliefs were able to shape the interview. According to Patnaik (2013, p.5) "reflexivity acknowledges the role of the researcher as a participant in the process of knowledge construction and not merely an outsider-observer of a phenomenon." In the case of this study, since the researcher has faced first hand prejudice in this setting or social phenomenon, the researcher was able to understand the experiences from the perspective of the participants. This did not disadvantage the findings of this research because the researcher was able to understand and acknowledge that each person's responses and experiences are different from another human being.

Authenticity in this research entailed a range of realities possessed by the participants. These realities were demonstrated by their concerns and values regarding the social phenomenon, and their experiences according to each sexual orientation or gender identity. It was clear that some of their experiences vary and some were similar according to each sexual identity. As a result, the researcher is confident that the point of saturation was reached with the twelve recruited participants. Further, the researcher was happy with all the responses, as the participants were honest in their responses.

3.5.4. Limitations of the study

The major limitation of this study in the incapability to easily approach LGBT individuals because some of them are still in the closet. The researcher had to be conscious in considering the implications of outing people who were not ready to come out of their closet. Hence, it was very difficult for the researcher to approach people that they did not know, but rather talked to people who were friends with the researcher and who knew the potential participants to avoid misunderstanding and outing them when they did not want to come out. However, this was not really the issue because the researcher used a snowball sampling technique and first approached the people the researcher knew and asked them to kindly speak to other potential participants who may wish to participate in the study.

It was clear that the moment some recruited LGBT individuals heard the word 'health', they immediately lost interest and enthusiasm to participate in the study. Some people believe that once a study is a health-related matter, they are mandated to share their deepest secrets that have been boiling deep down in their hearts. Additionally, since the study is voluntary, the researcher prevented explaining themselves furtherer to those who were not interested and had to find an easier way to approach the participants. Transgender participants were not easy to

recruit, however, through snowball sampling one was recruited and the other one approached the researcher themselves after reading about the study post outside the library.

It was also clear that sometimes doing a study on sexuality requires a researcher to be friends with most of the people in the LGBT who can refer the interviewer to the potential participants who may have an interest in participating in the study. The researcher was planning to collect qualitative data in all four chosen campuses but failed to recruit people from the Westville campus due to lack of establishment of the LGBTI forum. In addition, even the recruited participants said that they did not know anyone from the Westville campus. The poor establishment of the LGBTI forum in Westville campus disadvantaged this study because the researcher was looking forward to exploring the experiences of at least one person from the Westville campus.

3.6. Summary

This chapter has discussed all the methodological procedures that are significant for this study. The researcher was able to elaborate on each type of method and procedure that was chosen for this study. The qualitative research implemented by the interpretive approach was adopted to allow the researcher to gain an insight on each participant's experiences when they utilized health services. This study draws on the in-depth interviews conducted with twelve LGBT students who are currently registered at the University of KwaZulu-Natal. These participants were recruited using purposive and snowball samplings because they were either recruited by the researcher or referred to the researcher by other participants who were friends with them. Every participant who participated had to be sure about the terms and conditions of this study as they formally read and signed the consent form compiled by the researcher. In addition, the researcher was able to submit all ethics forms to the HSSREC for review and was granted approval in a few weeks following. This approval was granted on the second attempt because in the first attempt, the researcher failed to elaborate on some key things that would affect the confidentiality and comfortability of the participants. As a result, the next chapter is the data analysis of this study, which uses a thematic analysis that allows the researcher to group the collected qualitative data into salient themes.

CHAPTER FOUR: FINDINGS AND ANALYSIS

4.1. Introduction

The aim of this study was to provide insights into the utilization of health services among LGBT students in Durban. The findings of this study are drawn from in-depth interviews collected among students identifying as LGBT at the University of KwaZulu-Natal. In the interviews, promoting and inhibiting factors were identified. Promoting factors indicated the positive factors that influence the students to utilise health services on-campus and outside campus. The inhibiting factors indicated negative factors that limit the use of health services among students. It was clear that the inhibiting factors outweigh the promoting factors because participants elaborated more on the challenges and barriers that prevent them from utilizing health services. As a result, sub-themes are separated according to the main themes, which are promoting factors to use and inhibiting factors to use.

4.2. Promoting factors to use

In the interviews, participants were able to identify factors that promotes their use of health services. The factors include the availability of LGBT friendly services, convenience and nearness of the health facility, significance of internet, good health as a priority and resistance and support.

4.2.1. Availability of LGBT friendly services

In most western countries, reduction of health disparities has been one of their fundamental goals in improving public health research and practice (Branstrom and van der Star, 2015). South Africa has tried to improve the quality of life for the LGBT by allowing different organizations to cater for the health needs of the LGBT. Mule et al. (2009) note that it is imperative to know the population that is being targeted for health promotion interventions as it allows people to understand the importance of their health and how to treat it as a priority. In the interviews, they recognised the availability of LGBT friendly health services around Durban. They believed that having homosexuality decriminalized in South Africa, the country has allowed them to access private health organizations that exclusively address the health concerns of the LGBT.

"As I said, CHASU has a better approach to doing that compared to the clinic. If it were that CHASU and the clinic were working hand-in-hand, then the clinic would have a better chance at seeming more accommodating to the LGBT students." (Participant 3, 20 years).

"Well Anova assist gays, bisexuals, transgender and men identifying as MSM, by giving out lubes, condoms, HIV testing facilities and STI screening. It is more like men's clinic, but it only accommodates those who engage in anal intercourse, either receptive or insertive. They are very professional, they keep things confidential and they never judge." (Participant 10. 18 years).

In this present study, it is evident that some participants rely on the availability of LGBT friendly health services because they believe that their needs would be met. In addition, participants recognised CHASU and Anova Health for providing adequate care for the sexual health as they believe that it has a better approach when it comes to assisting the LGBT. CHASU and Anova Health are considered LGBT friendly as they provide the LGBT with certain sexual resources and facilities they need for their sexual health. In these findings, the Andersen Healthcare Utilization Model indicated that the availability of health facilities is one of the significant aspects to obtaining quality care. It is clear that some participants rely on the availability of LGBT friendly health services because they believe that their sexual health needs and concerns would be met.

4.2.2. The internet

Research has indicated that the establishment of the internet has significantly promoted access to information. In the interviews, few participants noted that prior to utilizing health services, they first used the internet to access health information relating to their health problem. It was clear that some participants indicated that the internet is a powerful tool for them to access information on medications they might need for a particular health problem. As cited in Moretti et al. (2012), it was found that approximately 52 million Americans had already searched online for medical information and 70% preferred the internet being the main source of access to

health information. In the present study, two participants noted that they have used the internet to look for health resources that would be useful to the health problems that were affecting them.

> *"First, I use google and search the type of medicine that would work on the health problem I am currently having, then I go buy that medicine in the pharmacy. However, when I feel like the problem persist from the meds I got from the pharmacy, I then go to the clinic.* (Participant 11, 24 years).

> *"I use the internet first before I even go to the clinic, especially when I'm stressed… I learnt about this new medication called PEP, which prevents one from contracting HIV after they have slept with someone positive. They said it works before 72 hours, luckily it was still a day."* (Participant 12, 22 years).

4.2.3. Good health as a priority

LGBT individuals have specific vulnerabilities to STIs and HIV infections due to their specific way of engaging in sexual practices, stigma-related issues and lack of knowledge about their sexual-health needs (Campbell, 2013). Most previous studies found that LGBT patients are more likely to delay their care because of their past experiences with health providers. A study in South Africa by Muller (2017) found that the LGBT patients were more likely to delay health seeking behaviours due to negative stereotypes and prejudice possessed by health providers. In the present study, one participant who frequently utilized mobile clinics for HIV testing noted that he stopped doing his HIV test in mobile clinics because the nurse was mean and judgmental toward him. However, he emphasized that this never stopped him from doing an HIV test in other health facilities because his health was a priority.

> *"I once went to this mobile clinic for HIV testing…Then we continued with the HIV testing…The fact that she was frightened about me having sex with both sexes made me very uncomfortable to even continue with the HIV test…I stopped utilizing mobile clinics after that incident. Even when my friend told me that they were offering USBs, I said I didn't care, I wouldn't want to risk my life and my feelings to be disrespected…Now, I use the campus clinic for*

my HIV testing and I must say that I always have a nice experience with those nurses." (Participant 7, 20 years).

Other participants noted continual utilization of health services after enduring long waiting hours, discrimination and stigma from health providers because they believed their health was a priority.

"Apart from being judged by health workers, I honestly do not fear anything else. I feel like I am the most comfortable person when it comes to talking to the nurses. I do not care about what people say, as long as I get assistance." (Participant 6, 19 years).

"I had to go and check what was wrong with me, but when I got there, I was so irritated and demotivated by the long lines and long waiting hours to get assistance. But I had no choice, but to wait until I get to a nurse or a doctor." (Participant 9, 21 years).

Participants also indicated that they are willing to improve their sexual behaviours and increase awareness towards ensuring that their sexual health needs are met and fulfilled. They also noted that they place their health as a high priority as such they would do anything to be safe. Three participants noted that even when they have engaged in risky sexual behaviours, they would do anything to get help to prevent themselves from contracting chronic diseases. They note:

"*Once in a while, I have used PEP. If ever I get exposed, I immediately go to the clinic to access PEP*." (Participant 1, 24 years).

"*There were no signs that there was a condom used…he said he doesn't remember anything about last night and I had to ask about his HIV status. He said he was clean, but I didn't want to believe that, so that's why I went to the clinic after the incident. When I got to the clinic, the nurses were helpful as we went through all procedures and they were able to give me PEP and I used it for 28 days...*" (Participant 5, 21 years).

"*I was very stressed that I started googling after the incident what might help me if maybe I got infected HIV. So after, I found this medication called PEP, which was very expensive in the pharmacy, so I then decided to go to the clinic, then the clinic transferred me to the hospital where I got help and I used this PEP for like 28 days.*" (Participant 12, 22 years).

Some of the previous studies have noted that the LGBT are quite reluctant when it comes to promoting their sexual health care, while in the present study, this was not the case for the students in Durban. The participants showed enthusiasm when it comes to protecting themselves from diseases because they even elaborated that they would go the clinic for HIV testing every three months. This emphasize that having an enabling factor such as support and awareness from health organizations allow the LGBT to access and utilize health facilities frequently.

4.2.4. Resistance and Support

The constitution of South Africa has been acknowledged globally for demonstrating the inclusive document that protects the sexuality of all citizens. The African continent is known as the most homophobic continent in the world, comprising many countries preventing all forms of same-sex behaviours and activities in the country (Carroll and Itaborahy, 2015; Jagessar and Msibi, 2015). The demise of Apartheid in South Africa has allowed the LGBT to formulate organizations and forums that would support and uplift this marginalized group. Universities have allowed students to establish forums that bring students who face similar challenges together, to allow them to come up with recommendations on how they can tackle those challenges. One in twelve participants noted that the LGBTI forum in their campus was not established like in other campuses because they are only a few students who have come out of the closet, hence they are a minority. This participant emphasized that since their forum is not well-established, the clinic on campus has never addressed their needs differently, hence they are treated like other students. He noted:

"*…forums do help there and there, but since our forum is not well established, I feel like it is very difficult to raise awareness about our needs.*" (Participant 1, 24 years).

Participants believed that having a good constitution has never guaranteed them happiness and equality within the territories of health centres. It was clear during the interviews that participants greatly vocalized the importance of raising awareness about their utilization of sexual health. The LGBT commented that they want public health facilities to follow the medical initiatives and incentives followed by organizations such as Anova Health and CHASU so that they could increase their use of health services. They also believed that hiring more LGBT individuals as doctors and nurses would allow them to use health services frequently because those individuals would have the best interest in them as patients identifying as LGBT.

> "*People should also be aware about their rights and the legislation that was established by the constitution, they should be able to make use of their rights, report discriminating health providers, so the new staff would be hired, a staff that would know that all human lives matters.*" (Participant 1, 24 years).

> "*We need a homosexual health provider who is going to be able to be friendly towards us in the campus clinic and I also think the higher education should have something on their curriculum that addresses the concerns of LGBT health. Even during the interview, they should include questions on the LGBT health so that they would see their suitability of dealing with a diversity of individuals.*" (Participant 2, 21 years).

> "*I think also there should be a compulsory module for all university students, especially the medical students, which would deal with understanding diversity.*" (Participant 5, 21 years).

Participants have also emphasized that they demand support from all university governing bodies, including the Student Representative Council (SRC) because they feel like they have not done much when it comes to supporting the events and campaigns hosted by the LGBT.

> "*Even the SRC is not helpful to the LGBT students because they have never promoted any awareness for the LGBT students on campus, the only people*

they care about are the heterosexual students and their needs" (Participant 2, 21 years).

"*…as the LGBTI forum, we have never been acknowledged by the university or the SRC because they feel like we are a minority and we don't have enough members in the forum for them to provide us with financial resources that might boost the forum.*" (Participant 9, 21 years).

During the interviews, participants made it clear that accepting attitudes towards same-sex relations would be a source of pride in universities because it would allow other students to learn more about same-sex desires and eliminate homophobic behaviours in the future professions. In addition, they believed that the university should implement compulsory programmes that would force every individual in the university to learn more about different behaviours and eradiate homophobia and stigma against the LGBT.

4.3. Inhibiting factors to use

In the interviews, participants perceived health providers as unfriendly and not helpful. Some felt that they were alleged to be mean and neglectful in providing adequate care for the LGBT. They commented that the immoral judgement of same-sex relations, using religion as a driving factor, and they believed that some of health providers were culturally incompetent when it comes to addressing the concerns of the LGBT. They added that they are often judged because of their physical appearance, stigma around LGBT and as a result, face challenges of disclosing sensitive information due to the age of the health provider. As a result, these factors outweighed the promoting factors of health services utilization.

4.3.1. Health provider's principles

Laws criminalizing homosexuality in many African countries have fuelled the incidences of the HIV epidemic, hence the LGBT are dissuaded from seeking treatment in health facilities that offer health care (Hagopian et al., 2017). This has increased high levels of stigma and discrimination by the health providers to provide health care to the LGBT. These anti-homosexuality laws have restricted access to services and have limited provider efficacy, whether intentionally or not (Hagopian et al., 2017). Research in Africa dealing with the LGBT

is often ‘silent’ because of the beliefs that many people perceive any sexual identity other than heterosexuality is deemed to be illegal and morally wrong (Esom et al., 2015; Matolino, 2017; Newman-Valentine and Duma, 2014). In addition, same-sex is regarded as un-African, as people in Africa have valued their cultural and religious principles that demonstrate homosexuality or any other same-sex activity as sinful and immoral. Located in the Southern part of Africa, South Africa has given the LGBT the right to health and has decriminalized all homophobic behaviours against the LGBT in the country. However, most health providers are still faced with challenges of changing their mindset toward the LGBT, as they have failed to treat them equally like other patients in the provision of health services. During the interviews, participants were able to confirm that most health providers are religious, and they tend to impose their religious affiliations in the work environments.

> “*I think religion has a huge impact in influencing the minds of people who are not really willing to learn. Even for health providers and doctors, I still think some would impose their religious beliefs in the workplace, which is just unacceptable because in the workplace, we should treat every patient equally and we are obliged to delivering the best of care they would require…”* (Participant 1, 24 years).

> “*…he was just reluctant to assist me because of how I looked. I was so mad because he was assisting every patient when I got there, but when it was my time to be assisted, he was just furious, and anger was ruling him…he just stepped out and asked someone else to come and help me. I asked the nurse who stepped in why the male nurse stepped out and she said he was uncomfortable in treating and assisting me because the way I am is against his religion. Umm I think if you’re health provider, you should put your differences aside*…” (Participant 5, 21 years).

> “*Religion and Tradition…religion has never approved any same-sex relations, so umh I think that’s where they take their values from”* (Participant 8, 21 years).

The above comments demonstrate that the participants perceive health workers as a barrier to access and utilization of health services. In the Andersen Healthcare Utilization Model, the enabling factor to obtaining care include the quality of social relationships between the health providers and patients. Therefore, this sub-theme can be interpreted as an indication of attitudes, values and interpersonal relationships between the LGBT and health providers. It implies how the health provider would impose their personal beliefs before attempting to providing care for the LGBT patient. Moreover, students were able to emphasize that it is difficult to teach someone who is attached to their religious beliefs and not willing to change because of their faithfulness to their religions. Participants identified a number of challenges with disclosing sensitive information to nurses because they fear that they might judge them by telling them that practising same-sex behaviours is immoral and is against the will of God. Other participant believed that nurses end up being rude once they disclose their sexual orientation or tell the nurses that their problem is sexual related. The participant noted:

> "*So, I got to this nurse who was just rude after I have told her that I had an abscess on my anus, she was like, we like sleeping with other men and doing a sexual intercourse that is unacceptable. Like who said that? She continued and started preaching and telling me that homosexual behaviours are against the will of God, that's why I'm still going to get sick.*" (Participant 10, 18 years).

4.3.2. Limited training

LGBT people have frequently reported negative health care encounters, as most healthcare providers acquire poor medical knowledge, care and training for the LGBT (Parameshwaran et al., 2017). In most previous studies (as elaborated in the literature review), some health providers have reported lack of training and lack of cultural competence in addressing the concerns of the non-heteronormative. During the interviews, participants reported that they were given wrong medication on health problem they were facing, and they elaborated that inadequate coverage of LGBT health-related content in medical schools' curricula influence this.

> "*When I got to the nurse, she just gave me painkillers because she said she could not see nor find anything, but before she even gave me those pain pills, she had to do a pregnancy test.*" (Participant 2, 21 years).

"*They also assume too much. You know even you have flu, they would tell you that you're pregnant, already that would make you feel so uncomfortable*" (Participant 4, 21 years).

"*…usually I do not get the best treatment I need for the sexual health problem I have…*" (Participant 11, 24 years).

"*…sometimes nurses would not express concern if you tell them your sexual health problem and they would give you wrong medication…*" (Participant 12, 22 years).

The above comments illustrate that inadequate knowledge for LGBT health has consequences in delivering appropriate health care. Two of the lesbian participants noted that the time they consulted for a non-sexual health related problem, the nurses forced them to do a pregnancy test as a belief that lesbians can also be impregnated. The participants emphasized that they have never been penetrated in their lives and they play a male figure in all their relationships. Nonetheless, the nurse's insistence to test for pregnancy implies her misunderstanding of the lesbian sexual orientation as conception is only possible through vaginal intercourse with a male. Another participant who is a medical student noted that what they are taught in medical school is not sufficient and adequate to cover all the health issues faced by the LGBT. This student noted:

"*…they do not teach these things in Medical school. Even if they do, they just do not dwell much on the practical experiences of the LGBT community. I think even some of us would finish that module and still feel clueless because of the lack of the practical part they offer in the module. You can even go to Medical school now…they would tell you that they have no clue.*" (Participant 1, 24 years).

The above comment illustrates that in medical schools, the lecturers who teach LGBT health modules are exclusive and they tend to teach without dwelling much on the deep experiences faced by the LGBT. This participant is concerned that the educational system has failed them

as medical students who will be future health practitioners and he emphasized that people who know this field better should be hired to teach them and stop hiring other graduates who just have a qualification in Medicine and Surgery.

4.3.3. Physical Appearance

During the interviews, it was clear that health providers would judge a patient by the time they enter the consultation room. Participants reported that the way they walk, dress and appear in the eyes of the health professionals influence the quality of care the provider would offer to them. According to Cele et al. (2015), LGBT patients cited experiences of discrimination in the health care facilities due to their perceptions of being judged based on their appearance and dress code. In the interviews, participants noted:

> "*I dress like females because that is how I feel. I have never changed myself for people. However, some people think this is a bit of a problem, especially those who also utilize health centres, including the nurses, but I care less, and I am not apologetic about the way I am...The moment you walk in, they start judging and whispering to each other. It is an unbelievable experience when you're transgender or a cross-dresser, the chaos and noise of glancing."* (Participant 5, 21 years).

> "*There was this other time when I was in the clinic and there was this trans-woman who was entering the clinic and sat in the waiting area…people were glancing about how she was. That was very disrespectful I must say*." (Participant 12, 22 years).

In the comments above, it is evident that transgender individuals are the ones who are most burdened when it comes to utilizing the health services because most of them have not transitioned to the gender of their preference and they still possess the features of the sex they were born with. In addition, gender being a predisposing factor in the Andersen Healthcare Utilization Models indicates that one's gender has an impact on the utilization of health services, as some transgender individuals have noted that the attention they receive from health providers and patients in the health centres makes them feel uncomfortable to even access and

utilize health services. In the findings, participant 5 also noted that it is a bit of a problem dressing like a female when in the health centres' forms, it says the opposite. This participant noted:

> "*My problem is that I haven't transitioned fully to a physical woman, so whenever I get to the public facilities, the issue of dressing as a woman while I have features of a man gives the nurses a problem on how they should address my health concerns. The fact that I identified as a male in the facility's form but dressing like a woman is a problem.*" (Participant 5, 21 years).

The comment above emphasize that there is a need for the health care systems to improve the format of their medical consultation forms to allow all patients to specify the gender they prefer to be addressed by in the health centre. Changing the consultation forms would allow patients to pre-identify themselves before the health provider and assess them. This would allow health providers to skip the patient if they feel uncomfortable to treat them and refer them to another health provider within the clinic. Other participant noted that the negative attitudes of health providers change once they see by their [LGBT] physical appearance that they are either gay or lesbian. During the interviews they noted:

> "*I strongly believe it is because of the way I dress, or maybe how I walk or even maybe how I speak because trust me I don't have female voice, even now you could hear me (laughs).*" (Participant 6, 19 years).

> "*No, I have never, I feel like they see through my physique, I don't know if maybe it's because of how I talk or walk, but they just have those perceptions.*" (Participant 8, 21 years).

> "*Obviously the way I dress, my sexual orientation on its own, the way I present myself, the walk, my tone, I think they are not comfortable with that.*" (Participant 9, 21 years).

Participant 8 reported that he never disclosed his sexual orientation, but some health providers would pick up on their sexual orientation in the way he speaks and walks and enters the consultation room. This participant also commented that he never disclosed his sexual orientation because nurses can sometimes be presumptuous, and he fears that if he does, he might lower his chances of being given adequate care he needs for his health.

4.3.4. HIV as a gay disease

Health and utilization of health care services among LGBT individuals are still tremendously affected by marginalization and exclusion, as most LGBT people have reported that they do not seek out health care services due to their past negative experiences in the medical institutions (Quinn et al., 2015). Stigma is still an issue for gay individuals who access and utilize health services within and outside campus because of the historical research of HIV, being an epidemic that was referred to a gay disease because gay individuals were among the highest numbers affected and infected. LGBT people, especially those identified as MSM in the South and Southern Africa have demonstrated higher risks of HIV since the beginning of the epidemic (Lane et al., 2011). According to Lane et al. (2011), several published studies of MSM in some African countries, including Botswana, Uganda, South Africa and Malawi have noted that there are higher rates of unprotected anal intercourse in gays, bisexual men, transgender women and men. During the interviews, participated noted:

> "*As for stigma, obviously people think that when you are gay and accessing a health services, you're probably HIV positive or probably have STIs, you know all those bad things.*" (Participant 1, 24 years).

> "*Being there, a stigma is attached because of being a gay and the type of disease you may have…the judgment is still there, even the stigma from the 90s that stipulate that as a gay person you have HIV, no matter what opportunistic illness you have, it will be associated with HIV.*" (Participant 3, 20 years).

"*As you know also that most non-LGBT identifying assume that we are the ones causing the expansion of HIV. Umh…even the posters you see in the clinic, they would associate gay partners with HIV.*" (Participant 8, 21 years).

The above comments demonstrate that gay individuals are often labelled as carrying HIV wherever they go, especially when they come closer to the territories of health. This stigma can be supported by the historical research on HIV, which associated gay people with the HIV epidemic because of their high risks of contracting the virus. However, in the interviews it was clear that that not only gay individuals perceived this as a stigma against them, even lesbian and transgender participants are labelled to have the virus. The lesbian participant noted that once the nurse see that you are identified lesbian, they force you to take an HIV test even when you are consulting about a non-sexual health problem. The participants noted:

"*For stigma, people see you a walking corpse when you're either gay or transgender because they believe that we are HIV positive...*" (Participant 5, 21 years).

"*…the first thing the nurse suspected was that I was HIV positive and I could not understand because I was very young. I told her I wasn't positive because I'm not sexually active, but then I was forced to do it.*" (Participant 9, 21 years).

This emphasizes that some nurses believe that if you are LGBT, you probably have a chronic disease, especially when they cannot diagnose your problem easily. Participant noted that they fear being labelled and being judged for utilizing certain health services.

4.3.5. Generational gap

During the interviews, participants noted that health providers perceive them as toddlers, and they emphasized that the age of the health provider is bit intimidating for them to disclose some of the sensitive information that made them go to the clinic. Subsequently, they report the wrong information. The participants noted:

"*I just thought she would judge me, considering the fact that she was old, and a female nurse, it felt like you're speaking to your mother telling her about your sexual problems, which is a taboo in our African culture…it just depends on how old they are.*" (Participant 1, 24 years).

"*I think those older nurses should be based in hospitals because it is very difficult to open up to them because it just feels like you are speaking to your parent, which prevents you from speaking a truth and end up addressing wrong information because of fear that they might shout at you because of the motherly love they have.*" (Participant 2, 21 years).

"*The presence of older women as nurses at the clinic might influence the students' withdrawal of disclosing their conditions or even from utilizing the clinic because of the fear of judgment, it is not said out loud but you can feel it. There is an aura of how they feel about certain things and how they feel about you, the impression they have of you.*" (Participant 3, 20 years).

In a study by Alli et al. (2012) among young people, it was found that some health providers were judgemental about young people utilizing SRH services. In this present study, one of the participants believed that having older health providers in the clinic limits their use because they feel like during their study period at medical school that they did not acquire adequate information and training pertinent to address the concerns of the LGBT. Hence that is why health professionals are often unwelcoming towards the LGBT. The participant commented:

"*We still have very old nurses in some health institutions, and I think during their years in medical schools, they did not get adequate information and training on the health of LGBT. Those who are currently studying medicine now, I think they do have something in their curriculum, but I wouldn't know if it is enough…*" (Participant 7, 20 years).

"*The nurses in the clinic back home are totally rude and very homophobic, I don't know if maybe it is because they have older nurses who are old enough to be our grannies, they just don't understand these things*" (Participant 10, 18 years).

The Andersen Healthcare Utilization Model takes age of individuals into consideration because it notes that the age of individuals has an impact on their utilization of health services. Age is very important as it allows individuals to know if they qualify for a type of health care. In the case of this study, LGBT participants emphasized that being young and attended by an older health provider is a problem because most of them are morally judgemental which results in delivering poor health care to the LGBT as they believe that same-sex relationships are against the will of God. Additionally, this study has demonstrated that SRH issues faced by the LGBT in terms of access to sexual health services are by and large similar to the challenges faced by young people in accessing SRH services. For instance, looking at the issues addressed by this study including intergenerational gap, cultural and religious perspective of health providers and the attitude with regards to age of the sexually active young person.

4.3.6. Financial constraints

This subtheme presents indications of what low-cost health services mean to the economically challenged populations. Being unemployed and financially disadvantaged has been linked to low utilization of health services as some patients cannot afford health insurances. During the interviews, participants noted that some preventative measures they need for their health are expensive and this forces them to delay their use to health services. Some participants noted that they would never attend public health facilities because of their past experiences, hence they would rather wait and save for a private doctor before they utilize health services. During the interviews, they noted:

"*I did try accessing hormonal therapy, only to find out that the process is financially constraining. The hormones and surgery are just expensive, so that is why I decided to delay until I get successful to transition.*" (Participant 5, 21 years).

> *"Some of us even decide to waste the money we do not have for consultations, we even delay because of saving for consultation fees with private doctors.*" (Participant 12, 22 years).

Other participants noted that they would prefer consulting a private health provider because they believe that most private institutions are well trained and informed to address the concerns of the LGBT or any individual, irrespective of their gender or sexual orientation. These participants felt that other incentives addressing the concerns of the LGBT are not usually there in public health services. Hence, they noted:

> "*Like I said, it is not seen as a priority in public clinics... It is when you go to private institutions where you might be able to access such implements.*" (Participant 3, 20 years).

> "*I have never been in a private facility, I don't have enough money to pay for their medical costs, but if I did, trust me, I'd be going to there every week for consultation because I believe that most providers there are well trained.*" (Participant 7, 20 years).

Another participant said that she pays a lot of money to consult with her general practitioner (GP) and she expects him to treat her equally like other patients. She noted:

> *"As for my GP, I feel like he would put his feelings aside to assist me because he is very professional and very good in what he does. I am also paying him a lot of money.*" (Participant 6, 18 years).

4.3.7. Unavailability of sexual health resources

In the interviews, participants noted that South Africa's health system has not guaranteed them adequate health care because in most public health facilities, LGBT health concerns are not often addressed. They mentioned that public health services are structured in a manner that is accommodating to only heterosexual participants. Almost all participants confirmed that public health services around Durban are not LGBT friendly and that they fail to address their sexual health concerns due to the unavailability of sexual resources such as lubricants. Lubricants are

used mostly by the MSM and transgender women to ensure comfortable anal intercourse. Sexual health resources required by the LGBT tend to be hidden and not displayed publicly like other resources required by heterosexuals. According to Rebe et al. (2014), lubricant distribution has remained poor in many developing nations, including South Africa. During the interviews, participants noted:

> "*…the resources are just not there, you know, knowing you going to get there and ask for lubes and not get them, it is just draining and tiring …*" (Participant 1, 24 years).

> "*Even in the table in the entrance, there are always condoms, but no lubes. I doubt they accommodate everyone. The unavailability of lubes at times reminds me of the clinics back home where they do not even know what lubes are.*" (Participant 7, 20 years).

> "*The clinics outside campus are just constructed in a manner that is friendly to only heterosexual patients, you wouldn't find lubes lying around in every corner just like female and male condoms.*" (Participant 8, 21 years).

> "*…the lubes are sometimes not available in the campus clinic*." (Participant 12, 22 years).

One of the questions in the interview guide wanted to explore the preventative measures commonly used by the LGBT. It was clear that condoms and lubricants were mostly used by LGBT individuals. Most interviewed lesbians noted that they did not practice any preventative measures because there is really nothing for them to use. However, one in four interviewed women who have sex with women (WSW), including the bisexual woman and the lesbians, said used finger cots and all of them reported being aware of condoms but never used them. The researcher then asked if they were aware of a dental dam, one in four said she was aware but has never used it. A dental dam is used for oral sex and it helps prevent the spread of STIs and other germs during oral sex. This implies that when most lesbian individuals utilize the clinic for advice on how they can practice safe sex, health providers are likely to report

incorrect information, telling them that they are not in any risk of contracting chronic diseases. The participants noted reported:

> "*I do not use any because we do not know of any preventative measure to use.*" (Participant 4, 21 years).

> "*I feel like they are not informed because look I did not even know about the dental dam, I think the nurse should have told me if she knew what it is. I think their education is not enough because it is just exclusive.*" (Participant 6, 19 years).

> "*I think I have heard of a dental dam, from friends…they said it doesn't have that a 'wow factor', and I doubt I'd ever use it unless if my partner insists.*" (Participant 9, 21 years).

At least half of the participants did not perceive health services as LGBT friendly and competent because they mentioned that many public health services do not have posters, pamphlets and brochures addressing the sexual health concerns of the LGBT. Hence, they find these health facilities as 'heterosexual-accommodating'. Most health services have been structured to serve and cater to the need of the heterosexual population, as most posters and brochures in the clinics and hospitals tend to display the sexual problems faced by the heterosexual people. Hence, participants noted that this has prevented them from utilizing health services because they never know if their needs would be met. They commented:

> "*But, I think another person may have felt a little uncomfortable, because you find that the clinics doesn't display or exhibit any forms of comfort or acceptance towards gay people, in any way. You don't necessarily have to have a big gay banner in the entrance but maybe a few posters regarding MSM or WSW would sort of make the place a little more accommodating for the LGBT and make them feel more comfortable, without anything being said but you just to feel comfortable walking in.*" (Participant 3, 20 years).

"*Even the posters in clinic speak for themselves, they are just accommodating to heterosexual patients. Even the pamphlets, they are just not addressing the problems of lesbians or LGBT community*." (Participant 6, 19 years).

"*I believe that if there are posters and pamphlets within public health services portraying some of the health conditions affecting the LGBT community, it would make things easier for us to continually utilize the clinic because we would know that our needs would be met.*" (Participant 8, 21 years).

4.3.8. Geographic location

During the interviews, participants were able to compare the services offered within campus and outside campus. Most respondents preferred the services offered by the university clinics because they believed that health providers who work there are understanding since they know that they are dealing with students.

"*…here on campus, the nurses know what they are doing, they are informed as they know they are also dealing with students.*" (Participant 8, 21 years).

"*Yes, they are well-informed, especially here on campus because I feel like they do get this kind of education in medical schools and the fact they know that they are dealing with students*." (Participant 12, 22 years).

Two in twelve participants noted that consulting in a clinic located in a township is a challenge, especially when you are gay. They emphasized that people would use defaming names or act homophobic when they walk towards the clinic and one in two implied that he never felt safe accessing the clinic that he was transferred to by the campus clinic.

"*It is a hostile environment, you find a variety of people from all walks of life; concerning for a person like me that is an openly bottom gay person in a public space of all ages and all mentalities of people.*" (Participant 3, 20 years).

"*It is in a township, where some people are still not accepting of the LGBT community.*" (Participant 10, 18 years).

Two participants believed that studying at UKZN allowed them to find themselves and to learn more about the things they were never told about in the clinic back home.

"*Being a student here has allowed me to come out of my closet and to explore most of the things I feared to explore during my high school days. As someone from the rural area, I think being in an institution, located in an urban area allowed me to stop being in denial about my sexual orientation.*" (Participant 7, 20 years).

"*So, before I got to the university, I would engage in sex without a lube and you would feel the anus being tense and not willing to allow the penis to enter, and you would find that the condom would break at all times. So, when I got to varsity, I learnt about the lube from the forum, and I started using it and it is so nice using it with my male partners, it softens the anus.*" (Participant 12, 22 years).

The Andersen Healthcare Utilization Model indicates that the location of the health service facilitates the accessibility, availability and utilization of those health services. It has been clear that participants were able to emphasize that moving to the urban area was of great significance as it positioned them to expand their knowledge of sexual health issues. Other quoted participants emphasized that they would endure hate crimes because the location of the health facilities they attended were nearby where hostile homophobes live.

4.3.9. Patient waiting time

According to Tran et al. (2017, p3), "patient waiting time is considered as a crucial parameter in the assessment of healthcare quality and patients' satisfaction towards healthcare services." Time is very important, and it assesses the quality of service delivery for patients accessing the

health services. During the interviews, it was clear that some participants noted that long waiting time in the clinics has a negative impact on the use of health services.

> "*I was so irritated and demotivated by the long lines and long waiting hours to get assistance. But I had no choice, but to wait until I get to a nurse or a doctor. I waited and waited and finally my name was called.*" (Participant 9, 21 years).

> "*Sometimes they would tell you to come the following day where there will be a doctor who can assist me, that's very demotivating, having to wait today and thinking of waiting on the long lines the following day.*" (Participant 11, 24 years).

4.4. Summary

It is evident from the in-depth interviews that students perceived public health services to be more accommodating to the heterosexual people. They emphasized that the health system of South Africa has failed them because certain preventative measures they require for their sexual health care are not always available in most health services. The use of health services among LGBT students relied on how culturally competent they perceive a health facility because they noted few private organizations that are addressing their concerns. In the interviews, it was clear that the LGBT is continually experiencing stigma, discrimination and marginalization because health providers are not adequately informed to address their needs and they fear judgement from other patients and health providers.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

5.1. Introduction

Previous research has indicated that the utilization of health services among LGBT is dependent on their past experiences, level of comfort to disclose their sexual orientation or gender identity and knowing that their health complications will be taken care of when they visit the health facilities (Quinn et al., 2015; Whitehead et al., 2016; Felsenstein, 2018). In the present study, it was clear that non-heteronormative individuals are continuously excluded in government health policies because they emphasized that only a few private organizations are able to meet their sexual health needs, and nurses are not well trained and informed to address the concerns of the LGBT. It has been clear that research on the health of the LGBT is presently growing as many governmental public health agencies have called for policy and intervention programmes aiming at addressing the concerns and needs of the LGBT (Bränström and van der Star, 2015). However, this has been relevant in European countries where most countries have legislated against anti-homosexuality laws, whereas in Africa, governments have been reluctant to entertain the concerns of the LGBT as they believe that same-sex activities are un-African and an affront to God and the natural order (Bränström and van der Star, 2015; Kalamar et al., 2011).

This study has shed light on the factors influencing utilization of health care services by the LGBT, and it was clear that some of the findings of the research are consistent with other research undertaken in the previous years. Research on the health of transgender remains limited; however, a number of studies are emerging that are focused on this marginalized group. In previous studies, it was clear that transgender patients continue to be marginalized and excluded in health policies, as their health education is not covered in medical schools (Luvuno et al., 2017). Consistently with this study, transgender participants noted that they do not receive assistance for their sexual health because health providers are not informed in addressing their concerns and needs.

Qualitative research methods were used to provide insights into the utilization of health services among LGBT students. Qualitative research has been criticized for lacking representation due to the number of participants recruited for the study. First, this is a sexual health research and the population group selected is among the most marginalized social groups in the world. Second, information collected, no matter how minimal, adds richness and value because the LGBT is marginalized, and research has been limited in this population because

people do not have courage to speak due to fear of rejection. Finally, it is in the hope that this study will open more discussion around homosexuality and provision of care, even in countries where homosexuality is criminalized. Hence, the findings of this study were not generalized to display the experiences faced by other LGBT individuals because participants are in a higher education institution. As a result, this study draws on the Andersen Healthcare Utilization Model (AHUM), which emphasizes the factors influencing utilization of health services.

5.2. Discussion

In the study, it was clear that there are several factors influence the LGBT's access to health care services, additionally, the inhibiting factors outweighed the promoting factors. Participants had more negative comments to say about South Africa's health care system, compared to the positives that promoted their use of health services. Participants believed that health services are still constructed in a way that is accommodating to heterosexual people. They emphasized that by the setting and construction of the health service, one would know if their needs would be met.

In the findings, participants perceived health providers to be judgmental because they felt that they tried to impose their beliefs onto clients during the consultation time, which has led to the fear of disclosing sensitive information such as sexual health and sexual orientation. This is relevant to a study that was conducted by Cele et al. (2015) where it was found that health providers were curious about same-sex behaviours. In another study by Cele et al. (2015), some health providers would start to judge and impose religious beliefs onto their LGBT patients once they disclose their sexual orientation or if they see that, the health concern of the patient is closely related to engaging in same-sex sexual activities. In the present study, one participant also noted the judgmental and religious attitudes of the nurse after he told her that he had an abscess around his anal wall. Further, this participant believed that this is one of the main reasons that has prevented him from utilizing public health services because he felt like the nurse was rude and not willing to assist due to continuous judgement about his sexual orientation and his health concern. Consistent with a study by Hunt et al. (2017) in Zimbabwe where LGBT participants reported widespread stigma and discrimination because they were blamed for their illness as a result of their sexual identity.

Same-sex engagements has been fashioned to be un-African by many scholars. Previous research has indicated that most people in Africa disapprove of homosexuality because they

believe that it is a western imported social identity. They believe that God created a cis-gender man and woman, whom together would be able to increase the population. Msibi (2011) argued that homophobia and hatred against LGBT is not only dependent on the African leaders who have publicly disapproved of homosexuality, but also dependent on the unsubstantiated claims of the identity portrayed by homosexuality and their contradictory ideas on morality. Africa has remained the most homophobic continent because African leaders have continually criminalized homosexuality in their countries due to the beliefs that it is an affront to the natural order and morality. It was clear that, participants believed that some of health providers were very religious and this prevented them from delivering adequate and appropriate care for the LGBT. A transgender participant noted that the male nurse had to step out when she entered the consultation room, which led to being treated by another nurse who was able to tell her the problem of the male nurse. This emphasize that, some health providers have failed to put their differences aside to assist every patient equally.

The findings of this study have supported previous literature, which has indicated that health providers have limited training and knowledge in addressing the concerns of the LGBT. According to Luvuno et al. (2017), transgender health is not covered in the curriculum of the medical school, which have led to the alienation of their health care. In this study, it was clear that participants believed that health providers are not adequately informed to address their concerns. They believed that LGBT health is not covered broadly in medical schools because some do not even know the kind of medications they should be prescribing if one has a sexual problem. Butch lesbian individuals (male role in a relationship) noted that they were forced to take a pregnancy test, even when they knew that they have never been penetrated. This emphasize the assumptions health providers have when female patients access the clinic. Other participants, including gays and transgender individuals, believed that they did not receive the best medications to treat the health problem they experienced in the past. They noted that the medications they receive are similar to those prescribed to heterosexual patients when they have headaches or stomach cramps. In a recent study in the U.S. by Hafeez et al. (2017), LGBT respondents reported inadequate training of health providers in addressing their concerns. Consistent with this study, participants perceived health providers to be less knowledgeable and informed about LGBT health.

During the interviews, there was not much shared on the importance of sexual health care because participants emphasized that the health system of South Africa has failed them in normalizing homosexuality and constructing health services as accommodating for the LGBT.

They noted that enduring stigma and discrimination has become a norm because they would continually utilize health services even after they were treated badly in the past. However, some emphasized that they would lie about certain information such as disclosing their true sexual orientation or identity to receive assistance. For instance, one bisexual participant gave incorrect information to allow the nurse to prescribe PEP for him. This emphasizes the inability of patients to disclose some sensitive information because they believed that they were going to be denied health care and be judged for engaging in a particular sexual activity.

Participants believed that the availability of private health organizations such as CHASU, Anova Health and Isidayi has had significant impact on their sexual health. They noted that health providers in these facilities are well informed and they know what they are doing pertaining to assisting the LGBT. They added that all preventatives measures such as lubricants, condoms and finger cots are always available and accessible in places where they can collect them easily. In this study, participants believed that public health facilities in South Africa are constructed and structured in a manner that is accommodating to only heterosexual individuals. They commented that lubricants are often hidden and not displayed publicly for them to access. Rebe et al. (2014) noted that the distribution of lubricants in developing countries, including South Africa has remained poor. MSM in these countries has been forced to buy lubricants, however research have shown that lubricants are often expensive and the MSM end up engaging in risky behaviours as a result of feeling alienated in the health services (Romijnders et al., 2015).

The relationship between patients and health services is considered significant and essential in strengthening the quality of life and care (Albuquerque et al., 2016). In this study, participants noted that it is very intimidating to communicate openly with a health provider that is much older than you are. They believed that speaking to an older nurse is like speaking to their biological parent, who does not know that their child has started engaging in sexual activities. In the study, participants noted that their ability to open up to health providers about any health problem relied on the age of the provider and how friendly the provider is towards them when they enter the consultation room. Most studies on young people utilizing SRH services have indicated that they are likely to be judged by health providers, which often limits their use of health services and their willingness to disclose sensitive sexual information (Alli et al., 2012; Bearinger et al., 2007). The findings of the study are consistent regarding the health providers being mean and judgmental towards the LGBT. However, the participants also emphasized that not only the LGBT face the burden of being judged, but also the heterosexual patients.

In the study, participants noted that some health providers would judge them as they walk into the consultation room. A study by Cele et al. (2015) found that homosexual respondents cited experiences of prejudice and stigmatization when health providers labelled them on the basis of their physical appearance. Consistent with the present study, it was clear that participants experienced judgement and stigma due to their physical appearance. They mentioned that the attitude of the health provider changes once they enter the consultation room. One of the two transgender participants noted that the moment she entered the consultation room, the male nurse decided to step out. However, she added that not all nurses hold negative attitudes, some would be nice and willing to listen to what she had to say.

During interviews, participants had much to say about barriers limiting their access and utilization of health services. They mentioned stigma, discrimination, marginalization through the construction and planning of health services as accommodating to heterosexual patients, unavailability of sexual health resources, financial constraints, nearness of health services and the waiting time in public health facilities. The LGBT has been stigmatized and discriminated because of the historical research that HIV was a gay disease. In the interviews, participants cited that they fear coming closer to public health services for consultation because they would be judged by other patients in the clinic. One participant emphasized that the services are good on the campus clinic because there are students who understand the LGBT, however some participants noted that they fear utilizing a clinic on-campus because a friend might see them accessing a particular service that might be for chronic infections.

Studies have shown that MSM are at a high risk of contracting HIV due to the way they engage in sexual practices and the discriminatory attitudes they endure when accessing health services (Lane et al., 2011). It was clear in this study that all participants perceive themselves to be at risks of contracting any disease because their needs are not adequately met by health services. Previous research has indicated that only heterosexual women, MSM and transgender people are at a high risk of contracting HIV (Reif et al., 2018). In this present study, lesbian noted to be labelled HIV positive, however they never perceived themselves to be at any risks regarding contracting and transmitting sexual infections. Studies indicated that lesbians can also contract HIV or STIs because some of them have engaged in sexual relationships with men in the past (Sandfort et al., 2013; Muller, 2014). This study calls for future research that would investigate medical risks required by each sexual orientation. Research on lesbian would have a great impact in health research and public health advocacy for WSW because there has been limited information on their health risks.

Studies has indicated that MSM and transgender women who cross-dress are likely to experience HIV stigma due to historical research of HIV and gay people (Bockting et al., 1998; Lane et al., 2011). In the present study, lesbians also noted that they have experience of HIV stigma from their peers, even when they were not HIV positive. They emphasized that other patients who utilize clinics would label them HIV positive due to their beliefs that everyone who identifies as LGBT is promiscuous and has multiple sexual partners. This study has found that not only gay individuals perceive themselves as stigmatised, but also lesbian individuals. Previous studies on LGBT health and utilization of health services could not cover the significance of internet in browsing for medications. This present study found that some LGBT people perceive the internet the easiest tool that allows them to know which medications could work in case they are afraid of utilizing health services due to the past experiences.

The health system of South Africa does not adequately provide health care for the LGBT because most public health facilities are constructed in a manner that is accommodating and friendly to heterosexual patients. During interviews, participants noted that there is a lack of posters and brochures addressing the health concerns faced by the LGBT. They believed that if health services are constructed in a manner that is accommodating to the LGBT, their access and utilization would be improved because they would know that their needs are met in that health centre. Participants were also concerned about the admission forms in the health services provided in the country. They mentioned that health services should allow them to self-identify themselves in the forms before they are attended to by health professionals. Moreover, they believed that this would eliminate the fear of disclosing their sexual orientations or gender identity to health providers because they would know the kind of human being they are treating. This is similar to a study by Felsenstein, (2018) in the U.S. where LGBT patients considered 28 clinics to be heterosexually constructed because the admission forms did not allow them to identify their sexual orientation or gender identity before consultation.

Preventative measures required by the LGBT for their sexual health care are not always available in the campus clinic or in public government health facilities. Participants noted that lubricants are not displayed publicly, and if they are, they are displayed in a place where everyone accessing the clinic can see. Some commented that this is rather intimidating because they are still in the closet, having to take a lubricant in front of students or other patients would attract attention and raise questions about their sexuality that they were not willing to discuss at that moment. Studies have indicated that only in homophobic countries, the LGBT is disproportionally burdened in accessing appropriate preventative sexual health measures due

to beliefs that those preventative measures would perpetuate homosexuality (NWLC, 2014; Fallon, 2016). The present study is conducted in South Africa and it was clear that even in South Africa, the LGBT find it difficult to access some of the preventative measures such as lubricants and dental dams. Gay participants commented that the nurse's lack information about lubricants, as they mentioned that they would ask for a lubricant from a nurse and the nurse would not know what that is. This implies inadequate LGBT health education in medical schools because if they did have adequate training, they would know what a lubricant is or what other certain preventative measures are required by the LGBT.

Research has indicated that most lesbians often receive inappropriate health care because health providers make incorrect assumptions about them and some are not aware of their health risks (Simkin, 1998). This present study found that health providers still lack appropriate knowledge in treating lesbian patients because lesbian participants reported that ever since they have utilized health services, health providers have never told them about certain preventative measures they can use for their sexual health. Moreover, all participants demonstrated lack of information about other preventative measures used for LGBT sexual health. It was clear that some had no knowledge about a dental dam that is used when practicing oral sex. Lesbians believed that if health providers had adequate knowledge on LGBT health, they would know the kind of preventative measures required by lesbians when engaging in sexual activities. Matebeni et al. (2013) argued that lesbians have been perceived as not being at risk of HIV infection because of their assumed sexual activity with other women. In the present study, one lesbian participant commented that the nurse said she was not at risk because the type of sex she engages in is already safe. Studies have shown that this assumption overlooks one's sexual history and does not consider the facts that they might have engaged in sex with men (Matebeni et al., 2013; Sandfort et al., 2013).

Low- and middle-income countries (LMICs) have been affected by inequities of access to health services due to financial barriers. According to WHO (2010), more than a billion of people in LMIC have been unable to access needed health services, as those services are unaffordable. South Africa's legislation has promised adequate health care for all; however, incidences of inequity largely remain (Harris et al., 2011). Participants demonstrated willingness to access private health services because they believed doctors in the private health sectors are well educated about the needs and concerns of the LGBT. They noted that the public health sector has inadequate provision of services and long patient waiting times, which have contributed to the inhibiting factors to use of health services. Participants mentioned that

preventative measures such as PEP and lubricants are expensive in pharmacies. They noted that in order to get PEP in public health facilities, one has to lie about their sexual orientation or gender identity due to fear of denial and delays in being given PEP. Participants also noted that the proximity of the health centre promotes their use of health facilities. They were able to compare the on-campus clinic with the outside health facilities and they noted that the on-campus clinics are better than those provided outside because those outside campus are always full and sometimes they do not find the assistance they need for their sexual health.

Previous studies on health care utilization among LGBT were unsuccessful in acknowledging the significance of internet for the access and use of health services among LGBT. This present study found that the internet is a powerful tool for some LGBT, as it allows them to access medical information before they utilize health services. Participants noted that the internet has profound influences on their quality of healthcare. They emphasized that the internet has allowed them to access certain health information to prevent and treat themselves from different illnesses. It was clear that their use of the internet was depended on the challenges and barriers they endured in the health services, including long waiting time, negative attitude from health providers and discrimination they faced from other patients who were utilizing the health service. They implied that the internet allows them to improve their sexual health through buying medications in pharmacies to treat a perceived illness.

The Andersen Healthcare Utilization Model has confirmed some of the factors that influence the use of health services among the LGBT. It was clear that there were more predisposing and enabling factors influencing the use of health services among LGBT in Durban. The predisposing factors included age, gender, knowledge that patients have towards health care system and the attitudes towards health services. In this study, LGBT students were quite concerned about their age and the age of the health provider, as they noted the difficulty to feel comfortable to disclose sensitive information to a health provider that is much older. Participants noticed a generational gap that limited their use of health services because they believed that when a health provider is much older, they are less likely to be accommodating towards same-sex relations as a result of cultural and religious attachments. Participants commented on the construction of health services as non-LGBT friendly and accommodating towards them. They mentioned that gender also has an impact on the utilization of health services because an individual would know if their needs are met in a particular health service by looking at the design and construction of that health service.

The knowledge that LGBT students have towards the health care system was also noticed in this study. Lesbian participants perceived themselves to be at lower risks in contracting STIs. They continually mentioned that the sexual activity they practise is already safe and others would not contract any illnesses for them. Almost all participants noted that they would engage in oral sex without using anything to cover their mouths because they are not aware of any preventative measure that is used to protect someone from contracting diseases when practising oral sex. All participants commented that the health care system of South Africa has failed them by hiring incompetent and unfriendly health providers who lack training on the health of the LGBT. Participants demonstrated a negative attitude toward public health services because they believed that it is only accommodating to only the heterosexual patients. Further, they mentioned the lack of preventative measures they require for their sexual health, absence of posters and brochures addressing their concerns in the health facility and the stigma and discrimination attached to the LGBT when they utilize health services.

The enabling factors that came up in this study were logistical aspects of obtaining care such as income or health insurance, quality of social relationships with health providers, the availability of health personnel and facilities and the waiting time. In the interviews, those participants who could not afford medical aids emphasized that if they had a stable income, they would consult private doctors because they believed that paying them would also force them to deliver quality care. They emphasized that if lubricants and condoms were not available in the health facilities, they were forced to use the last money they had to buy those preventative measures. The quality of social relationships with health providers in this study was unsatisfactory because LGBT students perceived other health providers to be unfriendly, mean and judgemental towards them when they disclose their sexual orientation. LGBT students, especially gay participants were satisfied with the care delivered by private organizations such as CHASU, Anova Health Institute and Isidayi because they noted that health providers in these organizations are well trained and knowledgeable to address their sexual concerns. Hence, the availability of health personnel and facilities that are accommodating towards the LGBT has a significant impact on their continual use of health services to maintain their sexual health.

In this study, there were limited need factors that influenced the use of health services among LGBT. Participants noted that they perceived themselves at risk and demanded health care only when they have engaged in unprotected sex. The need factors in the AHUM emphasizes people's perceived and evaluated needs when they judge their own health status and their need for medical care (Andersen, 1995). In this study, participants noted that they immediately

utilize health services for PEP and HIV status when they engaged in a sexual intercourse with someone they did not know of their status.

5.3. Recommendations

During the interviews, students were able to mention what they want to improve their use of health services. The researcher gave them an opportunity to recommend measures to win their dignity back as the LGBT. Participants suggested that there should be a compulsory module in all higher education institutions that would teach all students diversity and gender identities to eliminate homophobia. They were confident that implementing a compulsory module would teach students how to behave around people who are different, to treat them equally and keep in mind that everyone was born to serve some purpose in this world. Students also recommended that each LGBT person studying in higher education institutions should use their degree as a weapon to change the world when it comes to promoting justice and equality. They believed that with their degrees, they would inspire the youth back home and tell them about university life, to make things easier for them when they get to university or college. Concerning health care, they noted that health providers should be given adequate training to better serve the needs of the LGBT health in medical schools, to reduce incidences of stigma, discrimination and prejudice because they believed that their lack of acceptance towards the LGBT was also a significant factor that continuously inhibits their use of health services.

South Africa still had much work to do to improve the quality of life for LGBT individuals. Globalization has been a significant tool that has allowed the interconnectedness of countries. Taking globalization into consideration, countries should work together to implement policies that can assure equality and dignity to all individuals accessing health services. Studies have shown that most western countries have taken an initiative to promote equity for all by increasing LGBT friendly health services that are affordable to all citizens. According to Branstrom and van der Star (2015), governmental health agencies in Europe has called for policy and intervention programmes addressing the specific needs of the LGBT. Studies have indicated that health disparities among the LGBT are not as prevalent in the western countries because governments have invested and funded research to examine health disparities and the determinants for the health of LGBT.

Ineffective policy planning has led to health disparities, barriers to seeking health care and delayed utilization of sexual health care services among the LGBT worldwide. Hence, South

Africa should adopt certain public health policies that would specifically address the improvement of the health of the LGBT. According to Albuquerque et al. (2016, p.8), "intervention strategies, such as continuing education, can be adopted to prepare health professionals for non-discriminatory service directed at the LGBT group, granting the right to comprehensive care, as provided in the legislation." Health providers and medical students should be exposed to a curriculum that specifically deal with LGBT health, and the Department of Health should create initiative programs in public spaces where every health worker would be able to interact with the LGBT through medical check-ups, STI screenings and SRH education to improve their exposure to the concerns of the LGBT. In Kenya, a training for health providers on MSM education and their sexual behaviours demonstrated a reduction in prejudice attitude and increased health workers' knowledge regarding addressing the concerns of the MSM (Van der Elst et al., 2013).

Branstrom and van der Star (2015) recommended that more education, knowledge and research concerning the health of LGBT is needed to reduce health disparities. This present study confirmed that there is still limited research on the health of lesbians and the transgender persons. It was clear that lesbian participants perceived themselves not to be at any health risk as they do not practice any safe sex because they were told by health providers that their sexual activity is already safe. Future research should explore the health risks among lesbians because some of them have experienced sexual intercourse with men in the past. Hence, this should be integrated into comprehensive LGBT education and advocacy.

Implementations of anti-homophobic initiatives should be implemented through allowing every citizen to partake in decision making in a country. Considering homophobic countries, a constitution should favour every citizen that reside in that territory. There is a need to normalize LGBT sexualities in homophobic regions, where heterosexuality would be challenged and destabilized to protect the rights of the LGBT. It was evident in this study that participants mentioned that health services are constructed in a manner that is accommodates only heterosexual patients. Hence, interventions such as destabilizing heteronormativity and normalizing LGBT concerns in health facilities are recommended to allow the LGBT to feel free when they enter health facilities.

5.4. Conclusion

The overall aim of the study was to provide insights into the utilization of health services among LGBT students in Durban. The findings indicated that there are both promoting and inhibiting factors that influence the utilization of health services among the LGBT. It was clear that the inhibiting factors outweigh the promoting factors because students had much to comment on regarding the factors that limit their use of health services. In the in-depth interviews, students were able to propose solutions to the numerous challenges that limits their use of health services on-campus and outside campus. However, students believed that they have no voice because they are still a minority and they tend to be not heard when it comes to advocacy and support because heterosexuality is still dominant in all the spheres of society.

In previous research, it was clear that most of the focus is on MSM and gays due to the stigma attached to HIV. Africa has remained the most homophobic continent, making it a challenge to conduct research among the LGBT due to the criminalization of same-sex activities. The available literature in some African countries indicated that the LGBT individuals are continually deprived access to adequate health care (Fallon, 2016; Hunt et al., 2017; Kaliza, 2017). In addition, studies showed that health providers display homophobic attitudes towards the LGBT through their denial of health services and judgmental attitudes during consultation. It was clear that previous studies support the findings of this study, however, there were also new findings that this study established. New findings demonstrated that not only gay and transgender women are stigmatised and labelled HIV positive, but also lesbians have endured that stigma. Previous research failed to emphasize the construction of health services and their impact on the utilization of health services among LGBT patients. In the interviews, participants noted that the unavailability of posters and brochures in public health facilities inhibit their use of health services because they believe that their needs and concerns would not be met when only heterosexual concerns are pervasive in the health institution. Every human being deserves access to good quality health care regardless of their sexual orientation or gender identity.

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APPENDICES

APPENDIX ONE: ETHICAL APPROVAL LETTER

25 May 2018

Mr Sthembiso P Mkhize 214512335
School of Built Environment and Development Studies
Howard College Campus

Dear Mr Mkhize

Protocol reference number: HSS/0302/018M
Project title: "An exploratory assessment of health services in meeting the sexual-health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people in Durban: a case study of students in the University of Kwa-Zulu Natal."

Full Approval – Full Committee Reviewed Application

With regards to your response received on 22 May 2018 to our letter of 10 May 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shamila Naidoo (Deputy Chair

/px

cc Supervisor: Prof P Maharaj
cc Academic Leader Research: Prof O Mtapuri
cc School Administrator: Ms N Mzolo

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: Edgewood, Howard College, Medical School, Pietermaritzburg, Westville

APPENDIX TWO: GATEKEEPERS APPROVAL

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

4 June 2018

Mr Sthembiso Pollen Mkhize (SN 214512335)
School of Built Environment and Development Studies
College of Humanities
Howard College Campus
UKZN
Email: pollen255@gmail.com maharajp7@ukzn.ac.za

Dear Mr Mkhize

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"An exploratory assessment of health services in meeting the sexual-health needs of Lesbian, Gay, Bisexual and Transgender people in Durban: a case study of students in the University of KwaZulu-Natal".

It is noted that you will be constituting your sample by conducting interviews with Students on the Howard College, Westville, Edgewood and NRMSM campuses.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book. Identity numbers and email addresses of individuals are not a matter of public record and are protected according to Section 14 of the South African Constitution, as well as the Protection of Public Information Act. For the release of such information over to yourself for research purposes, the University of KwaZulu-Natal will need express consent from the relevant data subjects. Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR SS MOKOENA
REGISTRAR

APPENDIX THREE: INFORMED CONSENT FORM

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT

Information Sheet and Consent to Participate in Research

Date: _____

I would sincerely like to thank you for making and dedicating time to meet with me today.
My name is Sthembiso Pollen Mkhize from the University of Kwa-Zulu Natal, Howard College. I am a Master's student from the School of Built Environment and Development Studies, under the College of Humanities (Cell: 060 342 6439; Email: pollen255@gmail.com) My Supervisor is Professor Pranitha Maharaj (Tel: 031 260 2243; Email: maharajp7@ukzn.ac.za), also from the School of Built Environment and Development Studies.

You are cordially invited to consider participating in a study that involves '*An exploratory assessment of health services in meeting the sexual-health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people in Durban: a case study of students in the University of Kwa-Zulu Natal.'* The aim and purpose of the study is to explore the efficiency of health services in meeting the sexual-health needs of the LGBT students in Durban. The study is expected to enroll twelve participants registered in UKZN.

It will involve the following procedures:

All participants will answer questions that require them to give details about their experiences, knowledge and attitudes towards health services. The duration of your participation if you choose to enroll and remain in the study is expected to be an hour or less. This imply that if the participants do not feel comfortable in answering some of the questions, they may be allowed to drop the interview at their specific time.

The study may involve discomforts such as to explaining to the researcher about your sexual orientation or gender identity and give an overview of your experiences when accessing and utilizing health services.

I hope that the study will create the following benefits such as contributing to the universal academic debates on sexuality and health. If ever you feel like other questions are too deep and makes you feel uncomfortable, I will make sure that you get an appointment to see the Student Counselling unit within campus. The study will be conducted at your safest environment whereby you will feel free to answer the questions posed by the researcher.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number **HSS/0302/018M**).

In the event of any problems or concerns/questions you may contact the researcher at (Cell: 060 342 6439 or Email: pollen255@gmail.com) or feel free to contact the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Remember, your participation in this study

is voluntary. You do not have to explore more on anything you do not want to, and you may withdraw your participation at any point. In the event that you withdraw from the study, please remember that you will still be treated with respect as you will not incur penalty or loss of treatment. Thus, there will be no negative consequences on your part should you choose to or not withdraw. However, if you feel like you need counselling after the interview sessions, please do not hesitate to contact me (Sthembiso Mkhize), either on my email address or cellphone number, I will book an appointment or counselling session for you in Student Counselling Services offered by the University of Kwa-Zulu Natal within your campus.

Except for your time, you will not incur any other costs by your participation in this study. Unfortunately, there will be no compensation of any kind neither will you be paid financially should you choose to participate in this study. The study will be conducted at a location of your choice within campus, failure to find the perfect location, I will book a room for two in the campus library. There is will be no need to travel, hence no compensation will be given to the participants.

During the interview sessions, I will be taking notes, however, since it will not be possible to capture all the relevant information fast, I will be tapping the session just so that none of your comments are missed. While doing the interviews, please make sure that you speak-up to avoid any response or comments to be left out. If ever you mistakenly say your name during the interview sessions, I will make sure that I trim out that part in the recordings.

All responses will be kept confidential and will only be accessed by the researcher and the supervisor for purely academic purposes. The recordings and notes captured during the interviews, including this consent form will be kept safe in the cabinet in the Supervisor's office for five years. After, they will then be permanently deleted and shredded and will not be made available to anyone else.
I will ensure you that any information to be included in the final report will not identify you as the respondent, as you will be kept anonymous. Protecting your identity is a priority for this study because I understand that you may feel uncomfortable prevailing your sexual orientation.

If you have any questions regarding the above information, please point out and ask.

CONSENT (Edit as required)

I_____ have been informed about the study entitled '*an exploratory assessment of health services in meeting the sexual-health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people in Durban: a case study of students in the University of Kwa-Zulu Natal.'* by Sthembiso Pollen Mkhize (Student no.: 214512335)

I understand the purpose and procedures of the study which includes answering questions that requires me to draw on my experiences in accessing health services

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed that there is no available compensation or medical treatment if I become distressed as a result of study-related procedures, however, I have been informed to contact the Student Counselling unit within my campus or contact the researcher to make an appointment for me.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (Cell: 060 342 6439 or Email: pollen255@gmail.com)

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview	YES	NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

APPENDIX FOUR : IN-DEPTH INTERVIEW GUIDE

Participant number	
Age	

Section 1 – Understanding sexual orientation and the importance of sexual healthcare

1. How would you describe your sexual orientation?
2. How do you attend to your sexual healthcare needs?

Section 2 – Access to Healthcare facilities

3. How would you describe your experiences in the campus clinic or any health facility outside campus?
4. How does this health facility help in assisting students from the LGBT community?
5. What factors promote the LGBT students from utilizing the health facility?
6. What are discouraging factors in utilizing these health services as an LGBT individual?
7. What preventative measures are you aware of?
8. Do you practice the mentioned preventative measures?

Section 3 – Attitudes

9. Please describe your experiences of what the care provided by the health service mean to you as an LGBT individual?
10. How would you describe the attitudes of the healthcare providers towards you?
11. Do you perceive health providers knowledgeable and well-informed to address the needs of the LGBT?

Section 4 – Barriers to access/ Challenges

12. What are your perceived challenges in accessing healthcare services?
13. What are the opportunities regarding changing behaviours towards the LGBT in the university?
14. What stigma-related constraints discourage changing behaviours towards the LGBT?
15. What do you suggest can be done by the university to reduce challenges experienced by the LGBT community in accessing health services?