Healthcare workers negotiate religious pluralism in men who have sex with men health care provision

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Supervised by

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DECLARATION

I, Aziel Ardon Gangerdine, declare that this dissertation titled; ***Healthcare workers negotiate religious pluralism in men who have sex with men health care provision***, unless specifically indicated to the contrary in the text, is the result of my research and that all sources used have been acknowledged using complete references.

To better understand how healthcare workers reconcile religious beliefs with professional obligations in the context of MSM care, my study analysed demographic data and open-ended responses from 18 study participants using the Centrality of Religiosity Scale (CRS) and the principles of Principlism. To complement manual coding and enhance pattern recognition, Claude.ai was employed to identify subtle linguistic trends and thematic relationships. The tool was particularly helpful in uncovering non-obvious patterns, such as frequent use of justice-related language among highly religious participants, and similarities in reasoning between participants at opposite ends of the religiosity spectrum. These patterns might have been missed without computational support. This enriched the study's insights into how ethical reasoning varies across religious orientations.

However, the software was used strictly as an assistive tool. Interpretation remained my responsibility, especially in relation to culturally specific concepts that required contextual understanding. In line with emerging ethical guidance on the use of artificial intelligence (AI) in research, the analysis adhered to principles of transparency, human oversight, and accountability (Floridi & Cowls, 2022; van Dis et al., 2023). All AI-generated insights were reviewed and validated through manual analysis to ensure the integrity and rigour of the study were maintained.

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There are no words that can fully capture or account for my vast blessings. My lived experiences and this academic milestone are a testament to the presence of God in my life. This truth is unwavering, requiring no justification, evidence, or explanation. I know with absolute certainty that God is present. I pray for a more rewarding and blessed journey determined by Him who gifted me life.

To *Professor Charlene Van Der Walt*, your unwavering support and guidance have been invaluable. While others might have chosen to disengage, you remained steadfast. Despite the challenges I brought to your doorstep, you not only embraced them but also helped me grow into a better version of myself. Gratitude is a word I use often, yet your dedication and commitment have given it deeper meaning. You have exemplified what it means to invest in the growth of another, even in the face of a complex and demanding journey. To me, you are more than a supervisor. You are an academic guardian and a steward of knowledge. Thank you for leading me on this transformative journey.

Sister Ulenta Chetty, HAST Co-ordinator: Northdale Hospital, thank you for accepting to journey with me to generate new academic insights and knowledge to empower the next generation of healthcare workers who, relentlessly give of their time and skills to saves lives every day. The value of every healthcare worker, in a healthcare system under tremendous pressure, cannot be measured.

DEDICATION

For you:

- *Papa* – If only I could, I would ask the heavens for just one more day with you. To see the look in your eyes, to feel grounded by your presence, and to be embraced by your love once more.
- *Mother* – Because God blessed me with you, I have come to understand the true meaning of love and resilience.
- *Panda* – Your unwavering presence has been a pillar of strength in my life, and for that, I am endlessly grateful.

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I dedicate this work in recognition of the passionate and committed teams at Northdale Hospital and the Thembalethu Wellness HIV/TB Clinic in Pietermaritzburg, and with deep gratitude to the Executive Leadership at TB HIV Care for their vital support in making this work possible.

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Chapter 1: Introduction

I was born and raised during the years of apartheid, a form of colonial rule codified into every aspect of life that dispossessed non-White South Africans of civil, socio-economic, and political rights. My childhood was shaped within the confines of a segregated community, known as the 'location,' where difference in race, religion, opinion, or identity was systematically used to justify discrimination rather than celebrated as a foundation for collective progress. Decades into our democracy, the remnants of this past persist, manifesting in enduring socio-economic inequalities and deeply ingrained prejudices. This lived experience remains imprinted in my DNA, shaping my worldview and my professional ethos.

Throughout my career in public health research and development, I have witnessed first-hand how these historical injustices continue to fuel disparities in healthcare access and quality. The prejudice embedded in our past still dictates who receives dignified care and who is marginalised in the very system meant to serve all. In our democratic nation, we must be intentional in transforming these structures, not by erasing differences, but by preserving them as a testament to our past and as a means to shape an inclusive future. Difference should not divide; it must be the reason we strive for coexistence, respect, and equity. April 2004, marked a decade in the aftermath of South Africa's transition to a democratic country. Former President, Nelson R. Mandela, issued a statement illuminating the outcomes of the efforts that unearthed apartheid.

> "*Not only did we avert such racial conflagration; we created amongst ourselves one of the most exemplary and progressive non-racial and non-sexist democratic orders in the contemporary world.*" *(Mandela, 2004)*

Hope, vested in South Africa's Bill of Rights promised the realisation of racial equality and equal access to education, healthcare, economic opportunities, and political activism for all. Two decades on from 1994, the South African Human Rights Commission (SAHRC) in its 2016 report revealed, (a) that two-thirds of equality related complaints were attributed to race-related discrimination; and (b) elucidated how "long-standing grounds of discrimination such as race" introduced "newer forms of discrimination on the basis of HIV and AIDS status, age, language, culture, religion, sexual orientation, and gender identity" (SAHRC, 2016, p. 22).

South Africa's bioethical framework, rooted in Constitutional principles, mandates equitable access to the highest standard of care, free from discrimination and prejudice, to foster strong patient-healthcare worker relationships (Mahomed, 2023; Nevhutalu, 2011). However, despite this commitment to equality, discrimination persists, particularly against marginalised groups. With 61% of South Africans viewing homosexuality as unacceptable, religious pluralism plays a significant role in shaping attitudes toward sexual minorities, often leading to compromised care for men who have sex with men (MSM) (Mudarikwa, 2018; Muller, 2016). This raises urgent questions about whether South Africa's bioethical framework effectively safeguards the right to equitable healthcare in a society where religious beliefs influence clinical practice.

As a South African coloured man born and raised in the Pentecostal Christian faith, my personal, cultural, and spiritual identity inevitably shapes how I engage with the topic of religiosity in this study. I hold firm to my belief in the authority and integrity of the Bible as sacred scripture and do not believe it should be changed to reflect shifting human perspectives. I recognise, however, that we live in a democratic society such as South Africa, where difference has historically been used as a basis for exclusion, oppression, and socio-economic marginalisation. Within this context, I strongly support the constitutional rights of all people, including gender-diverse individuals and those in same-sex relationships, and I affirm the importance of fostering an inclusive and tolerant society.

While I do not believe that Christianity, or any faith tradition, should be reinterpreted or altered to align with evolving social norms, I also do not support the use of religion to justify hate, exclusion, or violence. I acknowledge that hate crimes and discrimination are often committed in the name of religion; however, these acts, in my view, reflect personal choices rather than the essence of faith itself. Religion has long been misused in both interpersonal and geopolitical conflicts, often as a tool to justify war, violence, and human rights violations. Such misuse of faith undermines its core purpose of spiritual guidance, ethical living, and human connection.

Ultimately, my aim in this study is not to challenge or affirm any belief system, but rather to understand how individuals locate themselves within their own religious frameworks in a complex and diverse society. While I remain rooted in my faith, I also recognise the importance of respecting difference, allowing for diverse expressions of identity, and upholding the dignity of all people, without imposing a singular worldview or moral code.

It is through this balance that I seek to uphold academic integrity, ethical research practice, and humanity. In this research, I have taken deliberate steps to ensure that my own beliefs do not overshadow the voices of study participants. The focus of this study remains on their lived experiences and religious positionalities, particularly as measured through the Central Religiosity Scale (CRS). To support a more rigorous and reflexive analysis, I employed Claude.ai as a complementary tool to assist in identifying themes and refining insights from qualitative data.

1.1. Navigating Differences in the Pursuit of Ethical and Equitable Care

My study embraces difference and positions itself in the contested space where religious pluralism, gender diversity, and bioethics intersect. It examines the complex reality of healthcare in South Africa, where bioethical principles, largely shaped by a Western consciousness, are applied within a nation still striving to dismantle systemic inequalities and embrace transformation. The relationship between healthcare workers and patients should be guided not only by universal ethical frameworks but also by the African philosophy of *Ubuntu* which is a recognition of our shared humanity.

My study is, in many ways, a reconciliation of my past and present and a commitment to action. If apartheid was a system designed to disadvantage and dehumanise, then today, we must critically examine whether our bioethical frameworks are truly fit for a democratic society that enshrines both freedom of religious association and the right to dignity and equitable care. This research is not merely an academic inquiry; it is an act of redress, an effort to ensure that healthcare in South Africa reflects the values of justice, respect, and human dignity for all.

While my study highlights critical issues affecting dignified care, it also raises pressing questions about South Africa's pursuit of true democracy:

- How long will it take to unlearn racial discrimination and prejudice, deep-seated remnants of an unjust past that continue to hinder equal access to socio-economic rights?
- Can an African-centered bioethics framework expose and address prejudice in healthcare delivery?

1.2. Background to the Research Problem

In South Africa, since the advent of democracy in 1994, and albeit measurable progress, healthcare equality is fractured in economically challenged regions. Geographical location, racial divisions, and socio-economic conditions stifle the equitable allocation and distribution of healthcare to all (Van Rensburg, 1994; Dikotla, 2021). Those inequities compound the health care seeking experiences of patients who, at a healthcare facility, are very likely to encounter barriers such as the limited availability of medicines, personnel shortages, discrimination and prejudices, and mistrust in how healthcare workers provide care (Chinyakata, 2021).

In South Africa, 95% of its people are religious (Jogee, 2018; Jonas, 2018). Religions in homogenous and multicultural societies have been 'arbiters of ethical norms' and influence the relationship between a healthcare worker and a patient (Iserson, 1999, p. 516). Religion, 'a multidimensional construct that includes beliefs, behaviours, rituals, and ceremonies developed over time within a community', and healthcare is the dynamic relationship in which the former impacts the delivery of the latter (Koenig, 2012, p. 2). In healthcare, religious pluralism is the conflict experienced by healthcare workers, when navigating personal religious beliefs and convictions, in the provision of care (Kirchhoffer, 2022).

Discrimination and systems bias against gender and sexual minorities such as men who have sex with men, 'men who engage in sexual activity regardless of how they identify themselves' and may 'dispense with sexual identity altogether' (Pachauri, 2022, p. 9), is extensively documented in public health facilities within a heteronormative health system (Mudarikwa, 2018; Muller, 2016; Fallin-Bennet, 2015; Kadivar, 2018; Isano, 2022; Mbeda, 2020). This is likely attributed to a significant percentage (61%) of South Africans who consider homosexuality unacceptable' (Poushter, 2020). As such healthcare workers' provision of care is influenced by their own values and 'their perceived moral worth of a patient (Muller, 2016).

Religious pluralism in healthcare can foster harmony between deeply held beliefs and the provision of dignified care (Bano, 2022; Du Plessis, 2016). While promoting understanding and respect for diverse religious convictions is ideal, it has also contributed to discriminatory experiences for MSM in healthcare settings (Coertzen, 2016; Muller, 2016).

Conversely, Westwood (2022, p.17) highlights the workplace tensions and cognitive dissonance faced by highly religious healthcare workers when expected to fully affirm and advocate for gender and sexual minorities. In a context such as South Africa which embodies a 'linguistically, racially, religiously, and culturally plural society', understanding how to accommodate religious pluralism in the optimal provision of health care is paramount to address issues which led to one of the most unequal global societies (Du Plessis, 2016; Behrens, 2013, p. 34; Bano, 2022). Behrens (2013, p. 34) draws attention to the benefit of developing a bioethical framework 'that resonates with the pre-existing values, morals, and religious beliefs and convictions' of South Africans as an antidote to past injustices and to improve on, for example, the moral dilemmas in the provision of dignified care.

My study offers a critical opportunity to explore whether bioethics tailored to the African context can expose and address prejudice and discrimination in the care of sexual minorities. Additionally, it seeks to provide balanced insights into the complex South African healthcare landscape, where religion, gender diversity, and bioethics intersect. Understanding these dynamics is essential to ensuring equitable healthcare for all, regardless of religious or sexual identity.

1.3. Research Questions and Objectives

My study titled: *Healthcare workers negotiate religious pluralism in men who have sex with men health care provision*, is guided by the following key research question, research sub-questions and the associated research objectives.

Key Research Question

How do healthcare workers navigate religious pluralism in MSM health care provision?

Research Sub-Questions

1. Does a correlation between religious positionality and the provision of MSM care exist?
2. What are healthcare workers' dominant religious objections to MSM?
3. What bioethical considerations, specific to Africa, can improve the provision of care to sexual minorities in public healthcare facilities?

Research Objectives

1. To examine the correlation, if any, between religious positionality and the provision of MSM care.
2. To highlight healthcare workers' religions indifference to MSM.
3. Specific to Africa, recommend a bioethical framework of considerations, to augment existing bioethical frameworks to improve the provision of care to sexual minorities in public healthcare facilities.

Bioethics is a 'subset of ethics that provides reasoned and defensible solutions that incorporate ethical principles for actual or anticipated moral dilemmas' and defines the relationships between healthcare workers and patients, healthcare workers and society, and society and patients' (Iserson, 1999, p. 284). Pursuing 'African bioethics' (bioethics which is indigenous to and reflective of an African identity) is necessary but must be done in 'response to African and global challenges of moral significance, irrespective of the origin of the principles and at the same time focus on strategies for ensuring compliance with resulting principles' (Barugahare, 2018, p. 1).

Bioethics is not monolithic as it lacks the 'polyphony of voices' to address the 'potential marginalisation of sexual and gender minorities' (Kahkonen, 2018, p. 3). Queer bioethics which 'builds on medical humanities, promotes queer advocacy and the active involvement in debate on the ethics and moral conceptions in medicine and biosciences', is a framework in which to situate the impact of religious pluralism as a means to resolve the ethical issues impacting the provision of care for sexual minorities which mainstream bioethics has not resolved (Kahkonen, 2018, p. 3-4).

1.4. Research Methodology

For this study I will employ a qualitative research methodology, 'an interpretative approach, which attempts to gain insight into the specific meanings and behaviours experienced in certain social phenomena through the subjective experiences of participants' (Palmer, 2006, p. 1). Palmer (2006, p. 18) makes the observation that qualitative research 'captures the details, practices, and experiences of the study participants (subjects) as they occur'.

To benefit and contribute value to the study, I will use purposive sampling to recruit a cohort of ten gender diverse healthcare workers who experienced religious pluralism in the workplace, and who have a minimum of three years' work experience in a public healthcare facility (Radhakrishnan, 2014). Following an informed consent process with study participants, I will administer anonymous online questionnaire with demographic, Likert-scaled, and open ended questions to collect data.

A three-sectioned questionnaire will collect, (a) Section 1: demographical data, (b) Section 2: data to measure study participants' religiosity, and (c) Section 3: responses to open-ended questions which will be analysed against the framework of Principlism. Behrens' (2013) and Ssebunnya's (2016) Ubuntu-based framework of African-inspired Principlism in which the principles of *Justice as Harmony* and *Autonomy as Respect for Persons*, underscore the relevance of African moral philosophy in modern healthcare practice, will also be used to analyse healthcare workers' responses to the open-ended questions.

Demographical data will describe the study participants' diverse professional and religious backgrounds. I will use the Centrality of Religiosity Scale (CRS) to measure healthcare workers' degree of religiosity also known as their religious positionality (Huber, 2012, p. 1). Open-ended questions will (a) explore healthcare workers' perspectives on sexual minorities in relation to their religious identities and beliefs, (b) examine how they navigate religious pluralism when providing care to sexual minorities, and (c) gather their recommendations for improving bioethical standards.

To safeguard the identity of study participants and their potentially sensitive views on religion and gender, they will complete the questionnaire anonymously. The study will be guided by principles of respect, strict ethical standards, and a strong emphasis on informed consent. To ensure a well-informed and comprehensive approach, I will collaborate with medical ethicists and individuals who identify as MSM. Additionally, I will consult and involve officials from the Clinic's Employee Assistance Program to provide counseling support for study participants when needed.

1.5. Outline of the Study

Five chapters will constitute this thesis. Chapter one introduces, as a problem statement in public health, how the provision of dignified care to gender minorities is impacted at the intersection of religion, gender identity, and bioethics. Chapter two explores three areas of literature: (a) the impact of religious pluralism on the South African healthcare system, (b) in the public health system, documented prejudices and discrimination experienced by health care seeking men who have sex with men (MSM), and (c) the pursuit for bioethical justice in the development of indigenous African bioethics.

Chapter three elucidates Principlism as a normative ethical framework designed to assist healthcare workers with decision-making in multi-cultural and socio-economically diverse healthcare settings. Also, the chapter describes how Principlism and an Ubuntu-based framework of African-inspired Principlism, will be used to determine how healthcare workers navigate religious pluralism in the provision of MSM care.

Chapter Four will present the study's data and analysis in a clear and structured manner, addressing the primary and sub-questions. Chapter Five will conclude the thesis by (a) reaffirming the study’s significance in an emerging economy like South Africa, (b) present a discussion on the key findings, (c) frame recommendations for the development of indigenous African bioethics to improve MSM and sexual minority healthcare, and (d) offer concluding motivations to guide future research on the intersection of bioethics, religion, sexual minorities, and the provision of dignified care.

1.6. Conclusion

In this Chapter, the importance of my study is contextualised in South Africa’s public healthcare setting which is strained under the documented scourge of discrimination and prejudice towards health care seeking sexual minorities and MSM. The resulting consequence is the evisceration of patients’ Constitutional rights to dignified care. The study background postulates the correlation between religious pluralism and the provision of compromised care to sexual minorities such as MSM and underscores the need to conduct the study. The key research question, study sub-questions, and the study objectives are presented and aligned to the study rationale. Chapter two will examine study relevant literature.

Chapter 2: Literature Review

The challenges outlined in Chapter 1 highlight the pressing need to examine how religious pluralism influences the provision of care to sexual minorities, particularly MSM, within South Africa’s strained public healthcare system. The documented discrimination faced by MSM patients raises critical questions about the effectiveness of the country’s bioethical framework in safeguarding their Constitutional rights to dignified and equitable care. Building on this foundation, Chapter 2 delves into existing literature to explore the intersection of religious pluralism, gender diversity, and bioethics in healthcare. It investigates the perspectives of healthcare workers navigating these complexities, examines the adequacy of South African bioethics in balancing patient rights with religious convictions, and underscores the necessity of bioethical justice in strengthening inclusive healthcare practices.

2.1. Cause and effect: Influence and Impact of Religious Pluralism on Healthcare

South Africa's healthcare landscape is marked by the simultaneous use of different medical systems, including Western medicine, traditional African healing, and faith-based healing. This coexistence often results in treatment conflicts and poses challenges in patient care coordination (Gabasiane, 2023). Many South Africans, regardless of religious affiliation, consult multiple healing practitioners such as Western-trained doctors, traditional healers, and spiritual healers, sometimes concurrently.

The Zion Christian Church (ZCC), one of South Africa’s largest African Independent Churches (AICs), integrates faith healing into its religious practices. Healing methods include prayer, prophecy, the use of “holy water,” and ritual purification practices such as vomiting and bloodletting (Gabasiane, 2023, p. 166). While these practices are deeply rooted in spiritual belief systems, they often lead patients to forgo or delay biomedical treatment, which can have critical health implications. Religious syncretism (the blending of indigenous spirituality with Christian beliefs) has given rise to a unique healing framework that challenges conventional biomedical models (Galvin, Chiwaye, and Moolla, 2024). Many Traditional Health Practitioners (THPs) function as both sangomas (traditional healers) and prophets (faith healers), indicating a fluid intersection of indigenous religious traditions and Christianity. However, Pentecostal churches, commonly referred to as bazalwane, largely reject traditional healing, creating tensions between biomedical, faith-based, and traditional healing approaches.

Medical pluralism is deeply entrenched in South Africa, with approximately 70–80% of the population seeking traditional healing at some point (Galvin et al., 2024). While many THPs acknowledge the effectiveness of biomedical treatment, they often interpret certain diseases through a spiritual lens, attributing them to factors such as ancestor displeasure or witchcraft. As a result, conditions such as HIV/AIDS and tuberculosis are frequently addressed through both biomedical and spiritual interventions.

A major challenge in South Africa’s healthcare system is the lack of coordination between different medical traditions. Unregulated traditional healing practices can sometimes delay life-saving biomedical interventions, leading to worsened health outcomes. Furthermore, some THPs view biomedical approaches as inadequate for addressing spiritual ailments, creating a disconnect between patients' beliefs and available medical care (Galvin et al., 2024). Healthcare providers face significant challenges when navigating a system where biomedical ethics, religious beliefs, and traditional healing practices coexist. Western-trained doctors and missionary medical professionals often discourage faith-based healing due to concerns about medical efficacy and scientific validity (Gabasiane, 2023). However, religious healing remains a widely accepted practice, leading to tensions between these systems.

Despite the challenges, there are opportunities to integrate religious and traditional healing practices into a cohesive healthcare system. Collaborative efforts between THPs, faith healers, and biomedical professionals can help bridge the gap between different healing traditions (Galvin et al., 2024). Integrating traditional healing practices into formal healthcare systems has demonstrated positive outcomes, as evidenced by the AO Alliance's Traditional Bonesetter Training Program in Ghana. Launched in 2021, the program aims to prevent complications arising from traditional bonesetter treatments and reduce lifelong disabilities through fracture care education (AO Foundation, 2022). The program has trained 197 bonesetters across the Ashanti, Northern, and Upper West regions, exposing them to appropriate non-operative fracture treatment methods. This collaboration has led to a 57% decrease in bonesetter-related amputations and an increase in referrals from bonesetters to teaching hospitals, indicating improved patient outcomes (AO Foundation, 2022). These results underscore the benefits of integrating traditional healing practices with conventional medical care, enhancing healthcare delivery in regions where traditional healers are primary caregivers (AO Foundation, 2022).

However, ethical and regulatory concerns remain. The World Health Organization (WHO) has proposed retraining traditional practitioners to function within primary healthcare settings, yet theological and scientific incompatibilities persist (Gabasiane, 2023). The ZCC and other AICs emphasise spiritual explanations for illness, challenging conventional bioethical models that prioritise biomedical evidence. This raises critical questions about how religious pluralism should be accommodated within South Africa's bioethical framework while ensuring that patients receive effective, evidence-based care.

South Africa upholds patients' rights to dignified care by enacting its National Health Act No. 61 of 2003 (NHA) and the Patient's Right's Charter (Mahomed, 2023). Those rights underpin the relationship between a healthcare worker and a patient. Nevhutalu (2011, p. 1-2) draws on Neary (2000), who describes how a patient is subject to a 'structure in which they trust that their rights will be protected' and in so doing, 'delegate all subsequent authority' to the healthcare worker to make the right decisions when providing care. To guide the provision of care, healthcare workers rely on an array of frameworks and policies which are underpinned by ethics, 'a broad set of values and beliefs, derived from the values of the society, in which they are proposed and applied to human activities' (Iserson, 1999, p. 513-514).

Religions in homogenous and multicultural societies have been 'arbiters of ethical norms' and influence the relationship between a healthcare worker and a patient (Iserson, 1999, p. 516). Michel Clasquin (1994) in his work noted that 'religion has stood as the basis and guarantor of ethics in society, and has a hold over the minds of millions of people as a potent weapon for good or evil'. Iserson (1999, p. 516) observes that no single religion influences an entire population, rather they adopt a 'golden rule', 'to do unto others as you would have them do unto you'. Trust fortifies the patient-healthcare worker relationship which is the focal point converging the intersections of care, religion, gender, and bioethics.

It is at this juncture of the relationship that religious pluralism manifests, recognising that healthcare workers are inseparable from their personal religious beliefs and convictions. Religious pluralism is the conflict experienced by healthcare workers, navigating their personal religious beliefs and convictions, in the provision of care (Kirchhoffer, 2022). Religious pluralism must be handled, *firstly* on the principle of respect for autonomy; that no healthcare worker must be compelled to act in violation of their religious beliefs.

Secondly, on the principle of justice; that acting on religious grounds should not be 'contrary to the best interest of the patient and the principle of justice regarding access to legal and available healthcare practices' (Kirchhoffer, 2022, p. 88 - 90).

In South Africa, health care workers' recusal from performing, for example, services such as abortions on the basis of non-verifiable personal beliefs, usually religious, are no longer legal or ethical grounds to deny care in life-or-death emergencies (Mudarikwa, 2018). In an international scoping review (70 selected studies from 25 different countries, including South Africa), scholar Sue Westwood (2022) highlighted how the religious attitudes and religiosity (the frequency of religious participation, attendance of faith groups, reading religious texts and prayers and depth of involvement in/identification with one's religion) of healthcare workers impacted the provision of care to gender and sexual minorities such as MSM.

Westwood (2022, p.10-14) found that healthcare workers (a) 'affiliated with a religion are more likely to have negative attitudes towards sexual and gender minorities, (b) use religious beliefs to refuse treatment, (c) demonstrated a higher amount of stigmatisation towards a gay sexual relationship', and that homophobia and transphobia 'are associated with religious fundamentalism'.

Religious pluralism presents ethical dilemmas for healthcare providers, particularly when religious convictions influence medical decision-making. De la Porte (2016) highlights how healthcare professionals often struggle to balance their personal religious beliefs with the obligation to provide equitable and non-discriminatory care. This tension is particularly pronounced in areas such as sexual and reproductive health, sexual minority rights, and end-of-life care.

One of the critical bioethical challenges in South Africa is ensuring that religious beliefs do not impede access to comprehensive healthcare. Healthcare professionals may experience moral distress when their religious convictions conflict with their professional obligations (De la Porte, 2016). In some cases, this can result in the refusal to provide care to certain patient groups, further exacerbating healthcare inequalities. The intersection of religious pluralism and healthcare necessitates a bioethical framework that is both inclusive and contextually relevant.

De la Porte (2016) argues that South Africa’s bioethics is largely shaped by Western principles, which may not fully account for the country's religious and cultural diversity. This misalignment can create conflicts where religious beliefs dictate medical decisions, sometimes undermining patient autonomy and equitable care access.

A culturally responsive bioethical framework must balance religious diversity with medical ethics, ensuring that patient-centered care is upheld while respecting spiritual and cultural traditions. This requires clear guidelines for healthcare professionals on navigating religious pluralism without compromising ethical standards (De la Porte, 2016).

2.2. Barriers and Discrimination in MSM Healthcare Access

Charlene Donald in her work made the following observation:

> *‘It’s an uncomfortable reality for many that, lawfully, all members of South African society are equal and able to live free from homophobia or stigma; yet in practice the culture remains biased, conservative, homophobic, and patriarchal…’ (Donald, 2023).*

Extensive literature documents the discriminatory treatment in South Africa of MSM by healthcare workers compared to the general population (Mudarikwa, 2018; Muller, 2016; Fallin-Bennet, 2015; Kadivar, 2018; Isano, 2022; Mbeda, 2020). The term men who have sex with men (MSM) is prevalent in public health and is used to describe a sexual and gender minority population. MSM ‘may not always correlate with self-identification sexual orientation’ as not all men who identify as homosexual would be considered MSM (Esie, 2019, p. 2). Pachauri (2022, p. 9) defines MSM as men who engage in sexual activity with other men, regardless of their self-identification, and who may choose not to adopt a specific sexual identity. This definition will be used in the study.

The widespread belief that homosexuality is unacceptable (61% of the South African population) likely fuels ongoing discrimination in the healthcare system (Poushter, 2020). Limited public protections and homophobia are underlying factors that impact the provision of MSM care resulting in increased reports by MSM patients of substance misuse, deliberate self-harm, suicidal ideations, and mental disorders (Mbeda, 2020; Muller, 2016).

Denying dignified care based on sexual and gender identity in South Africa is a human rights violation, creating healthcare barriers, worsening HIV vulnerabilities, and impacting employment and community relationships. (Chimatira, 2023; Rispel, 2011).

Ikhile (2024) examines the systemic barriers and discrimination faced by men who have sex with men (MSM) in South Africa's public healthcare system. Ikhile's study highlights that despite South Africa's progressive legal framework protecting sexual minorities, MSM continue to experience significant healthcare disparities due to stigma, discrimination, and structural barriers. Using qualitative research methods, the study conducted in-depth interviews with 25 MSM in Umlazi township, KwaZulu-Natal.

The findings reveal that MSM face various obstacles, including prejudiced attitudes from healthcare workers, long wait times, lack of confidentiality, inadequate medical equipment, and the absence of MSM-friendly services. Many MSM reported avoiding public health facilities due to fear of discrimination, leading to negative health outcomes such as increased HIV transmission rates and mental health issues.

Müller (2017) explored the structural barriers affecting sexual minority individuals in South Africa's public health system, using the UN International Covenant on Economic, Social and Cultural Rights to assess healthcare accessibility. The study identifies four key challenges: availability, accessibility, acceptability, and quality of care. Public health facilities often lack sexual minority-specific services, including HIV prevention tools (e.g., lubricants, dental dams) and gender-affirming care for transgender individuals. Additionally, clinics provide limited information on sexual minority-specific health concerns, further restricting access to appropriate care (Müller, 2017).

Discrimination within the healthcare system also impacts accessibility, with MSM and transgender individuals frequently denied care or treated with hostility. Anticipated stigma discourages many from seeking healthcare, leading to delayed treatment or complete avoidance of medical services (Müller, 2017). Concerns regarding acceptability are highlighted by breaches of confidentiality, as healthcare workers often gossip about patients' sexual orientation. Moral and religious biases influence medical interactions, with some providers attempting to fix sexual minority identities rather than offer appropriate care.

The quality of care is further compromised by limited provider knowledge about sexual minority-specific health needs, resulting in misdiagnoses, misinformation, and denial of services. Transgender individuals, in particular, experience misgendering and invasive questioning, further alienating them from healthcare settings (Müller, 2017). Many MSM and lesbians receive incorrect information about HIV risk, while psychological support is often influenced by religious bias rather than evidence-based clinical care (Müller, 2017).

These systemic failures have led to widespread distrust in healthcare institutions among MSM and other sexual minority individuals. Many avoid seeking care altogether, and complaint mechanisms are viewed as ineffective, reinforcing existing health disparities and limiting access to dignified, inclusive healthcare (Müller, 2017).

Dos Santos et al. (2014) investigated the stigma and discrimination faced by people living with HIV/AIDS (PLHIV) in South Africa, using the People Living with HIV Stigma Index. The study, conducted across ten clinics in four provinces, found widespread stigma and discrimination, with over 50% of participants experiencing gossip, verbal harassment, or exclusion due to their HIV status. Additionally, 16.1% reported physical assault, with more than half of these incidents involving a spouse or partner.

Many PLHIV also faced exclusion from religious and social activities, further exacerbating their isolation. Access to healthcare was a significant challenge, with 5.5% of participants denied health services, while 6.4% were refused family planning services, and 10.5% were denied sexual and reproductive health services. Breaches of confidentiality were also reported, with 8.4% of healthcare workers disclosing patients' HIV status without consent (Dos Santos et al., 2014).

Economic discrimination was another key issue, as 11.7% of participants lost their jobs, and 7.7% were denied employment due to their HIV status. Additionally, 51.4% of participants were unemployed, with the majority living in poverty. Internalised stigma was also prevalent, with 49.2% blaming themselves for their condition and 47.5% feeling ashamed. This led to avoidance of healthcare, with 14.4% staying away from clinics and 8% avoiding hospitals despite needing medical attention. Moreover, 30% of participants chose not to marry, and 27% avoided sexual relationships due to stigma-related fears (Dos Santos et al., 2014).

The study also revealed low awareness of legal rights, with 48.8% of PLHIV unaware of protective policies, such as the Declaration of Commitment on HIV/AIDS. Even among those who experienced human rights violations, only 54.7% sought legal redress, often deterred by fear of intimidation and distrust in the legal system. MSM were identified as facing heightened discrimination, often avoiding public healthcare facilities due to prejudice from healthcare workers. The low number of MSM participants in the study suggested underreporting due to fear of stigma. Overall, Dos Santos et al. (2014) concluded that stigma remains a major barrier to healthcare access, economic stability, and social inclusion for PLHIV, particularly for marginalised groups like MSM. The study underscores the urgent need for legal protections, community education, and healthcare reforms to mitigate stigma and discrimination.

In her work Muller (2016, p. 199-201) describes how, in 1993, a self-identifying 'flamboyant queen' who expresses his gender identity in a feminine and non-conforming way was subjected against his will to 'religious practices aimed at changing his sexual orientation' while receiving care at a district hospital in South Africa. The case also evidenced legislative contraventions by the healthcare workers who on the basis of their religious beliefs influenced their provision of care by (1) violating his right to privacy and confidentiality by disclosing his sexual orientation to other medical personnel and (2) impeding the potential for an investigation and legal recourse by not documenting homophobia as the motivation for his assault (Muller, 2016).

Albeit that South Africa offers sexual and gender minorities constitutional protection and the right to the highest attainable standards of health care, religious pluralism pervades the health system illuminating the compromised delivery of a constitutional imperative (Muller, 2016). Healthcare workers' provision of care is influenced by their own values and their perceived moral worth of a patient (Muller, 2016).

2.3. Bioethical Reform: The Driving Force Behind Health Justice

Historical events such as the Holocaust, the need to manage organ transplantation (Niekerk and Benatar, 2011), the coerced participation of United States servicemen to test mustard toxic gas in gas chambers, or the non-treatment of Afro-American male patients for syphilis in the Tuskegee Syphilis Study in 1932, set in motion the birth of bioethics (Nevhutalu H, 2011). Bioethics, 'is moral reasoning applied to life sciences, biotechnologies, health and medical care' (Barugahare, 2018, p. 9).

The introduction and importance of bioethics in South Africa is intricately linked to past atrocities. Nevhutalu (2011) highlights how two district surgeons failed to provide dignified care to Steve Biko after he was detained by the apartheid security police, ultimately resulting in his death due to being denied dignified care and life. The case sparked international criticism of the then South African Medical and Dental Council (SAMDC), mandated to ensure that patients received appropriate and ethical health care, regardless of the policies of the apartheid government (Nevhutalu H, 2011).

The Health Professions Council of South Africa's (HPCSA) (the former SAMDC) code of conduct for healthcare workers set to change the past and prescribed the following tenets:

> *"...practice as a health care professional is based upon relationships of mutual trust between patients and health practitioners ... to be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society..." (HPCSA, 2007, p. i).*

The Western-European concepts of bioethics advocate for a 'Western conception of liberation rights-based autonomy' whereas the African perspective is embedded in 'communitarian ethics', a connectedness with other people in society and the 'African moral philosophies of Ubuntu/Botho and Ukama (Akpa-Inyang and Chima, 2021, p.2). Ssebunnya (2016) critiques the dominance of Western bioethics in Africa, arguing that bioethics in the region has largely focused on empirical research ethics, with little conceptual development. The lack of an African-driven bioethical framework, he argues, limits the relevance of contemporary bioethics in African contexts. African bioethical practitioners who rely on a Western-based bioethical approach may encounter 'ethical dilemmas generated by the traditional values, practices, rituals, and taboos that still govern the people's behaviour and relationships' in an African context of application (Akpa-Inyang and Chima, 2021, p. 2; Behrens, 2013).

Ssebunnya (2016) suggests that a major challenge in African bioethics is the tension between universal ethical principles and context-specific cultural and religious beliefs. Many healthcare workers navigate personal religious convictions while providing care, sometimes resulting in moral conflicts that can impact service delivery to marginalised groups, including sexual minorities such as MSM.

While Ssebunnya does not explicitly address queer bioethics, his argument about Africa's bioethics lag is relevant to the exclusion of sexual minority concerns from mainstream bioethical discussions. The lack of a robust African bioethical discourse means that critical issues, such as the intersection of religious pluralism and queer healthcare, remain inadequately addressed. Addressing bioethics from an African perspective requires balancing respect for religious diversity with the ethical obligation to provide non-discriminatory, patient-centered care.

In a context such as South Africa which embodies a 'linguistically, racially, religiously, and culturally plural society', understanding how to accommodate religious pluralism in the optimal provision of care is paramount to address issues which led to one of the most unequal global societies (Du Plessis, 2016; Behrens, 2013; Bano*,* 2022). Religious beliefs should have a place in healthcare on the premise that such 'convictions are judgements of conscience, and respect for conscience is core to what it means to respect human dignity' (Kirchhoffer, 2022; Kadivar, 2018).

According to Kadivar (2018), when dignified care is compromised due to religious pluralism, patients may withhold crucial information during medical history taking. Additionally, they may be reluctant to undergo physical examinations and may even exhibit aggression toward healthcare providers. Ssebunnya (2016) underscores the need for bioethics to engage with real-world ethical dilemmas, particularly in contexts where human dignity is at risk.

In South Africa, despite constitutional protections, sexual minorities, especially MSM, face discrimination in healthcare, often justified through religious or cultural beliefs. Upholding the fundamental human rights of healthcare seeking MSM is tantamount to addressing the root causes of the ongoing health inequalities in the country's health system (Nevhutalu H, 2011).

Barugahare (2018, p. 7) proposes five key aims for developing effective and socially acceptable bioethics in Africa: cautiously pursuing identity, evaluating ethical principles for addressing contemporary health challenges, ensuring social acceptance, enriching global bioethics with African moral insights, and implementing bioethical strategies rigorously. The imperative to develop local bioethics 'cannot rely on importing established roles, principles, and practices; rather, conditions must be created for mutual exchange and genuine reliance on local experience and expertise' (Ryan, 2004, p. 171).

Scholars argue for a ‘principled alternative approach’ which supports African communitarian bioethics and which will provide ‘tools for ensuring that the public goods of medicine and biotechnology serve everyone’ (Ryan, 2004, p.177). Ryan (2004, p.174) emphasises the necessity of a ‘bioethics from below’, a ‘bioethics not of the privileged but of the marginalised’. Sudenkaarne and Kähkönen (2018) examine the intersection of queer theory, biopolitics, and bioethics, arguing that mainstream bioethics has historically overlooked the specific needs of sexual minority individuals.

Drawing on Foucault’s concept of biopolitics, they highlight how institutional power structures regulate bodies and identities, often reinforcing exclusionary norms. As an institutionalised field, bioethics has traditionally aligned with these frameworks, failing to fully consider the lived experiences of queer individuals.

Queer bioethics introduces critical debates on normative power and its effects on individuals whose identities do not conform to heteronormativity (Kähkönen & Sudenkaarne, 2018, p.3). It employs interdisciplinary methods from medical history, philosophy, and narrative research to bridge biosciences and the humanities, aiming to dismantle injustices and enhance bioethical justice (Kähkönen & Sudenkaarne, 2018, p.4).

By centring the experiences of sexual minority individuals, queer bioethics challenges traditional paradigms and advocates for more inclusive, justice-oriented healthcare policies. Sudenkaarne and Kähkönen (2018) highlight key gaps in mainstream bioethics, particularly in areas such as gender-affirming care, reproductive rights for queer individuals, and the medicalisation of non-heteronormative identities. Addressing these issues requires a shift in bioethical discourse that recognises and actively challenges structural discrimination within medical and legal systems.

African bioethics has long argued that the dominant, principle-centred frameworks exported from the Global North (e.g., autonomy-heavy, individualist paradigms) inadequately reflect African moral worlds shaped by relationality, interdependence, and communal flourishing (Tangwa, 1996; Mkhize, 2008; Metz, 2011).

An “ethics from below” approach complements communitarian African ethics (often articulated through *ubuntu*) in at least four ways:

1. *Epistemic justice and knowledge pluralism:* Ethics from below deliberately draws on the moral grammars and experiential knowledge of those most governed by biopolitical regimes and includes patients, queer and gender-diverse people, rural communities, migrants, and traditional healers. This aligns with ubuntu’s insistence that personhood is constituted through relationships and mutual recognition (Metz, 2011). In practical terms, it treats local moral insight (including indigenous healing and care practices) as constitutive of ethical deliberation, not a cultural afterthought (Tangwa, 1996; Mkhize, 2008).

2. *Power-aware analysis of institutions:* By taking Foucault’s biopolitics seriously, a bottom-up ethics scrutinises how hospitals, research protocols, registries, prisons, and clinics materialise exclusion, for example, by gatekeeping access to gender-affirming care, by pathologising queer identities, or by neglecting languages and practices through which African patients articulate suffering and care (Kähkönen & Sudenkaarne, 2018).

3. *Procedural inclusion and co-production:* Ethics from below shifts how we make ethical decisions (who is in the room; whose stories count). It institutionalises community advisory boards, patient-led guideline development, and participatory methods that have already shown impact in African health (Audet et al., 2024; Moyi et al., 2022).

4. *Justice-first outcomes:* Rather than deriving conclusions from abstract principles, ethics from below begins with concrete inequities (access, dignity, safety) and tests whether policies measurably improve the lives of those most burdened by harm, particularly marginalised and gender-diverse people (Ryan, 2004; Kähkönen & Sudenkaarne, 2018).

Queer bioethics sharpens African ethics’ critique by naming how hetero- and cis-normativity are baked into clinical pathways, diagnostic categories, and legal-administrative systems. In South Africa, despite a progressive constitution, trans women’s access to public-sector healthcare is constrained by stigma, clinical gatekeeping, and fragmented services (Lunn et al., 2023).

Ethics from below would (a) recognise trans women as moral experts on their health, (b) prioritise service integration led by affected communities, and (c) hold institutions accountable to equitable outcomes, for example, timely access to hormones and respectful primary care, rather than formal non-discrimination alone.

Similarly, across the region, punitive laws intensify biopolitical harms. Uganda's Anti-Homosexuality Act (2023) has been shown to undermine public health by driving LGBTQ+ people away from services and chilling providers' willingness to offer care (Konde-Lule et al., 2024). A bottom-up African bioethics would treat repeal and harm-reduction advocacy as ethical imperatives grounded in ubuntu's concern for human dignity and communal wellbeing, not as external "Western" impositions (Inter-American et al., 2021; Konde-Lule et al., 2024).
African bioethics need not choose between communitarian values and critical queer insights. Ethics from below provides the procedural bridge: it redistributes voice and authority to those historically excluded, surfaces locally resonant moral languages (ubuntu), and measures success by whether marginalised and gender-diverse people actually experience safe, dignified, effective care. This is the decolonial move that transforms bioethics from a regulatory overlay into a justice-producing practice in, and accountable to, African communities.

Egan (2017) highlights the inherent difficulties in practicing bioethics within South Africa's pluralistic and postcolonial setting. The field draws from philosophy, law, and medicine, each discipline marked by internal debates and often incompatible epistemologies. Egan argues for deeper interdisciplinarity and academic humility, warning against superficial applications of Western ethical theories without due attention to their philosophical underpinnings or relevance in African contexts.

> *"There is an even deeper risk: superficiality... the best we can do is to present provisional moral arguments as coherently as possible, while having the epistemological humility to recognise that we may not have solved a problem for all time" (Egan, 2017, p. 10).*

This observation is particularly pertinent in moral debates on homosexuality, abortion, and euthanasia, where legal acceptance often outpaces societal values. Bioethicists must, therefore, engage with religious, cultural, and historical dimensions of moral reasoning, not dismiss them, as valid ethical frameworks.

Kotzé and Loubser (2018) provide empirical data demonstrating the divergence between South Africa's liberal constitutional values and public moral attitudes. For example, despite legal recognition of same-sex marriage since 2006, Protestant and African Independent Church (AIC) adherents remain largely opposed. A majority of South Africans still view homosexuality and abortion as unjustifiable, even as opinion leaders (elites) trend more liberal.

> *"The South African public has gradually become more accepting of the liberal values of the constitution... That being said, South Africans have not become liberals as such" (Kotzé & Loubser, 2018, p. 1).*

This reveals a significant moral divide. To navigate it, African bioethics must create space for dialogue between secular ethics and theological anthropology especially as religion remains a central moral compass for many. Importantly, ethical advancement does not require abandoning faith-based convictions but invites a deeper interrogation of how those beliefs coexist with evolving rights-based frameworks. Kotze (2018) explores the theological and ethical challenges posed by biotechnological enhancements, such as genetic engineering and transhumanism. She frames the conversation through Christian anthropology and the *imago Dei*, the belief that humans are created in the image of God. Enhancement, Kotze argues, must be critically assessed not only for its medical utility but also for its implications on human dignity and theological identity.

> *"Christian anthropological views on what it means to be human, especially by being created imago Dei, will provide the doctrinal and theological support to this contemplation" (Kotze, 2018, p. 2).*

This perspective is crucial in South Africa, where the intersection of tradition, innovation, and theology requires ethical frameworks that can both accommodate scientific progress and honour religious identity. A purely secular bioethics risks alienating large segments of the population for whom morality is rooted in scripture and spiritual tradition. Ssebunnya (2016) calls for a shift in African bioethics from passive acceptance of Western frameworks to active engagement in shaping ethical discourse. Rather than adopting a separate "African bioethics," the goal should be to integrate African values such as communal well-being into global bioethical debates.

This approach is crucial for addressing healthcare disparities affecting queer communities and ensuring that bioethics remains relevant to the realities of religious pluralism, cultural diversity, and access to care in Africa. Behrens (2013) advocates for the development of an "indigenous African bioethics" grounded in the country's cultural norms, religious diversity, and healthcare realities to address past injustices and enhance ethical decision-making in dignified care. The advancement of African bioethics requires a deliberate and contextually grounded effort to challenge exclusionary frameworks and to reimagine ethical discourse in a way that honours both indigenous values and the lived experiences of marginalised communities. Queer bioethics and African bioethics, though distinct in their origins, share a critical orientation toward the historical erasure of vulnerable groups in healthcare ethics.

Queer bioethics highlights the systemic marginalisation of sexual minorities and advocates for justice-driven, inclusive approaches to health and well-being (Sudenkaarne & Kähkönen, 2018). In parallel, African bioethics critiques the passive transplantation of Western ethical paradigms and instead calls for a reorientation toward indigenous knowledge systems, cultural values, and moral traditions that reflect African realities (Ssebunnya, 2016).

At the core of this convergence is the shared emphasis on context-sensitive and inclusive bioethics. The African concept of communal well-being, central to ethical frameworks such as *ubuntu*, offers a moral foundation for addressing health inequities, while also affirming interconnectedness and relational responsibility (Behrens, 2013). When coupled with queer bioethics' focus on equity and recognition, this approach has the potential to transform bioethics into a more culturally responsive and socially just discipline.

South Africa’s moral and legal landscape underscores the urgency of this transformation. While the constitution guarantees equality for all, including LGBTQ+ individuals, public attitudes often diverge sharply. A significant proportion of South Africans, 61% continue to view homosexuality as unacceptable (Kotzé & Loubser, 2018), a perspective that contributes to systemic discrimination, particularly in healthcare. Men who have sex with men (MSM), for example, often encounter barriers to care that are rationalised through religious or cultural belief systems, thereby violating the fundamental bioethical principles of non-maleficence, justice, and respect for persons.

In light of this, the development of African bioethics must move beyond binaries of faith versus rights. It must instead embrace what can be termed "moral bilingualism", the capacity to engage both religious conviction and human rights discourse with intellectual honesty and compassion. This does not require the erasure of theological traditions, nor the imposition of liberal secularism. Rather, it calls for dialogue that centres dignity, care, and inclusion, enabling ethical frameworks that resonate with local beliefs while upholding universal human dignity.

Ultimately, a future-facing African bioethics must be interdisciplinary, intersectional, and grounded in African realities. It must be bold enough to challenge prejudice; whether justified through religion, culture, or law; and generous enough to build bridges across difference. Only through such an approach can bioethics in Africa evolve as a force for equity, inclusion, and healing.

2.4. Conclusion

A more inclusive healthcare system will affirm the humanness of MSM and uphold their right to dignified care. Achieving this requires context-appropriate interventions that balance religious pluralism with the need to eliminate discrimination in healthcare. This, in turn, demands a deeper understanding of the patient-healthcare worker relationship and the bioethical framework guiding care. An African bioethics approach, enriched with queer bioethics, offers a crucial foundation for fostering equity and ethical integrity in healthcare. The imperative is to advocate for and develop indigenous African bioethics. Chapter three will present the study theoretical framework and research methodology.

Chapter 3: Theoretical Framework and Research Methodology

This chapter builds upon the discussion in Chapter Two, which highlighted the need for an indigenous African bioethics framework to promote equity and ethical integrity in healthcare. By integrating queer bioethics with indigenous African bioethics, the study challenges dominant paradigms that have historically marginalised sexual minorities in healthcare. Queer bioethics critiques the exclusion of sexual minority experiences, advocating for justice-oriented approaches (Sudenkaarne & Kähkönen, 2018), while African bioethics emphasises the integration of indigenous values to address healthcare disparities (Ssebunnya, 2016).

Combining these perspectives highlights the importance of creating inclusive, culturally responsive, and context-specific ethical frameworks, especially when navigating the complexities of religious pluralism in healthcare. This chapter outlines the theoretical framework guiding the study, focusing on Africa-specific bioethical considerations to improve MSM healthcare in public facilities. It also details the research methodology, including the primary research question; how healthcare workers navigate religious pluralism in providing MSM healthcare, and the strategies used to explore this issue.

Furthermore, the chapter examines Principlism as a theoretical framework for developing indigenous African bioethics, evaluating its advantages and limitations, and explores how queer bioethics bridges gaps between mainstream bioethics and the ethical concerns of marginalised groups, particularly MSM populations, in African healthcare systems.

3.1. Examining Principlism: A Western Born Framework

Bioethics emerged in pluralistic and democratic societies as a structured response to fundamental 'moral disagreements' on biomedical knowledge, new medical technologies, and the organisation and delivery of healthcare services (Lukow, 2018, p.3). However, dominant bioethical paradigms have been largely shaped by Western moral philosophies, particularly Principlism, which relies on four foundational principles; autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2008). Principlism has been described as 'the most influential approach' in bioethics (Ainslie, 2002, p.3) and offers a structured framework for addressing ethical dilemmas.

The four core principles underpinning Principlism; autonomy, beneficence, nonmaleficence, and justice, provide a common-morality approach that enables decision-making in diverse healthcare contexts (McCormick, 2023). While Principlism serves as a widely recognised ethical framework, its emphasis on individual autonomy makes it difficult to apply in African contexts, where communal values and relational ethics play a central role (Behrens, 2013).

The Role of Principlism in Navigating Religious Pluralism

One of the significant challenges in African bioethics is religious pluralism, which influences healthcare delivery and the rights of marginalised communities, including MSM individuals. Keeling and Bellefleur (2016, p. 2) argue that Principlism provides a way to ‘bypass intractable moral disagreements’ in biomedical ethics, making it a suitable model for addressing ethical conflicts in healthcare settings. Principlism plays a crucial role in ensuring that MSM individuals receive non-discriminatory and ethically sound healthcare by providing a framework that reconciles religious diversity with medical ethics.

By emphasising the principles of justice and beneficence, healthcare providers can ‘advocate for inclusive policies’ that prioritise equal access to care, regardless of religious or cultural beliefs (Kahkonen, 2018, p. 3-4). This approach helps mitigate systemic discrimination while fostering a more ethical and equitable healthcare environment for marginalised communities.

The Four Principles of Principlism in African Bioethics

Respect for Autonomy: Traditionally, autonomy in bioethics refers to an individual's right to make independent medical decisions free from coercion. However, in African ethical traditions, autonomy is relational, meaning that healthcare decisions are not made in isolation but involve families, elders, and broader community structures (Behrens, 2013). This communal approach challenges the Western individualistic model of autonomy and underscores the importance of collective decision-making in medical ethics.

Nonmaleficence: The principle of nonmaleficence obligates healthcare workers to prevent harm and protect patients from unnecessary suffering. In the African healthcare context, this extends beyond clinical interactions to recognising broader social determinants of health that may contribute to harm, such as stigma, discrimination, and limited access to essential medical services. Addressing these factors is essential in ensuring that healthcare remains ethical, equitable, and culturally sensitive.

Beneficence: Beneficence requires healthcare providers to actively promote patient well-being by prioritising medical interventions that enhance health outcomes. Within an African bioethical framework, beneficence is extended to communal well-being, ensuring that healthcare decisions foster harmonious relationships and do not disrupt social cohesion. This perspective aligns with African moral philosophies, which emphasise interdependence and collective well-being over purely individualistic benefits.

Justice: Justice in Western bioethics is often understood as fairness in the distribution of healthcare resources. However, in African bioethics, the concept is more closely associated with harmony, which encompasses both social justice and equity (Behrens, 2013). Rather than focusing solely on individual entitlements, justice in an African framework ensures that healthcare policies promote communal stability, fairness, and shared responsibility for health equity and accessibility.

By contextualising the four principles of Principlism within an African ethical landscape, bioethics can become more inclusive, socially relevant, and culturally responsive, addressing both historical injustices and contemporary healthcare challenges.

3.2. The Intersection of Queer Bioethics and Indigenous African Bioethics

Queer bioethics challenges normative power structures and their impact on sexual minority individuals in healthcare, particularly by critiquing the dominant frameworks that often marginalise sexual minorities (Kahkonen, 2018). It offers a critical lens through which the intersection of religious pluralism and cultural traditions can be examined, especially regarding their effects on the treatment of sexual minorities in African healthcare systems.

The Role of Queer Bioethics in African Bioethical Development

Addressing Religious and Cultural Barriers: Many African nations maintain heteronormative medical ethics that marginalise men who have sex with men (MSM). Queer bioethics introduces inclusive ethical frameworks that promote equal healthcare access and rights for sexual minorities (Kahkonen, 2018).

Bridging Gaps in Mainstream Bioethics: While Principlism offers a consistent ethical framework, it lacks the depth needed to address the nuances of marginalised identities. Queer bioethics strengthens African bioethics by advocating for culturally sensitive, justice-driven approaches to healthcare for MSM individuals.

Social Justice and Communitarian Values: Aligning queer bioethics with indigenous African bioethics ensures that the principle of justice is understood in a contextual manner, emphasising community values such as harmony and solidarity, which are central to ethical decision-making in many African cultures (Behrens, 2013).

3.3. Principlism in Developing Indigenous African Bioethics

Advantages of Principlism

Universality and Flexibility: Principlism provides a universal ethical framework that can be adapted to various cultural and religious contexts, making it suitable for diverse settings, including African nations (Ainslie, 2002).

Resolves Ethical Conflicts: The prima facie nature of the four principles in Principlism allows for context-sensitive decision-making, particularly when navigating ethical dilemmas arising from religious pluralism (Keeling & Bellefleur, 2016).

Promotes Ethical Healthcare Policies: Principlism's widespread use in global health policymaking makes it a valuable tool for promoting equitable healthcare policies for marginalised groups, including MSM individuals (McCormick, 2023).

Drawbacks of Principlism

Overemphasis on Autonomy: Principlism's emphasis on individual autonomy contrasts with African moral philosophies that prioritise relational autonomy and communal interdependence (Behrens, 2013).

Ethical Reductionism: Principlism's simplification of ethical issues may limit the analysis of deeper moral concerns, particularly those related to structural inequalities and historical injustices that affect marginalised groups (Callahan, 2003; Keeling & Bellefleur, 2016).

Lack of Communitarian Emphasis: While African bioethics values interconnectedness and harmony, Principlism does not fully integrate these communitarian principles into its ethical framework, potentially overlooking the importance of community-centered decision-making (Ssebunnya, 2016).

While Principlism provides a foundational ethical structure, it must be revised and contextualised for African settings. Scholars such as Behrens (2013) and Ssebunnya (2016) advocate for an African-inspired Principlism, which integrates communitarian values, relational ethics, and social justice. Queer bioethics also plays a pivotal role in challenging bioethical norms and ensuring marginalised voices are included in the development of African bioethics.

By replacing *justice with harmony* and redefining *autonomy as respect for persons*, bioethical decision-making in Africa can become more inclusive, socially responsive, and culturally relevant. Moving forward, the decolonisation of bioethics should aim to merge indigenous values with global ethical debates, ensuring that ethical frameworks remain both locally grounded and globally informed.

3.4. Research Methodology and Sampling

For this study a qualitative research methodology, 'an interpretative approach, which attempts to gain insight into the specific meanings and behaviours experienced in certain social phenomena through the subjective experiences of participants', will be employed. (Palmer, 2006, p. 1).

Palmer (2006, p. 18) makes the observation that qualitative research ‘captures the details, practices, and experiences of the study participants (subjects) as they occur’. To benefit and contribute value to the study, purposive sampling will be employed to recruit a cohort of ten gender diverse healthcare workers who have experienced religious pluralism in the workplace, and have a minimum of three years’ work experience in a public healthcare facility (Radhakrishnan, 2014).

In consideration of institutional buy-in and ethical support, a structured approach will guide the study at the clinic. A gatekeeper letter and accompanying study brief will be sent to the Hospital Chief Executive Officer to request permission and ethical clearance to conduct the study by inviting healthcare workers to volunteer as study participants. Once written approval is obtained, I will deliver a presentation to the clinic team introducing the study, outlining the informed consent process, and highlighting both the benefits of the study and its relevance to healthcare in South Africa. This presentation will also explain how the study’s objectives aim to strengthen bioethics by helping healthcare workers navigate religious pluralism when providing care to gender-diverse patients. Following the presentation, healthcare providers will be given the opportunity to engage in a question-and-answer session, particularly concerning their participation. The risks and benefits as voluntary study participants will be discussed in detail, with explicit reassurance that participation, or non-participation, will have no bearing on their employment or standing at the clinic or hospital.

To ensure that participants contribute meaningfully to the study, specific inclusion and exclusion criteria have been established. These criteria ensure that selected individuals have the necessary experience and expertise to provide insights into how healthcare workers navigate religious pluralism in MSM healthcare provision.

Inclusion Criteria

Participants must be practicing healthcare workers in a public healthcare facility. This includes doctors, nurses, clinical officers, and allied health professionals who engage in direct patient care. To ensure adequate professional experience, participants must have a minimum of three years' work experience in a public healthcare setting. Recognising the importance of diverse perspectives, the study aims to include gender-diverse healthcare workers.

This approach ensures that the study captures a broad spectrum of experiences regarding religious pluralism and MSM healthcare. Furthermore, participants must have experience with religious pluralism in the workplace, particularly in how it affects the provision of care to MSM individuals. Another critical criterion is direct involvement in MSM healthcare. Participants must have provided healthcare services to MSM patients or engaged professionally with MSM health concerns. Lastly, all participants must demonstrate a willingness to discuss their experiences and perspectives on religious pluralism, MSM healthcare provision, and bioethical considerations.

Exclusion Criteria

Participants who do not meet the inclusion criteria will be excluded from the study. This includes healthcare workers who do not work in public healthcare facilities or lack experience in MSM healthcare. Additionally, individuals with less than three years of work experience in a public healthcare setting will not be eligible, as their limited exposure may not provide the depth of insight required. Those who have not encountered religious pluralism in their workplace setting will also be excluded, as the study focuses on the interaction between religious diversity and MSM healthcare provision. Furthermore, individuals who are not comfortable discussing religious pluralism, MSM healthcare, or bioethical considerations will be excluded to maintain the integrity of the research discussions.

Finally, healthcare professionals whose primary responsibilities are administrative or policy-related, rather than direct clinical engagement with MSM patients, will not be included. Their perspectives, while valuable in other contexts, do not align with the study's focus on frontline healthcare providers navigating religious pluralism in MSM healthcare. By adhering to these inclusion and exclusion criteria, the study ensures that participants provide relevant, experience-based insights into the ethical and practical challenges of MSM healthcare in religiously pluralistic settings.

Purposive sampling is an effective method for selecting healthcare workers with direct experience in providing care to MSM populations. This approach ensures that participants possess specialised knowledge and insights into the challenges associated with navigating religious pluralism in healthcare settings. By deliberately selecting individuals with relevant expertise, the study can generate in-depth, meaningful data.

A qualitative study conducted in Indonesia demonstrated the effectiveness of purposive sampling by capturing detailed perspectives from nurses caring for HIV-positive MSM, illustrating its ability to access specialised experiences (Sari et al., 2022). Research on MSM healthcare often involves sensitive and stigmatised issues, making it difficult to explore through random sampling methods.

Purposive sampling enables the deliberate inclusion of participants who are both knowledgeable and willing to engage in discussions on these topics, thus facilitating richer and more insightful data collection. A systematic review identified non-probabilistic sampling methods, including purposive sampling, as particularly useful in accessing hard-to-reach populations such as MSM and sex workers. This highlights the method’s effectiveness in investigating sensitive research areas where participant selection requires careful consideration (Shaghaghi et al., 2011).

By selecting study participants who work within specific cultural and religious contexts, purposive sampling ensures that the study's findings are rooted in the socio-cultural dynamics relevant to MSM healthcare. This approach is particularly important when examining how religious pluralism influences healthcare delivery, as it captures the intersection between religious diversity and medical practice. Through purposive sampling, the study can provide a nuanced understanding of how healthcare workers navigate these complexities, offering culturally and contextually relevant insights into MSM healthcare provision.

3.5. Data Collection Methods

Demographical, Likert Scale, and open-ended questions administered using an online anonymous questionnaire will gather study participant information following an informed consent process. The questionnaire will have three sections: (a) Section 1: demographic data, (b) Section 2: religiosity data, and (c) Section 3: open-ended responses. Data for this study will be collected from participants employed at the Thembalethu Wellness HIV/TB Clinic, located at 1389 Chota, Motala Road, Northdale Hospital, within the Pietermaritzburg Health Complex in KwaZulu-Natal, South Africa. Questionnaires will be distributed to willing participants, who will have between March to May 2025 to complete them. The collected data will later be analysed in June 2025.

3.6. Analytical Approach

Demographical data gathered from Section 1, will provide insights to study participants' professional and religious backgrounds. Data resulting from Section 2, will be analysed using the Centrality of Religiosity Scale (CRS) to measure healthcare workers' degree of religiosity into three categories; "highly-religious", "religious", or "non-religious" (Huber, 2012, p1). It includes 15 Likert-scale questions across a Five-Dimensional Model of Religiosity, designed to explore individuals' religious life experiences. This approach highlights the interplay between sociologically defined core dimensions and the psychologically defined personal religious construct of each individual (Huber, 2012, p. 3-4).

Open-ended questions from Section 3 will be analysed using the Principlism framework to explore how healthcare workers navigate religious pluralism in providing care for MSM within existing bioethical frameworks. Principlism invokes the question of common morality by judging the human conduct and decisions of healthcare workers against the principles of respect for autonomy, nonmaleficence, beneficence, and justice (Gordon, 2009; Keeling, 2016).

John-Stewart Gordon (2009) stipulates that common morality does not solve every moral question and disagreement, rather it is a framework or system that can help individuals decide what to do when faced with moral problems within limits. The actions of healthcare workers navigating religious pluralism are guided by reflective equilibrium, a process involving the continual refinement and clarification of ethical principles through a back-and-forth comparison with real-world observations and moral judgments from specific cases (Keeling, 2016).

Principlism addresses the challenge of developing a structured moral system such as indigenous African bioethics where (1) certain rights within a specific category are given fixed priority over others in different categories, and (2) it becomes extremely difficult for even morally compelling social goals to override these basic rights (Beauchamp, 2013). When applied effectively, Principlism can improve the relationship between the healthcare worker and the patient by demonstrating the extent to which one human, responsible for the provision of care to another, can remain committed to their religious beliefs and convictions without compromising the provision of care.

Coding is the process of assigning meaningful labels to data to identify key themes (Linneberg & Korsgaard, 2019; Saldana, 2015). This study will analyse participants' responses using deductive coding, which applies a pre-defined set of theoretical concepts, and abduction, which allows for flexibility in recognising unexpected patterns while maintaining theoretical alignment (Linneberg & Korsgaard, 2019). These methods will be used to explore (a) healthcare workers' perspectives on sexual minorities in relation to their religious identities and beliefs, (b) how they navigate religious pluralism in providing care, and (c) their recommendations for improving bioethical standards.

In this study, Claude.ai will be used as a supportive tool to assist with the qualitative analysis of interview transcripts and open-ended responses. The software will help organise thematic content, summarise participant narratives in relation to the Central Religiosity Scale (CRS), and suggest patterns not immediately apparent. However, its use will not replace my role in interpretation. Rather, it will support deeper reflection and enhance analytical consistency. The integration of the software will be guided by emerging ethical standards that prioritise transparency, human oversight, and accountability in academic research (Floridi & Cowls, 2022; van Dis et al., 2023). In line with these principles, full responsibility for coding, theme development, and interpretation will remain with me, ensuring that the use of Claude.ai enhances but does not compromise the integrity, nuance, or ethical rigour of the study.

3.7. Ethical Considerations

An ethics application will be submitted to the University of KwaZulu-Natal’s Ethics Committee to comply with research ethical standards and guidelines and withstand ethical scrutiny. Study participant engagement will be underpinned by an informed consent process to explain the risks, benefits, and potential harms that could arise from study participation. Study participants will voluntarily complete an anonymous online questionnaire, mitigating the potential risk to identity exposure as legal identification details will not be used. Study participants may withdraw from the study at any time without any consequences. As a South African coloured man raised in the Pentecostal Christian tradition, I bring to this study a personal and faith-based lens that shapes my worldview. However, I acknowledge that I am an outsider to both academic religious and gender studies. My engagement with these fields is therefore grounded not in academic authority, but in a deep respect for the complexity and diversity of human experience.

While I remain rooted in my Christian convictions, I recognise the pluralistic and democratic nature of South African society where difference must be respected and protected. My professional background in public health has equipped me with practical experience in navigating social inequities and ethical complexities in real-world settings. This experience gives me a degree of institutional and analytical power, which I will exercise with care and reflexivity.

To preserve the integrity of this study, I will ensure that participants' narratives, particularly as expressed through the Central Religiosity Scale (CRS), are centred and not overshadowed by my own beliefs. I will avoid leading questions, uphold voluntary participation, and use culturally appropriate, objective data collection tools. The use of Claude.ai will support consistent and transparent analysis, but all interpretive responsibility will remain mine. In line with ethical guidelines for research with human participants, I will prioritise dignity, clarity, and informed consent throughout the study. My commitment is to honour participant voices, ensure methodological rigour, and approach the research with humility and academic integrity.

3.8. Conclusion

This study will examine and advocate for the development of indigenous African bioethics to address MSM healthcare discrimination in the context of religious pluralism. Using Principlism's four core principles; respect for autonomy, nonmaleficence, beneficence, and justice, healthcare workers' decisions in MSM care will be analysed. Responses will be analysed through Principlism to identify the intersection of personal beliefs and professional duties. Chapter four will present the study data, analysis, and findings.

Chapter 4: Data Presentation, Analysis, and Findings

My study was undertaken as part of my commitment to contributing to the improvement of South Africa’s public healthcare system, particularly in ensuring equitable and dignified care for all. While the Constitution guarantees the right to healthcare free from discrimination (Republic of South Africa, 1996), structural barriers continue to undermine the realisation of this right, especially for socio-economically disadvantaged and gender-diverse populations, including men who have sex with men (MSM). Studies have consistently shown that LGBTQI+ individuals face stigma in public health settings, often leading to poor health outcomes and limited engagement with services (Müller, 2016; Mudarikwa, 2018).

My data collection, initially scheduled for one month at the Thembalethu Wellness HIV/TB Clinic in Pietermaritzburg, extended over three months due to a range of systemic challenges. These included poor infrastructure, lack of basic office supplies (paper, ink), unreliable internet connectivity, and limited staff access to email. These issues mirror broader inefficiencies in South Africa’s overstretched public health system (Pillay-van Wyk et al., 2019). Despite enthusiasm for the study's long-term benefits, particularly in equipping healthcare workers to better engage MSM, the immediate day-to-day burdens on staff such as resource shortages and high patient loads were understandably prioritised.

To accommodate these limitations, I adapted the study methodology. After limited uptake at the clinic, I disseminated the anonymous online questionnaire with hospital management to broaden participation. This required additional approval processes, ultimately delaying data collection by two months. My observation is that these practical challenges highlight how routine operational constraints in public facilities can significantly affect research, service delivery, and the ability of health workers to implement inclusive care practices.

Despite these hurdles, the study successfully captured critical insights into healthcare workers’ attitudes and experiences, offering an evidence base to support future training and system-level reforms. It also affirms the pressing need to address the structural conditions that constrain both patients' access to care and health workers' capacity to deliver it.

This chapter presents study data of 18 healthcare workers organised through demographic trends, the Centrality of Religiosity Scale (CRS), and an analysis of open-ended responses. Study data are analysed against the principles of Principlism to determine how healthcare workers reconcile their religious beliefs with professional obligations. While Principlism offers a universal ethical foundation, it requires adaptation for African contexts where communal values and relational ethics play a central role (Behrens, 2013; Ssebunnya, 2016). This study integrates Behrens' (2013) approach by redefining *justice as harmony* and *autonomy as respect for persons*, aligning ethical principles with African moral philosophy. The analysis applies these adaptations by examining collective decision-making and communitarian ethics in MSM healthcare provision.

The analysis of participants' responses required a methodical approach that could capture both the explicit content of their statements and the underlying patterns that might reveal deeper insights about how healthcare workers navigate religious pluralism in MSM care. Drawing on established qualitative research principles, I employed a systematic coding process that combined predetermined theoretical frameworks with openness to unexpected themes emerging from the data itself.

Developing the Coding Framework

My analytical approach began with the development of an appropriate coding framework grounded in the theoretical foundations established in earlier chapters. The framework needed to accommodate both the Principlism principles central to bioethical analysis and the African contextual adaptations proposed by Behrens (2013), particularly the reconceptualisation of justice as harmony and autonomy as respect for persons within communitarian frameworks.

For each of the five open-ended questions, I determined primary coding categories that reflected anticipated response patterns while remaining sufficiently flexible to capture nuanced perspectives. The first question, examining participants' understanding of their religion's position on same-sex relationships, initially seemed straightforward, suggesting categories such as "condemns," "supports," or "neutral." However, early reading of responses revealed the need for more sophisticated categories that could capture the theological complexity many participants demonstrated.

The coding scheme that emerged recognised that participants often distinguished between different levels of religious authority, scriptural, denominational, pastoral, or personal interpretation when discussing their religion's stance. This distinction proved crucial for understanding how healthcare workers positioned themselves relative to various sources of religious guidance and created space for personal agency within institutional religious frameworks.

Similarly, the second question exploring alignment between personal and religious positions required coding categories that could accommodate the sophisticated reasoning processes participants employed. Rather than simple agreement or disagreement, responses revealed complex negotiations between institutional religious teachings, personal spiritual convictions, professional ethical obligations, and individual moral reasoning. The coding framework evolved to capture these multiple dimensions of moral decision-making.

The Deductive Coding Process

I began the systematic coding process by applying the predetermined categories to each participant's responses, working methodically through the dataset while maintaining notes about coding decisions and emerging patterns. This deductive approach provided essential structure for the analysis while ensuring that theoretical frameworks remained central to the interpretation process.

During this initial coding phase, I paid particular attention to language that reflected the African bioethical adaptations central to this study. Responses that emphasised collective considerations, community impact, or relational approaches to ethical decision-making received special notation, as these elements distinguished African ethical reasoning from Western individualistic frameworks. For instance, when participants discussed their obligations to MSM patients in terms of broader community harmony or collective well-being, these responses were coded differently from those emphasising individual patient rights or personal autonomy. The integration of Behrens' adapted Principlism framework required careful attention to how participants conceptualised ethical obligations. Traditional Western Principlism might interpret a response emphasising community acceptance of diverse sexuality as relevant primarily to the justice principle.

However, within African communitarian frameworks, such responses might simultaneously engage concepts of harmony, collective decision-making, and relational ethics that span multiple principles. As I worked through the coding process, I documented decisions, questions, and emerging insights. This practice proved invaluable for maintaining consistency across the dataset and for tracking the evolution of my understanding as patterns became clearer. When coding decisions proved difficult or ambiguous, I would return to previous similar responses to ensure consistency in application.

Recognising Unexpected Patterns

While the deductive framework provided essential structure, some of the most significant insights emerged through patterns that exceeded the boundaries of predetermined categories. Early in the coding process, I began noticing sophisticated theological reasoning strategies that had not been anticipated in the original framework. Rather than simply accepting or rejecting religious teachings about sexuality, many highly religious participants demonstrated complex interpretive work that drew upon core theological concepts to support inclusive healthcare practices. These theological reframing strategies required the development of new analytical categories within the existing framework. For example, several participants employed what I came to understand as "theological universalism", using concepts like being created in God's image or divine love to argue for inclusive care regardless of sexual orientation. Others demonstrated "pastoral theology" approaches that emphasised love, compassion, and non-judgment over doctrinal specificity.

Another unexpected pattern emerged in how participants integrated scientific knowledge with religious and ethical frameworks. Rather than viewing these knowledge systems as inherently conflicting, several participants demonstrated sophisticated synthesis approaches that used genetic or medical knowledge to support theologically grounded arguments for inclusive care. These responses challenged assumptions about inevitable conflicts between religious faith and scientific understanding. The emergence of these unexpected patterns required flexibility in the analytical process. I found myself developing sub-codes and cross-references that could capture the complexity of participants' reasoning while maintaining the overall coherence of the coding framework. This process demonstrated the value of maintaining openness to data-driven insights while working within established theoretical frameworks.

Enhancing Analysis Through Technology

To complement the manual coding process and identify patterns that might escape initial observation, I employed Claude.ai to examine linguistic patterns and thematic relationships across the dataset. This software proved particularly valuable for identifying subtle vocabulary patterns and frequency distributions that would be difficult to track manually across eighteen participants and five questions each. The software analysis revealed interesting linguistic patterns that enhanced my understanding of how different religious categories approached ethical reasoning. For instance, highly religious participants showed unexpectedly frequent use of justice-related terminology, challenging conventional assumptions about the relationship between religious commitment and social justice orientations. The technology also identified co-occurrence patterns between different ethical concepts, revealing how participants who employed certain conflict resolution strategies tended to demonstrate particular approaches to other ethical questions.

One of the most valuable applications of the software involved cross-referencing response patterns with CRS scores to identify relationships between religiosity levels and specific ethical reasoning approaches. This analysis revealed non-linear patterns that manual coding might have missed, such as the finding that the most and least religious participants sometimes demonstrated more similar reasoning patterns than either group shared with moderately religious participants. However, I remained cautious about allowing software analysis to override interpretive understanding, particularly when dealing with culturally specific concepts that required contextual knowledge for appropriate interpretation. The software served as a tool for pattern identification rather than meaning interpretation.

Validation and Refinement

Throughout the analytical process, I employed different strategies to review the accuracy and credibility of my interpretations. I employed a limited member checking strategy to selected participants to confirm that my analytical interpretations accurately reflected their intended meanings. This process proved particularly important for responses involving culturally specific concepts or theological reasoning that might be susceptible to misinterpretation by someone outside those traditions.

I also engaged in systematic triangulation with existing literature on African bioethics and religious pluralism in healthcare. This process helped validate emerging themes while identifying areas where my findings extended or challenged existing theoretical understanding. When my interpretations aligned with established patterns in the literature, this consistency enhanced confidence in the analytical conclusions. When findings diverged from expected patterns, I conducted additional analysis to ensure that these divergences reflected genuine insights rather than interpretive errors. Regular consultation with colleagues familiar with African healthcare contexts and religious diversity provided additional validation of interpretive decisions. These conversations proved particularly valuable for identifying potential cultural blind spots or assumptions that might influence my interpretation of participants' responses.

Integration and Synthesis

The final phase of analysis involved systematic integration of insights derived from manual coding, technological pattern identification, and validation processes. This integration required careful evaluation of convergent and divergent findings, with particular attention to ensuring that software-enhanced insights complemented rather than contradicted contextually informed human interpretation. Where software analysis identified patterns that had not emerged during manual coding, I returned to the original response data to examine these patterns in context. This process often revealed subtle linguistic or thematic relationships that enriched my understanding of participant reasoning processes. Conversely, when manual analysis had identified significant themes, I used software capabilities to examine their frequency and distribution across the dataset more systematically.

The synthesis process revealed several key insights that emerged only through the combination of analytical approaches. The identification of four distinct conflict resolution strategies, for instance, resulted from manual recognition of individual approaches combined with systematic analysis of their frequency and co-occurrence patterns across religious categories. Throughout this integration process, I maintained notes of which insights emerged from different analytical approaches, ensuring transparency about the methodological foundations of various findings. These notes inform a thinking to evaluate the credibility of different conclusions appropriately while understanding the methodological complexity underlying the analysis.

Maintaining Cultural Authenticity

Central to my analytical approach was a commitment to preserving the authenticity of participants' perspectives and ensuring that interpretations respected the complexity of their reasoning processes. This commitment required ongoing vigilance against imposing external frameworks that might distort or oversimplify the sophisticated ethical thinking many participants demonstrated. The integration of African bioethical frameworks proved crucial for maintaining this authenticity, particularly when interpreting responses that reflected communitarian values and relational approaches to ethical decision-making. I employed software capabilities cautiously in these areas, ensuring that software-based pattern identification did not override culturally informed human interpretation.

My positioning as a researcher within African contexts, although limited, required deliberate reflexive attention throughout the analytical process. I systematically documented personal responses to emerging themes, noted potential areas of bias, and recorded the strategies used to address interpretive challenges. This reflexive practice was critical in identifying where Western bioethical assumptions might inadvertently shape my interpretations of responses rooted in African ethical traditions. By combining multiple analytical approaches with careful documentation of methodological decisions, I sought to maintain interpretive rigour and ensure that the analysis respected both theoretical frameworks and participant perspectives. Equally important was recognising how my own social identity shaped the research encounter.

As a Coloured Christian male in South Africa, my perspectives are influenced by histories of marginalisation, my faith, and experiences of travel across both developed and emerging economies. These cultural and experiential lenses affect how I understand and talk about health. For example, I often recall events not in calendar years but in relation to church life, family and professional milestones, or travel. Without sensitivity to these dimensions, my responses, and those of participants with similar positionalities, could easily be misinterpreted.

The systematic integration of multiple analytical approaches, combined with the documentation of methodological decisions and ongoing reflexive practice, provided a foundation for trustworthy interpretation that respects both theoretical frameworks and participant perspectives.

4.1. Study Participants' Demographical Data

Data collection involved obtaining informed consent and administering structured anonymous online questionnaires to healthcare workers in public health facilities. The questionnaire comprised three sections: (1) demographic data on professional roles, work experience, and religious affiliations; (2) the Centrality of Religiosity Scale (CRS) assessing religious commitment (Huber, 2012); and (3) open-ended questions exploring healthcare workers' views on MSM healthcare, religious pluralism, and ethical decision-making.

Table 1: Demographical Breakdown of Study Participants

Date	Participant	Sex	Gender	Religion	CRS Score	Category
4/8/2025	1	Male	Male	Christianity	3.93	Religious
5/20/2025	2	Male	Male	Islam	4.79	Highly religious
5/20/2025	3	Female	Female	Christianity	3.64	Religious
5/20/2025	4	Female	Female	Hinduism	4.14	Highly religious
5/22/2025	5	Female	Female	Christianity	3.86	Religious
5/30/2025	6	Female	Female	Other	1.57	Non-religious
6/2/2025	7	Female	Female	Christianity	3.36	Religious
6/2/2025	8	Male	Male	Christianity	4.43	Highly religious
6/2/2025	9	Female	Female	Christianity	4.07	Highly religious
6/2/2025	10	Female	Female	Christianity	4.86	Highly religious
6/2/2025	11	Female	Female	Hinduism	3.86	Religious
6/2/2025	12	Male	Male	Christianity	4.57	Highly religious
6/2/2025	13	Female	Female	Christianity	4.86	Highly religious
6/3/2025	14	Male	Male	Christianity	5.00	Highly religious
6/3/2025	15	Female	Female	Islam	3.71	Religious
6/3/2025	16	Female	Female	Christianity	2.86	Religious
6/3/2025	17	Female	Female	Christianity	4.07	Highly religious
6/3/2025	18	Female	Female	Other	3.14	Religious

This data forms the basis for analysing the interplay between personal beliefs, professional ethics, and bioethical considerations in African healthcare. This study included a purposive sample of 18 healthcare workers drawn from the public health sector. The age distribution indicated that the vast majority of participants (94.4%) were aged 35 years and above, with only one participant (5.6%) falling within the 26 to 30 age range. This age profile is reflective of a workforce with substantial experience (George and Reardon, 2013). Chart 1 presents sex assigned at birth data showing that 72.2% of participants were assigned female and 27.8% were assigned male at birth. Gender identity mirrored this distribution, with 72.2% identifying as female and 27.8% as male.

Chart 1: Study Participants' Sex Assigned at Birth

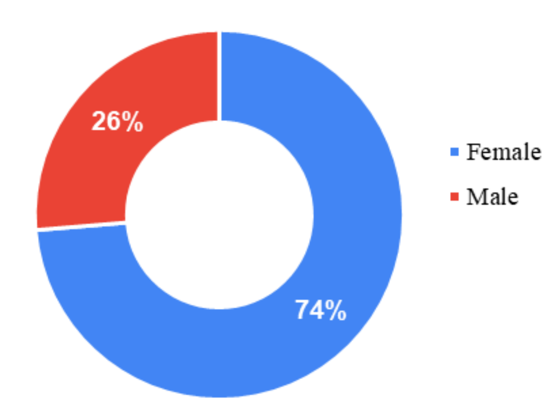
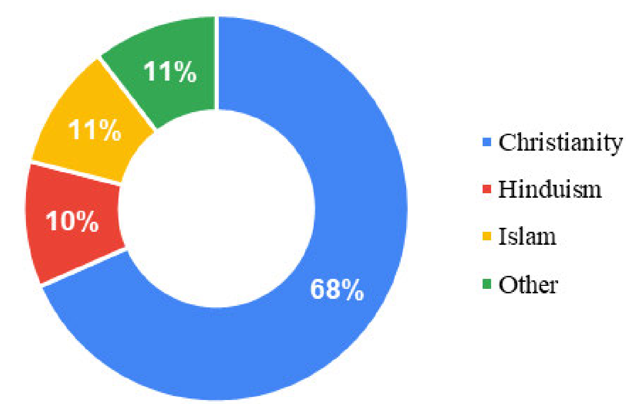


Chart 2: Study Participants' Religion



Religious affiliation presented in Chart 2 was also diverse among participants. Christianity was the most commonly reported religion (66.7%), followed by Islam (11.1%), Hinduism (11.1%), and other religions (11.1%). This diversity reflects the multicultural and multifaith composition of South African society and, by extension, its healthcare workforce (Statistics South Africa, 2022). A cross-tabulation between sex assigned at birth and religious affiliation revealed further nuances. Among participants assigned female at birth, 62% identified as Christian, 15% as Hindu, 15% as adherents of other religions, and 8% as Muslim. In contrast, participants assigned male at birth were more concentrated within Christianity (80%) and Islam (20%), with no representation from Hinduism or other religions. This suggests that religious diversity was greater among females in the sample, while males adhered to a narrower range of religious identities. Such patterns may be shaped by broader gendered trends in religious participation or community affiliations (Trzebiatowska & Bruce, 2012).

4.2. Measuring Study Participants' Religious Centrality

The measurement of religiosity represents a fundamental challenge in empirical research, as it encompasses multiple dimensions that cannot be adequately captured through single-item measures (Huber & Huber, 2012). To address this methodological concern, this study employed the Centrality of Religiosity Scale (CRS), a well-established multidimensional instrument developed by Huber and colleagues. The CRS has been extensively validated and applied in more than 100 studies across 25 countries with over 100,000 participants, making it one of the most robust measures of religious centrality available (Huber & Huber, 2012). The theoretical foundation of the CRS rests on Glock's five-dimensional model of religiosity, which identifies core dimensions that together represent the total scope of religious life (Glock, 1962; Stark & Glock, 1968). These dimensions include: (1) the intellectual dimension, measuring the frequency of thinking about religious issues; (2) the ideological dimension, assessing belief in transcendent reality; (3) the public practice dimension, evaluating participation in communal religious activities; (4) the private practice dimension, examining personal devotional practices; and (5) the experiential dimension, measuring direct religious experiences (Huber & Huber, 2012). Response coding followed the standardised procedures outlined in the CRS manual (Huber & Huber, 2012). Frequency responses were coded on a five-point scale (1 = never, 2 = rarely, 3 = occasionally, 4 = often, 5 = very often), while intensity and importance items utilised a corresponding five-point scale (1 = not at all, 2 = not very much, 3 = moderately, 4 = quite a bit, 5 = very much so).

Specific items requiring objective frequency coding, such as prayer frequency and religious service attendance, were recoded according to the established conversion tables provided in the original instrument documentation. The overall CRS score was calculated as the mean of all valid item scores, resulting in a possible range from 1.0 to 5.0. Following established categorisation criteria (Huber & Huber, 2012), participants were classified into three groups: non-religious (1.0-2.0), religious (2.1-3.9), and highly religious (4.0-5.0). This probabilistic categorisation approach recognises that individuals with higher CRS scores generally demonstrate a more central position of the religious construct system within their personality structure.

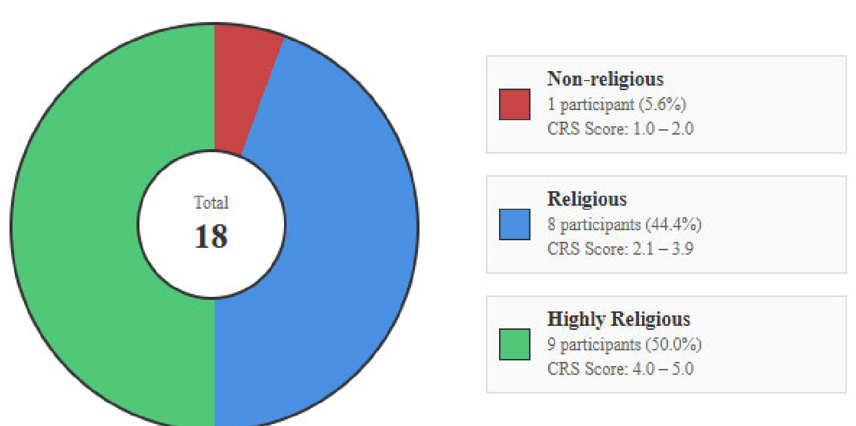
Table 2: Study Participants' Religious Centrality Categorisation

Participant	CRS Score	Category
1	3.93	Religious
2	4.79	Highly religious
3	3.64	Religious
4	4.14	Highly religious
5	3.86	Religious
6	1.57	Non-religious
7	3.36	Religious
8	4.43	Highly religious
9	4.07	Highly religious
10	4.86	Highly religious
11	3.86	Religious
12	4.57	Highly religious
13	4.86	Highly religious
14	5.00	Highly religious
15	3.71	Religious
16	2.86	Religious
17	4.07	Highly religious
18	3.14	Religious

The analysis of 18 study participants revealed a sample characterised by predominantly high levels of religiosity. The distribution across the three categories was as follows: one participant (5.6%) was classified as non-religious, eight participants (44.4%) as religious, and nine participants (50.0%) as highly religious. This distribution indicates a substantial presence of religiously oriented individuals within the study sample. The CRS scores demonstrated considerable variability, ranging from 1.57 to 5.00, with a mean score of 3.93 (SD = 0.82). The relatively high mean score, approaching the threshold for the highly religious category, suggests that religiosity occupies a central position in the lives of most participants. Notably, one participant achieved the maximum possible score of 5.0, indicating that religious constructs were maximally activated across all five dimensions.

Figure 1: Centrality of Religiosity Scale (CRS) Category Distribution

Study Participants (N = 18)



Statistic	Value
Mean CRS Score	3.93
Standard Deviation	0.82
Score Range	1.57 – 5.00
Religious + Highly Religious Combined	17 participants (94.4%)

Note: Categories based on Huber & Huber (2012) Centrality of Religiosity Scale classification criteria. The CRS measures religiosity across five dimensions: intellectual, ideological, public practice, private practice, and religious experience.

The non-religious category contained only Participant 6 (CRS = 1.57), representing a minimal activation of religious constructs across the measured dimensions. The religious category (CRS range: 2.86-3.93) included participants who demonstrated moderate levels of religious engagement, suggesting that while religious constructs are present in their personal construct systems, they are not maximally activated. The highly religious category (CRS range: 4.07-5.00) comprised exactly half of the sample, indicating that for these individuals, religious meanings occupy a highly central position in their personality structure.

The findings reveal important insights into the religious landscape of the study population. The predominance of participants scoring in the religious and highly religious categories (94.4% combined) suggests a sample where religious meanings play a significant role in personal identity and daily life. According to the theoretical framework underlying the CRS, individuals in the highly religious category should demonstrate greater differentiation in their religious construct systems and exhibit stronger connections between religious contents and general psychological dispositions (Huber & Huber, 2012).

The distribution observed in this study differs markedly from some normative samples reported in the international Religion Monitor, where greater variation across religious categories has been documented (Huber & Huber, 2012). This pattern may reflect specific characteristics of the recruitment context or geographic region, highlighting the importance of contextual factors in religiosity research. Africa and Asia have increasingly become the demographic and spiritual centres of global Christianity, a shift marked by the depth and pervasiveness of religious belief in these regions. Populations in both continents exhibit strong religious commitment, with high levels of theological engagement and integration of faith into personal and communal life. Empirical findings using the Centrality of Religiosity Scale (CRS) support this, showing that individuals with high CRS scores tend to demonstrate more developed religious meaning systems and stronger incorporation of theological constructs into their broader psychological functioning (Huber & Huber, 2012). In many African and Asian contexts, there is minimal identification with non-religious categories, highlighting the central role of faith in shaping identity, ethics, and social interaction. This pattern reflects a broader shift in the geography of Christianity, where the Global South, particularly sub-Saharan Africa and parts of Asia, now holds the majority of the world's Christian population and is actively shaping the theological and cultural contours of the religion (Jenkins, 2011; Pew Research Center, 2011).

4.3. Navigating Religious Pluralism in MSM Healthcare: A Principlism Analysis

This Principlism framework analysis builds on the religiosity assessment detailed in the previous section, where 18 study participants, using the Centrality of Religiosity Scale (CRS), were classified as non-religious (CRS 1.0-2.0), religious (CRS 2.1-3.9), or highly religious (CRS 4.0-5.0). The sample comprised one non-religious participant (5.6%), eight religious participants (44.4%), and nine highly religious participants (50.0%), representing a predominantly religious population.

Participants responded to five open-ended questions exploring their religious perspectives on same-sex relationships, personal positions relative to their religious teachings, the influence of religious beliefs on care delivery, strategies for navigating potential conflicts, and recommendations for enhancing bioethical standards. Those responses were analysed through a systematic application of Principlism's four core principles: autonomy, nonmaleficence, beneficence, and justice.

The coding process began with the systematic application of predetermined categories to each participant's responses, following a structured, deductive approach aligned with the study’s theoretical framework. Throughout this phase, I documented coding decisions and emerging patterns to ensure consistency and transparency. I paid attention to language reflecting African bioethical values, especially responses that highlighted communal responsibility, collective well-being, or relational decision-making. These were noted distinctly from responses framed around individual autonomy or personal rights. For example, when participants spoke of their ethical duties to MSM patients in terms of community harmony, these insights were interpreted within the African communitarian lens, rather than through a strictly Western principlist view.

The application of Behrens’ adapted principlism required careful reflection on how participants expressed ethical obligations, especially when responses intersected multiple principles such as justice, harmony, and relational ethics. When coding challenges arose, I reviewed similar cases to ensure consistency and refine thematic clarity. This iterative process strengthened the coherence of the analysis and deepened my understanding of how African ethical reasoning emerged in the data.

Figure 2: Principlism Framework Application in MSM Healthcare

Analysis by Religious Category (N = 18)

Four Principles Adherence Patterns

High (≥60%) Medium (30-59%) Low (<30%)

Principle	Non-religious (n=1)	Religious (n=8)	Highly Religious (n=9)
Autonomy	0% (0/1)	38% (3/8)	22% (2/9)
Nonmaleficence	0% (0/1)	13% (1/8)	11% (1/9)
Beneficence	100% (1/1)	63% (5/8)	78% (7/9)
Justice	100% (1/1)	38% (3/8)	67% (6/9)

The Religious Landscape of Ethical Decision-Making

The analysis revealed a complex relationship between religiosity and ethical healthcare practice that challenges conventional assumptions found in bioethical literature. Rather than finding evidence of a straightforward correlation where higher religiosity creates greater resistance to Principlism principles, the data illuminated varied patterns of adaptation, integration, and ethical reasoning across different levels of religious commitment. The single non-religious participant, with a CRS score of 1.57, demonstrated a clear compartmentalisation approach when discussing MSM care. This individual articulated an explicit separation between personal beliefs and professional responsibilities:

> *"My work and beliefs are totally different because it will feel like I'll be judging MSM. My job is to deliver a high standard of care without discrimination" (Participant 6, 30 May 2025).*

While this straightforward professional-personal boundary separation aligns with conventional expectations about secular approaches to healthcare ethics, the limited representation of non-religious participants in this sample prevents broader generalisations about this approach. The response does, however, illustrate one way that healthcare workers with lower religious centrality might navigate potential conflicts between personal perspectives and professional obligations. In contrast, both the religious and highly religious categories revealed unexpected sophistication in how participants approached potential conflicts between faith commitments and ethical healthcare practice.

Among religious participants (with CRS scores ranging from 2.86 to 3.93), responses reflected varying levels of comfort when working with men who have sex with men (MSM), as well as diverse strategies for reconciling personal beliefs with professional responsibilities. A recurring theme among several participants was the adaptation of religious interpretations to support non-discriminatory, inclusive healthcare; an approach that can be understood as a form of “theological flexibility”. This concept aligns with existing scholarship on how religious individuals negotiate identity conflicts in professional contexts. Yarhouse (2001) and Yarhouse and Tan (2004) describe this as "identity synthesis", a process by which individuals integrate seemingly conflicting aspects of their religious and professional selves without abandoning either.

Through the Sexual Identity Therapy (SIT) model, Yarhouse (2008) further illustrates how healthcare workers may reframe theological commitments to accommodate ethical professional care while maintaining personal faith. Westwood (2022) similarly notes that highly religious healthcare workers often face tension when asked to fully affirm LGBTQ+ identities. However, this dissonance can prompt the development of adaptive theological frameworks that allow them to maintain religious integrity while engaging compassionately with diverse patients (Crisp, 2017; Dessel et al., 2011; Héliot et al., 2020).

Pargament’s (2007) work on religious coping adds further theoretical grounding. He argues that individuals use their relationship with the sacred to find meaning during stress or conflict, often engaging in “active religious coping” strategies that involve theological reappraisal and a search for divine guidance (Pargament, Koenig & Perez, 2000). This framework helps explain how healthcare workers may reinterpret religious teachings to uphold both spiritual and professional values.

Chaplin (2023) advocates for accommodation within healthcare, suggesting that respectful, person-centred care must remain responsive to the moral and religious values of providers. Such flexibility, he argues, does not require compromising core beliefs but rather engaging with patients in a way that honours difference.

This perspective is reinforced by Holden et al. (2020), who note that professional identity formation in healthcare is shaped by dynamic and overlapping influences such as moral, religious, familial, and academic. He postulates that these identities evolve over time in response to social and clinical contexts. Taken together, the literature indicates that theological flexibility functions as a nuanced coping and identity management strategy. It enables religious healthcare providers to remain faithful to their beliefs while fulfilling professional obligations in inclusive, ethically grounded ways. This adaptive process reflects both spiritual maturity and an evolving professional competence shaped by reflective practice.

The highly religious category (CRS scores from 4.07 to 5.0) produced the most surprising findings. Rather than demonstrating the anticipated resistance to Principlism principles, many participants in this group articulated sophisticated theological and ethical frameworks that supported inclusive care. This challenges fundamental assumptions about the relationship between religious centrality and bioethical practice.

4.4. Principlism Application Patterns

Beneficence: The Unifying Principle

Across all religious categories, beneficence emerged as the most consistently applied and explicitly articulated principle. This finding suggests that regardless of religious orientation, healthcare workers share a fundamental commitment to patient welfare that transcends potential conflicts over sexual orientation. The non-religious participant demonstrated 100% alignment with beneficence themes, emphasising the duty to provide high-standard care. Among religious participants, 63% explicitly referenced beneficence-related concepts, while highly religious participants showed the strongest commitment at 78%.

The manifestation of beneficence varied across categories but consistently emphasised care, service, and assistance. Participant 9, with a highly religious classification (CRS 4.07), exemplified this orientation:

> *"I'm there to render a service not to judge." (Participant 9, 2 June 2025).*

This response demonstrates how beneficence can serve as a bridge between religious conviction and professional duty, providing a shared ethical foundation that transcends denominational or doctrinal differences. The dominance of beneficence across religious categories suggests that healthcare workers may intuitively prioritise patient welfare as a primary ethical obligation, potentially serving as a mediating factor when other principles create tension. This finding aligns with Gordon et al.'s (2011) observation that Principlism's strength lies in its ability to provide practical guidance while accommodating diverse moral frameworks.

Justice: The Unexpected Strength of Religious Commitment

Perhaps the most counterintuitive finding emerged in the analysis of the justice principle application. While conventional wisdom might suggest that religious commitment creates barriers to equitable treatment of sexual minorities, the data revealed the opposite pattern. Highly religious participants demonstrated the strongest justice orientation at 67%, compared to 38% among religious participants and 100% among the single non-religious participant. This pattern suggests that deep religious commitment may actually provide frameworks for understanding human dignity and equality that support rather than undermine just healthcare practices. Participant 10, with a highly religious classification (CRS 4.86), articulated this perspective:

> *"I treat all patients professionally and with dignity." (Participant 10, 2 June 2025).*

The emphasis on dignity, a concept deeply rooted in many religious traditions, appears to provide a theological foundation for equitable care delivery.

The justice principle manifestations among highly religious participants often drew explicitly on religious concepts of universal human worth. Participant 4 (CRS 4.14) exemplified this approach:

> *"I believe we are all made in the image of God, no matter what!" (Participant 4, 20 May 2025).*

This theological framework transforms potential discrimination into an affirmation of universal dignity, demonstrating how religious belief can reinforce rather than conflict with Principlism principles.

Autonomy: The Underemphasised Principle

Contrary to Principlism's traditional emphasis on autonomy as a cornerstone of medical ethics, this principle showed surprisingly low explicit recognition across all religious categories. Non-religious participants showed 0% explicit autonomy themes, religious participants 38%, and highly religious participants 22%. This finding suggests that healthcare workers may conceptualise patient autonomy differently than academic bioethical frameworks anticipate, or that autonomy may be implicitly assumed rather than explicitly articulated. When autonomy themes did appear, they typically focused on respecting patient rights and individual choice. Participant 18 (religious, CRS 3.14) captured this orientation:

> *"I think it's the individual's personal preference." (Participant 18, 3 June 2025).*

However, the relative underemphasis on autonomy across all categories suggests that other principles may take precedence in healthcare workers' ethical reasoning when addressing MSM care. This pattern may reflect the specific context of MSM care, where healthcare workers might prioritise non-discrimination and equitable treatment (justice) and compassionate care (beneficence) over explicit discussions of patient autonomy. Alternatively, it may indicate that autonomy is so fundamental to contemporary healthcare practice that it operates as an implicit assumption rather than an explicit consideration.

Nonmaleficence: The Articulation Gap

The principle of nonmaleficence showed consistently poor explicit articulation across all religious categories, with 0% among non-religious participants and approximately 11-13% among religious and highly religious participants. This finding is particularly noteworthy given nonmaleficence's status as one of medicine's most ancient and fundamental principles.

The limited explicit reference to "do no harm" concepts may reflect several factors. Healthcare workers might consider harm avoidance so fundamental to medical practice that it requires no explicit articulation. Alternatively, the specific context of MSM care might shift focus toward active care provision (beneficence) and equitable treatment (justice) rather than harm avoidance. When nonmaleficence themes did appear, they typically manifested as commitments to non-judgmental care rather than explicit harm avoidance language.

Across all religious categories, beneficence emerged as the most consistently expressed ethical principle, indicating a shared commitment among healthcare workers to patient welfare irrespective of religious belief. While 100% of non-religious participants reflected this principle, 63% of religious and 78% of highly religious participants also explicitly referenced beneficence, typically framed in terms of care, service, and non-judgment (Participant 9, 2 June 2025). This finding supports Gordon et al.'s (2011) argument that Principlism, when interpreted flexibly, offers a practical and cross-culturally resonant ethical framework. Beauchamp and Childress (2019), whose work established the four-principle approach, similarly affirm that beneficence is a universally relevant value, adaptable across diverse moral settings. Gillon (2003) reinforces this view, arguing that the principles are broad enough to encompass a wide range of moral traditions while prioritising respect for persons.

Interestingly, the justice principle was most strongly articulated among highly religious participants (67%), exceeding that of religious (38%) and non-religious (100%) participants. Responses grounded in concepts of universal dignity and theological affirmations such as the belief that all people are “made in the image of God” suggest that religious commitment may offer a compelling moral foundation for equitable care (Participant 4, 20 May 2025; Participant 10, 2 June 2025). This observation aligns with Ten Have and Gordijn's (2011) view that principlist frameworks, though Western in origin, can be meaningfully integrated with local moral and religious perspectives in global bioethics practice.

Autonomy was the least emphasised principle, with minimal explicit recognition across participant categories, 0% among non-religious, 38% among religious, and 22% among highly religious respondents. While Gillon (2003) argues for autonomy as "first among equals" within the Principlist model, its underrepresentation in this context may reflect a practical emphasis on relational ethics, community considerations, or the implicit assumption of patient autonomy within clinical norms (Participant 18, 3 June 2025). The principle of nonmaleficence, despite its longstanding status in medical ethics, was rarely mentioned directly, 0% among non-religious participants and only 11–13% among religious groups. References to harm were generally expressed through commitments to non-judgment rather than the explicit language of harm avoidance. Clouser and Gert (1990) critique the abstraction and ambiguity within Principlism, highlighting precisely such issues where principles like nonmaleficence may be too vaguely applied in practice.

Nevertheless, Gordon et al. (2011) argue that Principlism's strength lies in its adaptability, particularly when principles are used contextually rather than rigidly. Overall, the findings reinforce that, while not always evenly applied, the four principles of Principlism, particularly beneficence and justice, can function as ethical anchors in religiously diverse healthcare contexts, supporting Gordon et al.'s (2011) call for a culturally responsive yet universally applicable bioethical framework.

4.5. Conflict Resolution Strategies

The analysis identified four key strategies employed by religious healthcare workers to navigate tensions between personal religious convictions and professional obligations in delivering inclusive care to men who have sex with men (MSM). These strategies reflect complex ethical reasoning that challenges reductive assumptions about the incompatibility between religious belief and equitable healthcare delivery.

Compartmentalisation: Separating Belief and Duty

The most frequently observed strategy involved the clear separation of personal belief systems from professional healthcare roles. Participants across all levels of religiosity demonstrated this approach, recognising distinct ethical obligations within the clinical setting.

Participant 6 (non-religious, CRS 1.57) stated,

> *"My work and beliefs are totally different because it will feel like I'll be judging MSM" (Participant 6, 30 May 2025),*

while Participant 14 (highly religious, CRS 5.0) affirmed,

> *"I place my oath ahead of the religious belief" (Participant 14, 3 June 2025).*

This indicates that strong professional identity and training may function as ethical anchors capable of mediating internal value conflicts. Beauchamp and Childress (2019) emphasise the role of professional ethics in guiding practitioners when personal values may otherwise compromise patient care. Similarly, Gillon (2003) highlights the significance of principled autonomy and professional standards in maintaining impartial care delivery.

Theological Reframing: Adaptive Religious Interpretation

A second, more nuanced strategy involved reinterpreting religious teachings to align with inclusive care. Highly religious participants demonstrated theological flexibility, using doctrinal beliefs to affirm rather than reject MSM patients.

For instance, Participant 4 (CRS 4.14) stated,

> *"I believe we are all made in the image of God, no matter what!" (Participant 4, 20 May 2025),*

and Participant 12 (CRS 4.57) noted,

> *"My religious responsibility is to love sinners, not to judge them. I too am a sinner" (Participant 12, 2 June 2025).*

These responses exemplify theological reframing as a strategy to maintain religious integrity while delivering compassionate care.

Yarhouse and Tan (2004) describe a similar process in their concept of *sexual identity synthesis*, where religious individuals reconcile faith and ethical practice through interpretive re-evaluation, rather than doctrinal abandonment. This supports the idea that religious belief systems possess internal resources capable of ethical adaptation.

Scientific-Ethical Integration: Bridging Faith and Evidence

A third strategy involved the integration of scientific evidence with ethical and theological reasoning to support inclusive care. Participant 5 (religious, CRS 3.86) exemplified this approach by citing genetic research:

> *"There is robust scientific evidence that sexual orientation has a genetic component… Any judgement passed, based on sexual orientation, would therefore be grossly unfair, unethical and unscientific, whilst also discrediting the concept of a 'flawless creator'" (Participant 5, 22 May 2025).*

This strategy reflects the type of culturally and epistemologically pluralistic ethical reasoning advocated by Gordon, Rauprich, and Vollmann (2011), who argue that the four-principle model of bioethics can be adapted to support diverse cultural and religious frameworks, especially when practitioners actively engage multiple knowledge systems.

Professional Duty Prioritisation: Ethics Rooted in Training

The fourth strategy involved a strong emphasis on professional formation and ethical training as the primary framework for practice. Participant 7 (religious, CRS 3.36) stated,

> *"I just provide care based on how I was trained" (Participant 7, 2 June 2025),*

and Participant 8 (highly religious, CRS 4.43) echoed,

> *"I just do what is expected of me" (Participant 8, 2 June 2025).*

These responses underscore the centrality of professional education in establishing ethical boundaries and expectations. Gillon (2003) and Beauchamp and Childress (2019) argue that such training enables healthcare workers to prioritise patient welfare even when personal beliefs may differ. This highlights the importance of ethics education in preparing practitioners to navigate complex moral terrain with confidence and accountability.

Together, these strategies of compartmentalisation, theological reframing, scientific-ethical integration, and professional duty prioritisation demonstrate that religious healthcare workers are capable of complex, context-sensitive ethical reasoning. Far from being impediments to inclusive care, religious commitments, when engaged reflectively and supported by robust training, can coexist with and even reinforce principled, compassionate healthcare.

4.6. Religious Pluralism and African Bioethics in Healthcare: An Analysis

This analysis explores how healthcare workers navigate the moral complexities of providing care to men who have sex with men (MSM) through the lens of African bioethics. Using Behrens' (2013) and Ssebunnya's (2016) framework of African-inspired principlism, grounded in *Ubuntu*, it examines how the 18 healthcare workers align with or diverge from the redefined principles of *Justice as Harmony* and *Autonomy as Respect for Persons*, highlighting the relevance of African moral philosophy in contemporary healthcare practice. This framework emphasises that 'authentic personhood can only be attained through being in relationship or in community with others' (Behrens, 2013, p. 34).

Central to this approach is Metz's characterisation of Ubuntu as requiring 'harmonious relationships characterised by identifying with others and by solidarity' (Behrens, 2013, p. 34), reflecting the African understanding that 'my humanity is caught up, is inextricably bound up, in theirs' (Tutu, as cited in Behrens, 2013, p. 34).

Ssebunnya (2016) further develops this argument by identifying the 'conceptual bioethics lag in Africa' and emphasising that bioethics must be 'conceptualised and grounded in a matrix of moral values' (p. 9). He contends that authentic African engagement with bioethics requires moving beyond 'sterile African ethno-philosophy' toward 'authentic African conceptualisation and subsequent internalisation of bioethics' (p. 5).

Embodying Ubuntu: Love as the Overriding Principle

The most compelling demonstration of African bioethical principles emerges in Participant 12's response, a highly religious healthcare worker (CRS: 4.57) who navigates the tension between religious doctrine and professional care through the principle of love. Despite acknowledging that their religion "condemns" same-sex relationships and citing "multiple scriptures that call it sinful," the participant resolves this conflict by declaring:

> *"My religious responsibility is to love sinners, not to judge them. I too am a sinner... The principle of Love overrides my own beliefs." (Participant 12, 2 June 2025).*

This response powerfully embodies what Behrens (2013) identifies as the core of Ubuntu philosophy which is the recognition of shared humanity and interconnectedness. The participant's acknowledgment that "I too am a sinner" reflects the African understanding of communal vulnerability and mutual dependence that underlies authentic personhood.

By allowing "the principle of Love" to override doctrinal adherence, the participant demonstrates what Metz characterises as Ubuntu's emphasis on ‘living harmoniously or prizing communal relationships’ (as cited in Behrens, 2013, p. 34). This approach aligns with Behrens' (2013) critique of Western bioethics' focus on ‘autonomous, rational individuals that inhabit sterile theoretical worlds’ (p. 34), instead prioritising what he terms "flourishing human relationships."

The participant's response illustrates how African moral philosophy can provide a framework for healthcare workers to navigate religious pluralism without compromising either their spiritual convictions or their professional obligations.

Dignity Through Divine Creation: Universal Acceptance as Ubuntu Practice

Drawing from Anofuechi’s (2022) critical assessment of Ubuntu and participant perspectives in my study, the development of African bioethics must be rooted in indigenous moral frameworks while being critically aware of their limitations in diverse societies like South Africa.

Participant 16 (CRS: 2.86, Religious) exemplifies this complexity in their theological framing of diversity and embodiment:

> *"I do believe God has created individuals as unique and not in the absence of disability, such as genes malformation. We need to accept everyone... everyone is God creature." (Participant 16, 3 June 2025).*

This perspective echoes Behrens' (2013) and Ssebunnya's (2016) arguments for a communitarian African bioethics grounded in dignity, interdependence, and relational care. The participant's emphasis on shared divine creation and physiological variation reflects Ubuntu's moral emphasis on interconnectedness and human worth (Anofuechi, 2022). Such reasoning affirms Ssebunnya's (2016) claim that African bioethics should illuminate human dignity as an ethical anchor.

However, Anofuechi (2022) cautions against the universal application of Ubuntu, noting its contested and sometimes idealised nature. While Ubuntu promotes solidarity, reconciliation, and shared humanity, its practical limitations such as embedded patriarchy, heteronormativity, and exclusion of non-conforming identities require interrogation.

This is particularly relevant in contexts like South Africa, where constitutional rights for LGBTQ+ individuals often conflict with religious and cultural interpretations of morality. As Anofuechi shows, the different conceptualisations of Ubuntu by Shutte, Mbiti, and Gyekye underscore the lack of consensus on how communal identity and individual autonomy are balanced within African ethics. Participant 16's critique of religious texts for their silence on physiological differences further supports the need for bioethics that accounts for plural epistemologies and lived experiences, particularly concerning gender diversity. This reflects Metz and Gaie's (2010) view that Afro-communitarian ethics must evolve to remain relevant in rapidly changing societies. In conclusion, African bioethics must continue to develop through critical dialogue with religious thought, Ubuntu philosophy, and inclusive ethical reasoning. As Anofuechi (2022) argues, a nuanced approach to Ubuntu can offer valuable insights into moral formation, provided it remains contextually grounded and open to reinterpretation in light of contemporary moral challenges.

Compartmentalisation Versus Integration: The Limits of Professional Detachment

Some healthcare workers adopt a compartmentalised approach, separating personal beliefs from professional duties. Participant 6 (CRS: 1.57, Non-religious) exemplifies this stance:

> *"My work and beliefs are totally different because it will feel like I'll be judging MSM. My job is to deliver a high standard of care without discrimination." (Participant 6, 30 May 2025).*

While such detachment upholds professional standards of non-discrimination, it may miss the relational engagement emphasised in African bioethics. Behrens (2013) critiques Western bioethics for privileging abstract reasoning and individual autonomy, suggesting instead that African bioethics grounded in Ubuntu prioritises moral obligations that emerge from interpersonal connectedness and shared humanity. Ubuntu, in this sense, fosters a deeper ethic of care, not simply through neutrality, but through solidarity and moral interdependence (Behrens, 2013, p. 34).

Participant 5's scientifically reasoned stance, which appeals to constitutional and empirical ethics, also reflects a Western liberal paradigm. While rational and rights-based, this overlooks the communitarian dimensions central to African moral reasoning. As Ssebunnya (2016) argues, ethical frameworks grounded in African philosophy must not merely mirror Western principles but develop from indigenous moral content that prioritises community, dignity, and harmony (Ssebunnya, 2016, pp. 4–5).

Anofuechi (2022) similarly cautions against the uncritical application of Ubuntu in South African healthcare, noting that while Ubuntu offers valuable insights into communal ethics, its universal application is complicated by varying interpretations and contestations. Ubuntu, he argues, must be carefully contextualised to avoid superficial or romanticised applications that fail to address socio-political realities (Anofuechi, 2022, pp. 6–7).

Transcending Religious Doctrine: The Power of Shared Humanity

In contrast to compartmentalisation, Participant 4 (CRS: 4.14, Highly Religious) offers a deeply integrated and inclusive moral stance:

> *"I believe we are all made in the image of God, no matter what! I do not judge my patients; I'm there to listen and assist in any way I can." (Participant 4, 20 May 2025).*

This response exemplifies Ubuntu's ethical core: the assertion of shared personhood and interdependence. As Behrens (2013) notes, respect in African bioethics is not limited to autonomy but extends to the fullness of personhood situated within a relational community (p. 34). The participant's commitment to listening and assistance reflects Ubuntu's values of compassion, dignity, and care. Anofuechi (2022) reinforces this by highlighting Desmond Tutu's theology of Ubuntu as a framework for reconciliation and moral formation rooted in communal harmony, not doctrinal rigidity. Tutu's formulation, "I am because we are" expresses a moral obligation to affirm others' humanity, even amidst theological tension (Anofuechi, 2022, pp. 1–3).

Moreover, Egan (2017) stresses that in South Africa's pluralistic context, bioethics must move beyond strict analytical traditions to accommodate diverse epistemologies, including African philosophical insights. He warns against superficial applications of ethical principles and calls for deeper engagement with indigenous philosophies to foster genuinely inclusive and contextually grounded bioethics (Egan, 2017, p. 10). Together, these perspectives suggest that African bioethics, especially when shaped by Ubuntu, offers a powerful alternative to detached professionalism by encouraging morally engaged, relational care that harmonises professional duty with human solidarity.

4.7. Implications for African Bioethical Development

The analysis reveals significant variation in how healthcare workers integrate African moral principles into their professional practice when navigating religious pluralism. Those responses that most clearly embody Ubuntu philosophy; particularly Participants 4, 12, and 16, demonstrate the practical viability of Behrens' (2013) proposed African-inspired principlism.

These participants successfully navigate the tension between personal religious beliefs and professional obligations by drawing on deeper principles of love, shared humanity, and communal responsibility. These findings support Ssebunnya's (2016) argument that 'Africa's greatest contribution to bioethics might be in engaging, elaborating and enriching the foundational moral content of bioethics' rather than 'categorical rejection of Western conceptualised Principlism' (p. 5).

The responses demonstrate how African moral philosophy can provide resources for addressing contemporary bioethical challenges while remaining grounded in indigenous values and worldviews. The compartmentalised approaches, while professionally adequate, suggest the need for what Ssebunnya (2016) identifies as more comprehensive "conceptual bioethics" education that can help healthcare workers integrate African moral principles into their practice. This supports Behrens' (2013) call for bioethics education that emphasises "flourishing human relationships" rather than abstract principle application.

The concept of human flourishing as central to African bioethical development finds robust theoretical grounding in South African feminist theological scholarship, particularly through Nadia Marais' systematic theological exploration of contemporary soteriological discourses (Marais, 2011).

Marais' work identifies three distinct discourses on salvation that each contribute unique dimensions to understanding human flourishing: salvation as reconciliation (emphasising piety, joy, and comfort), salvation as liberation (emphasising fulfilled life, healing, and dignity), and salvation as transformation (emphasising grace, happiness, and blessing) (Marais, 2011). Her analysis demonstrates that human flourishing encompasses "healing, beauty and pleasure", concepts that resonate deeply with African Ubuntu philosophy's emphasis on communal wellbeing and holistic human development (Marais, 2013).

This theoretical framework is further enriched by Denise Ackermann's foundational contribution to African feminist theology, which portrays human flourishing as encompassing "liberation, grace and the goodness of life" with particular emphasis on "abundant life for all" (Marais, 2014).

Ackermann's theological methodology, grounded in the lived experiences of South African women, demonstrates how contextual theology can address "the theological problem of suffering" while promoting "integral liberation of the person and community" (Egan, 2003). Her emphasis on identity formation through "loving and accepting relationships" provides crucial insights for understanding how healthcare workers might navigate the integration of personal religious beliefs with professional obligations in ways that foster human flourishing (Ackermann, 2006, p. 234).

Sarojini Nadar's work as the Desmond Tutu Research Chair in Religion and Social Justice further extends this theological foundation by demonstrating how academic inquiry can be oriented toward "the flourishing of socially responsive and engaged citizens" rather than merely individual piety (Nadar, 2024). Her research on violence against women reveals how patriarchal religious interpretations can undermine human flourishing, while feminist theological approaches can provide transformative resources for promoting dignity and justice (Pillay, 2019).

This intersectional approach, developed through the Circle of Concerned African Women Theologians alongside scholars such as Miranda Pillay, provides a methodological framework for understanding how multiple forms of oppression, including those that may emerge from conflicts between religious and professional identities, can be addressed through liberatory theological praxis (Pillay, 2003; Nadar & Pillay, 2013). The significance of this South African feminist theological contribution to African bioethical development lies in its demonstration that human flourishing requires not merely the absence of harm, but the positive cultivation of conditions that enable all persons to experience "dignity and agency" within relationships characterised by love and justice (Pillay & Jakobsen, 2022). As Miranda Pillay's work on human rights culture demonstrates, this requires ongoing attention to "relational ways of becoming human" that challenge dominant power structures and create space for those "often seen as less than fully human" (Palm, 2019).

For healthcare workers navigating religious pluralism, these insights suggest that authentic integration of African moral principles requires not merely professional competence, but commitment to transformative relationships that promote the flourishing of both healthcare providers and the communities they serve.

4.8. Conclusion

This chapter outlined the data collection process and, guided by the study's theoretical framework, presented a detailed analysis of the data and key findings. A multi-layered analytical approach was employed. First, the Centrality of Religiosity Scale (CRS) was used to assess and categorise the religious centrality of healthcare workers. This was followed by an analysis of their responses against the principles of Principlism, as well as a partially adapted African-centred variant of Principlism. The next chapter will expand on these findings by discussing the implications for healthcare provision to men who have sex with men (MSM) in religiously pluralistic settings. It will also propose strategies for addressing ethical gaps in African bioethics. The final conclusion will highlight key study considerations and advocate for the progressive development of an indigenous African bioethical framework.

Chapter 5: Discussion, Study Limitations, Recommendations, and Conclusion

South Africa's post-apartheid Constitution enshrines the rights to equality, dignity, and access to healthcare. However, more than two decades later, various forms of discrimination persist within the public health system. The South African Human Rights Commission (2016) notes that race remains a primary axis of inequality, while exclusions based on HIV status, gender identity, religion, and sexual orientation, particularly concerning men who have sex with men (MSM) continue to undermine equitable care. Despite the existence of a bioethical framework that upholds non-discriminatory practice (Mahomed, 2023; Nevhutalu, 2011), MSM patients frequently experience compromised treatment, often shaped by prevailing societal disapproval of homosexuality (Mudarikwa, 2018; Muller, 2016) and the religious beliefs of healthcare providers.

My research examined how this public health problem statement affects the patient-healthcare worker relationship by endeavouring to answer, based on the study data and analysis: *How do healthcare workers navigate religious pluralism when providing healthcare to men who have sex with men (MSM)?*

In doing so, I also answer the study sub-questions: (1) Is there a correlation between healthcare workers' religious positionality and their provision of care to MSM? (2) What are the dominant religious objections to MSM among healthcare workers? and (3) What African-specific bioethical principles can guide and improve the care of sexual minorities in public health settings?

Using the Centrality of Religiosity Scale (CRS), my study first categorised 18 healthcare workers as religious, non-religious, or highly religious. Guided by the Principlism framework and adapted to include African-centric principles, the analysis examined how healthcare workers navigate religious pluralism in the context of providing care to men who have sex with men (MSM). It explored the extent to which religious positionality influences clinical behavior, and identified the most commonly expressed religious objections. My analysis also considered how African bioethical concepts, particularly *Ubuntu*, can contribute to reimagining care for sexual minorities in ways that resonate with both constitutional values and the moral realities of local communities.

5.1. Synthesis of Findings Against Research Questions

How do healthcare workers navigate religious pluralism in the provision of healthcare to MSM?

The analysis presented in Chapter four challenges the prevailing assumption that heightened religious belief among healthcare workers inevitably leads to discriminatory practices against sexual minorities. Contrary to expectations, the data reveal that many religiously committed healthcare professionals actively engage in strategies that balance their personal convictions with professional ethical obligations. These individuals do not simply resist the demands of bioethics; rather, they employ their religious frameworks to support ethical care, often reinforcing principles such as human dignity, compassion, and justice.

Healthcare workers demonstrated a capacity to maintain fidelity to the four principles of Principlism; autonomy, beneficence, non-maleficence, and justice, while navigating the complexities of religious pluralism. In particular, highly religious participants often demonstrated a pronounced commitment to justice, understood not merely as fairness, but as harmony, inclusion, and equity, aligning closely with Behrens' (2013) redefined principle of *Justice as Harmony*.

This finding disrupts the notion that religiosity is inherently at odds with inclusive healthcare and instead supports the idea that religious belief can serve as a resource for ethical practice.

Is there a correlation between healthcare workers' religious positionality and their provision of care to MSM?

The data indicate that while religious beliefs influence individual perspectives, they do not uniformly determine clinical behaviour. In fact, healthcare workers across a range of religious affiliations displayed a consistent commitment to patient welfare, particularly through the principle of *beneficence*. This shared value, which transcended denominational lines, highlights a powerful unifying ethic among healthcare workers that prioritises the wellbeing of patients over doctrinal differences. Importantly, those who integrated African moral philosophies into their ethical outlook, especially Ubuntu, exhibited greater flexibility and cultural competence in handling religious pluralism.

Ubuntu, with its emphasis on relational personhood and communal responsibility, allowed healthcare workers to honour both personal and religious values while engaging in respectful, non-discriminatory care. As Behrens (2013) argues, African ethical traditions offer distinct resources that can enrich and localise global bioethical discourse.

What are the dominant religious objections to MSM among healthcare workers?

The study identified several dominant religious objections to MSM identities and behaviours. These were primarily rooted in interpretations of sacred texts, doctrinal teachings, and community norms. However, even among those who voiced theological objections, many adopted harm-reduction approaches or invoked the principle of non-maleficence to justify compassionate care.

Some participants explicitly differentiated between personal belief and professional duty, maintaining that their role as healthcare providers required them to uphold the rights and dignity of all patients. A minority of responses reflected overt conflict between religious doctrine and ethical care, particularly when participants felt unsupported by institutional policies or lacked bioethical guidance. Nevertheless, the overall trend was one of negotiation and adaptation, not outright refusal of care.

What African-specific bioethical principles can guide and improve the care of sexual minorities in public health settings?

The findings of this study highlight several African-specific bioethical principles that can meaningfully guide and enhance the care of sexual minorities, particularly men who have sex with men (MSM), in public health settings. Central among these are the principles rooted in Ubuntu/Botho and Ukama, which offer culturally embedded moral frameworks aligned with both individual dignity and collective responsibility. Ubuntu, often summarised by the phrase *"a person is a person through other persons"*, emphasises relational personhood, interdependence, compassion, and mutual respect (Behrens, 2013). Healthcare workers who expressed a conscious or implicit commitment to Ubuntu were more inclined to treat MSM patients with empathy and inclusion, regardless of their own personal or religious beliefs.

These practitioners often viewed health as a communal good rather than a purely individual concern, promoting care practices that involved families, spiritual leaders, and peer supporters, thereby fostering more holistic and culturally competent approaches. Building upon this foundational understanding, the concept of Ukama, a Shona ethic closely related to Ubuntu, foregrounds the importance of kinship, community connection, and interrelational ethics.

These African moral philosophies offer an alternative to strictly individualistic interpretations of autonomy common in Western bioethics, without undermining respect for persons. In fact, Behrens' (2013) redefinition of *Autonomy as Respect for Persons* and *Justice as Harmony* was strongly reflected in the narratives of participants who prioritised relational care, collective wellbeing, and conflict resolution through dialogue and inclusion rather than exclusion or moral condemnation. This relational approach to bioethics aligns with Metz's (2011) articulation of Ubuntu as a moral theory that can inform human rights frameworks, demonstrating how African philosophical traditions can enhance rather than replace universal ethical principles.

The practical application of these principles becomes particularly evident in healthcare provision for transgender individuals. Clinical guidance from the Southern African HIV Clinicians' Society recognises gender-affirming healthcare as essential, outlining primary-care-level pathways for hormones and psychosocial support (Scheibe et al., 2021). Jurisprudence such as *September v Subramoney NO and Others* affirmed transgender people's equality rights and protection from discrimination in custodial settings, with implications for access to gender expression and healthcare (Williams Institute, 2023).

Yet empirical research documents persistent barriers for trans women in public healthcare (Lunn et al., 2023). This disconnect between policy and practice underscores the need for an ethics-from-below strategy that would require participatory guideline governance (e.g., trans-led panels), narrative-based consent processes, and metrics that track time-to-hormones and respectful care as ethical key performance indicators. Furthermore, the integration of traditional healing systems exemplifies how African bioethical principles can bridge cultural practices with contemporary healthcare needs. Research demonstrates that community-based participatory research (CBPR) with mobile and key populations has proven effective in improving HIV care outcomes (Moyi et al., 2022).

CBPR in HIV care for mobile populations shows how engaging those most affected improves design, acceptability, and outcomes. Systematic reviews likewise find CBPR effective with men who have sex with men and other key populations, precisely because it redistributes agenda-setting power to communities (Rhodes et al., 2017). This approach reflects the Ubuntu principle of collective decision-making while ensuring that sexual minorities retain agency in their care processes. Moreover, studies involving traditional health practitioners delivering HIV counselling and testing services demonstrate how African healing systems can be integrated into public health responses when guided by principles of mutual respect and cultural competence (Audet et al., 2025).

The synthesis of these findings reveals critical implications for building an indigenous African (queer-attentive) bioethics that can effectively guide sexual minority care. *First*, there is a need for robust institutional architecture that establishes community-led ethics fora at hospital and provincial levels, including queer and trans representatives, traditional healers, and disability advocates. These forums must mandate that ethics committees evidence how community inputs shaped deliberations and outcomes, moving beyond tokenistic consultation to meaningful participatory governance (Ryan, 2004; Metz, 2011).

Second, healthcare systems must embrace methodological pluralism that normalises narrative methods, ethnography, and community testimony alongside principlism in ethical review. This approach reflects African moral epistemologies and queer critiques of normativity, recognising that diverse ways of knowing and being can inform ethical decision-making (Mkhize, 2008; Kähkönen & Sudenkaarne, 2018). Such methodological diversity ensures that bioethical frameworks remain responsive to the lived experiences of sexual minorities while maintaining cultural authenticity.

Third, comprehensive curricular reform must ground training in Ubuntu, power analysis, and queer bioethics, incorporating case-based learning from regional jurisprudence and service innovations (Metz, 2011; Scheibe et al., 2021). This educational transformation ensures that healthcare providers are equipped not only with technical competencies but also with the cultural sensitivity and ethical grounding necessary for inclusive care provision.

Fourth, bioethical practice must recognise legal-policy advocacy as ethical work. Where criminalisation erects structural barriers to care, ethics bodies should publicly advocate for repeal and for provider protections to deliver non-discriminatory services (Konde-Lule et al., 2024). This activist dimension of bioethics reflects the Ubuntu understanding that individual wellbeing is inseparable from collective justice and that ethical healthcare provision requires addressing systemic inequalities.

Finally, the effectiveness of these bioethical principles must be measured through evaluation by justice outcomes that track indicators meaningful to marginalised groups: respectful treatment indices, time to gender-affirming care, continuity of Antiretroviral Therapy after traditional health practitioner testing, and safety from discrimination in clinics and prisons (Audet et al., 2025; Lunn et al., 2023). This outcome-oriented approach ensures that bioethical frameworks translate into tangible improvements in care quality and accessibility for sexual minorities.

African bioethics need not choose between communitarian values and critical queer insights. The principles of Ubuntu and Ukama, when combined with participatory methodologies and community-led governance structures, provide the foundation for an indigenous bioethical framework that is both culturally authentic and inclusive of sexual diversity. Ethics from below provides the procedural bridge: it redistributes voice and authority to those historically excluded, surfaces locally resonant moral languages, and measures success by whether marginalised and gender-diverse people actually experience safe, dignified, effective care. This represents the decolonial move that transforms bioethics from a regulatory overlay into a justice-producing practice that is genuinely accountable to African communities while affirming the dignity and rights of all persons, regardless of sexual orientation or gender identity.

The study also shows that African moral philosophy enables healthcare workers to navigate religious pluralism with greater ethical clarity**.** Religious frameworks, rather than being obstacles, often provided moral language and motivation that reinforced the core bioethical principles of beneficence, justice, and respect. This supports Gordon et al.'s (2011) argument that Principlism's mid-level, adaptable principles are uniquely suited to contexts marked by moral diversity. When grounded in African communitarian values, these principles gain deeper cultural resonance and operational effectiveness.

Moreover, the analysis affirms that professional identity and formation play a critical role in supporting ethical practice. Across religious and cultural lines, healthcare workers with a strong sense of professional duty, formed through education, mentorship, and ethical reflection, were better able to resolve tensions between personal belief and professional responsibility. This finding underscores the need for bioethical education that is not only technically rigorous but also culturally grounded and identity-forming. Training that incorporates African moral frameworks alongside global ethical standards can equip healthcare workers to deliver equitable, respectful care to all patients, including sexual minorities.

Finally, the study suggests that religious diversity within healthcare teams can be an asset rather than a liability. Diverse ethical and theological perspectives provided multiple pathways to ethical care, challenging the assumption that secular uniformity is superior. Instead, inclusive teams that reflect the moral and cultural complexity of the broader society may be better equipped to serve diverse patient populations with sensitivity and integrity.

In summary, African-specific bioethical principles such as Ubuntu, Ukama, and the redefined African Principlism articulated by Behrens (2013) offer valuable guidance for improving the care of sexual minorities in public health settings. These principles reinforce dignity, relational autonomy, and justice as harmony, core values that can transform healthcare practice in pluralistic societies. Embedding these African moral philosophies into healthcare education and institutional policy can help ensure that care for sexual minorities is not only ethically sound but also culturally affirming and socially just.

5.4. Study Limitations and Research Recommendations

While these findings provide valuable insights into the relationship between religiosity and bioethical practice, I must acknowledge the following study limitations.

- The sample size of 18 healthcare workers, while sufficient for exploratory analysis, limits generalisability. The single-context nature of the study means that findings may not transfer to other geographic, cultural, or healthcare system contexts.

- The predominance of religious participants (94.4% scoring above the non-religious threshold) provides limited comparative data for understanding secular approaches to these issues. Future research should examine these patterns in more religiously diverse samples and explore long-term outcomes of different navigation strategies.

- Additionally, this analysis focuses on stated intentions and reasoning rather than observed behaviours. Future research should examine whether the sophisticated reasoning processes identified in this study translate into measurably different care outcomes for MSM patients.

5.5. Conclusion: Toward Inclusive and Contextually Grounded Bioethics

This study reveals that the relationship between religiosity and adherence to bioethical principles in the care of MSM is more nuanced and generative than conventional literature often acknowledges. Rather than presenting an inherent conflict, varying degrees of religious commitment among healthcare workers give rise to diverse and sophisticated strategies for upholding ethical standards while remaining faithful to personal convictions. The consistent emphasis on beneficence and justice across religious orientations, coupled with creative ethical negotiation strategies, demonstrates that many religious healthcare workers are already engaging in complex, contextually grounded moral reasoning.

The four strategies identified in this study; compartmentalisation, theological reframing, scientific-ethical integration, and professional duty prioritisation, serve as practical models that can inform ethical training, policy development, and institutional practices. These approaches challenge the reductive notion that religious belief is inherently at odds with inclusive healthcare, highlighting instead the ethical potential embedded in faith-informed reasoning.

Importantly, the findings affirm the potential of Principlism, particularly in its mid-level, adaptable form, as a bioethical framework capable of bridging religious diversity and professional standards. Its flexibility enables alignment between diverse moral worldviews and core healthcare values, making it especially relevant in pluralistic societies. When interpreted through local ethical idioms and relational understandings of care, Principlism becomes a powerful tool for advancing equitable and respectful healthcare practices, even in contexts of moral and cultural complexity.

From the perspective of African bioethics, the study offers four key insights that warrant scholarly and institutional action:

1. *Religiosity is not a barrier to inclusive care;* when justice is understood as harmony and autonomy as relational respect, faith and inclusive practice can be mutually reinforcing.
2. *African bioethics presents a compelling alternative* to autonomy-centric frameworks by grounding ethics in communal values, human dignity, and relational accountability.
3. *Healthcare ethics education in Africa should integrate indigenous moral philosophies* to enhance relevance and resonance with practitioners' lived realities.
4. *Policy and practice must embrace moral pluralism* as a strength, using it to inform culturally grounded guidelines and interventions, particularly for stigmatised groups such as MSM.

My study calls for a recalibration of ethical discourse and practice in African healthcare, one that honours religious and cultural diversity as a foundation, rather than a threat, to dignified and ethical care. Such an approach holds transformative potential for healthcare systems striving to uphold justice, compassion, and inclusion in increasingly diverse and morally complex societies.

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Addendum 1: University Ethical Clearance

13 September 2024

Aziel Ardon Gangerdine (208519158)
School of Rel Phil & Classics
Pietermaritzburg Campus

Dear AA Gangerdine,

Protocol reference number: HSSREC/00007579/2024
Project title: Healthcare workers negotiate religious pluralism in men who have sex with men health care provision
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 08 August 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Sche dule, 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.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid until 13 September 2025.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours sincerely,

Professor Dipane Hlalele (Chair)
/nng

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